Supplementary Files Contents

Supplementary File 1. PRISMA 2020 Checklist

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	*Title*
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	*Abstract*
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	*Introduction* section
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	*Introduction* section
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	*Methods: Study designs, Participants, Interventions, Comparisons,* and *Outcomes* sections
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	*Search strategy and selection criteria* section
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	*Supplementary File 2*
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of	*Study screening and selection*

Section and Topic	Item #	Checklist item	Location where item is reported
		automation tools used in the process.	section
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	*Data extraction* section
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	*Outcomes* section
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	*Supplementary File 5*
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	*Quality assessments* section
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	*Synthesis* section
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	*Methods* and *Results* sections
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Not applicable
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	*Methods* and *Results* sections
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	*Synthesis* section
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	*Synthesis* section
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	Not applicable
Reporting bias	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	Not applicable

Section and Topic	Item #	Checklist item	Location where item is reported
assessment			
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	Not applicable
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	*Results* section and *Supplementary File 4*
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	*Results* section and *Supplementary File 3*
Study characteristics	17	Cite each included study and present its characteristics.	*Results* section and *Supplementary File 5*
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	*Confidence in the review results* section and *Supplementary File 6*
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	*Results* section and *Supplementary File 5* (where appropriate)
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	*Results*: *Demographic domain, Economic*

Section and Topic	Item #	Checklist item	Location where item is reported
			domain, Environmental events domain, Neighbourhood domain, and *Sociocultural domain* sections
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	Not applicable
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Not applicable
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	Not applicable
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	Not applicable
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	*Results* section and *Confidence in the review results* section
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	*Discussion* section and *Challenges and potential solutions* section
	23b	Discuss any limitations of the evidence included in the review.	*Limitations of the review* section
	23c	Discuss any limitations of the review processes used.	*Limitations of*

Section and Topic	Item #	Checklist item	Location where item is reported
			the review section
	23d	Discuss implications of the results for practice, policy, and future research.	*Discussion* section
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	*Methods* section
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	*Methods* section
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	Not applicable
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	*Funding* section
Competing interests	26	Declare any competing interests of review authors.	*Declarations of interest* section
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	*Supplementary Files*

Supplementary File 2. Search strategies for review

Search strategies are outlined here for each domain and the databases searched. Search string #1 for each domain (a = demographic, b = economic, c = neighbourhood, d = environmental events, and e = sociocultural) is combined with search strings #2 (outcome), #3 (study type) and #4 (limits/filters) in each database (PubMed, PsycInfo, and Scopus).

PubMed logic grid (#1 AND #2 AND #3 AND #4) – search in "All Fields"

#1a (Demographic)	#1b (Economic)	#1c (Neighbourhood)	#1d (Environmental events)	#1e (Sociocultural)	#2	#3	#4
Interventions	**Interventions**	**Interventions**	**Interventions**	**Interventions**	**Outcome**	**Study type**	**Limits / Filters**
((Gender-Based Violence[Mesh] OR Child Abuse[Mesh] OR Adverse Childhood Experiences[Mesh] OR Racism[Mesh] OR Xenophobia[Mesh] OR Men's Health[Mesh] OR Sexual and Gender Minorities[Mesh] OR LGBT* OR lesbian* OR gay OR bisexual* OR transgender OR non-binary OR queer OR "gender norm*" OR "gender-based violence" OR	((Economic Stability[Mesh] OR Economic Status[Mesh] OR Poverty[Mesh] OR Income[Mesh] OR Employment[Mesh] OR "social protection system*" OR "cash transfer*" OR "income grant*" OR "income equality" OR "income inequality" OR "income equity" OR "income inequity" OR employment) AND (Psychosocial Intervention[Mesh] OR Internet-Based Intervention[Mesh]	((Residence Characteristics[Mesh] OR Housing Instability[Mesh] OR Poverty Areas[Mesh] OR Rural Population[Mesh] OR Urban Population[Mesh] OR Sanitation[Mesh] OR Waste Management[Mesh] OR Recycling[Mesh] OR Sports and Recreational Facilities[Mesh] OR Parks, Recreational[Mesh] OR housing OR "housing security" OR	((Natural Disasters[Mesh] OR Climate Change[Mesh] OR Ecosystem[Mesh] OR Disaster Planning[Mesh] OR avalanche* OR cyclone* OR drought* OR earthquake* OR flood* OR landslide* OR "tidal wave*" OR tsunami* OR tornado* OR hurricane* OR wildfire* OR "bush fire*" OR bushfire* OR "natural disaster*" OR "heat wave*" OR heatwave* OR "global warming"	((Education[Mesh:noexp] OR Social Capital[Mesh] OR "social capital" OR "improved education" OR "access education" OR "education access" OR "better education" OR "increased education" OR Indigenous Peoples[Mesh] OR "Indigenous knowledge" OR "Indigenous culture*" OR "Aboriginal knowledge" OR "Aboriginal culture*" OR ((Social Support[Mesh] OR Social	(Mental Disorders[Majr] OR Mental Health[Mesh] OR Depression[Majr] OR Depressive Disorder[Mesh] OR Depression, Postpartum[Majr] OR Bipolar Disorder[Mesh] OR Developmental Disabilities[Mesh] OR Adjustment Disorders[Mesh] OR Mood Disorders[Majr] OR Stress Disorders, Traumatic[Mesh] OR Stress Disorders, Post-Traumatic[Mesh] OR Attention Deficit and Disruptive Behavior Disorders[Mesh] OR Anxiety Disorders[Mesh] OR Schizophrenia[Mesh] OR Psychological Trauma[Mesh] OR Psychotic Disorders[Mesh] OR Dementia[Mesh] OR Epilepsy[Mesh] OR Substance-Related Disorders[Mesh] OR Alcoholism[Majr] OR "severe mental disorder*" OR "mental	(Review[ptyp] OR review OR meta-analysis OR "systematic review")	(("2012/01/01"[PDAT] : "2022/10/04"[PDAT]) AND humans[MeSH Terms])

“gender violence” OR “child abuse” OR “child maltreatment” OR “child neglect” OR “adverse childhood” OR racism OR “racial discrimination” OR xenophobia) AND (Psychosocial Intervention[Mesh] OR Internet-Based Intervention[Mesh] OR Crisis Intervention[Mesh] OR Early Intervention, Educational[Mesh] OR Early Medical Intervention[Mesh] OR Pilot Projects[Mesh] OR Randomized Controlled Trials as Topic[Mesh] OR Non-Randomized Controlled Trials as Topic[Mesh] OR intervention* OR “randomised	OR Crisis Intervention[Mesh] OR Early Intervention, Educational[Mesh] OR Early Medical Intervention[Mesh] OR Pilot Projects[Mesh] OR Randomized Controlled Trials as Topic[Mesh] OR Non-Randomized Controlled Trials as Topic[Mesh] OR intervention* OR “randomised controlled trial*” OR “randomized controlled trial*” OR RCT* OR program* OR pilot OR “natural experiment*” OR trial))	“housing quality” OR neighbourhood* OR neighborhood* OR sanitation OR “waste management” OR recycling OR “open space*” OR “public open space*”) AND (Psychosocial Intervention[Mesh] OR Internet-Based Intervention[Mesh] OR Crisis Intervention[Mesh] OR Early Intervention, Educational[Mesh] OR Early Medical Intervention[Mesh] OR Pilot Projects[Mesh] OR Randomized Controlled Trials as Topic[Mesh] OR Non-Randomized Controlled Trials as Topic[Mesh] OR intervention* OR “randomised	OR "climate change" OR ecosystem* OR biodivers* OR "vulnerable ecosystem*" OR "disaster prepar*" OR "disaster plan*" OR Violence[Mesh] OR Warfare[Majr] OR Riots[Mesh] OR Armed Conflicts[Majr] OR Radiation Exposure[Majr] OR Accidents[Majr] OR Refugees[Mesh] OR Transients and Migrants[Mesh] OR Relief Work[Mesh] OR war* OR riot* OR "armed conflict*" OR "radiation exposure" OR refugee* OR migrant* OR "asylum seeker*") AND (Psychosocial Intervention[Mesh] OR Internet-Based Intervention[Mesh] OR Crisis Intervention[Mesh] OR Early Intervention,	Networking[Mesh] OR "social support*" OR "social network*" OR "social connection*") AND (Aged[Mesh] OR Aged, 80 and over[Mesh] OR "older adult*" OR "old adult*" OR "older people" OR "old people" OR elderly OR senior)) OR ((Schools[Majr] OR school*) AND (Bullying[Mesh] OR bully* OR Social Learning[Mesh] OR "social learning" OR "social skill*" OR "emotional skill*" OR "socioemotional" OR "social and emotional"))) AND (Psychosocial Intervention[Mesh] OR Internet-Based Intervention[Mesh] OR Crisis Intervention[Mesh] OR Early Intervention, Educational[Mesh] OR Early Medical Intervention[Mesh] OR Pilot	illness" OR "mental health" OR "mental disorder*" OR depress* OR "mood disorder*" OR anxiety OR "affective disorder*" OR "bipolar disorder" OR schizophrenia OR "common mental disorder*" OR "severe mental disorder*" OR "substance abuse" OR “substance misuse” OR alcoholism OR addiction OR epilepsy OR dementia)		

controlled trial*” OR “randomized controlled trial*” OR RCT* OR program* OR pilot OR “natural experiment*” OR trial))		controlled trial*” OR “randomized controlled trial*” OR RCT* OR program* OR pilot OR “natural experiment*” OR trial))	Educational[Mesh] OR Early Medical Intervention[Mesh] OR Pilot Projects[Mesh] OR Randomized Controlled Trials as Topic[Mesh] OR Non-Randomized Controlled Trials as Topic[Mesh] OR intervention* OR “randomised controlled trial*” OR “randomized controlled trial*” OR RCT* OR program* OR pilot OR “natural experiment*” OR trial))	Projects[Mesh] OR Randomized Controlled Trials as Topic[Mesh] OR Non-Randomized Controlled Trials as Topic[Mesh] OR intervention* OR “randomised controlled trial*” OR “randomized controlled trial*” OR RCT* OR program* OR pilot OR “natural experiment*” OR trial))			

PsycInfo logic grid (#1 AND #2 AND #3 AND Limiters)

#1a (Demographic)	#1b (Economic)	#1c (Neighbourhood)	#1d (Environmental events)	#1e (Sociocultural)	#2	#3	
Intervention	**Intervention**	**Intervention**	**Intervention**	**Intervention**	**Outcome**	**Study type**	**Limiters**
((Intimate Partner Violence.mp. OR gender-based violence.mp. OR Child Abuse.mp. OR Childhood Adversity.mp OR child maltreatment.mp. OR child neglect.mp. OR adverse child*.mp. OR Racism.mp. OR racial discrimination.mp. OR Xenophobia.mp. OR mens health.mp. OR mens mental health.mp. OR male mental health.mp. OR Sexual Minority Groups.mp. OR Gender Identity.mp. OR LGBT*.mp. OR lesbian*.mp. OR gay.mp. OR	((Economic Security.mp. OR Economic Inequality.mp. OR Economic Disadvantage.mp. OR poverty.mp. OR socioeconomic status.mp. OR Social protection system*.mp. OR income.mp. OR employment.mp. OR cash transfer*.mp.) AND (exp Intervention/ OR intervention*.mp. OR pilot*.mp. OR randomi?ed controlled trial*.mp. OR RCT*.mp. OR non-randomi?ed controlled trial*.mp. OR program*.mp. OR natural experiment*.mp. OR trial*.mp.))	((Hous*.mp. OR home.mp. OR Community Facilit*.mp. OR recreation area*.mp. OR Neighborhood*.mp. OR Neighbourhood*.mp. OR urban environment*.mp. OR rural environment*.mp. OR sanitation.mp. OR waste management.mp. OR recycl*.mp. OR open space*.mp. OR public space*.mp. OR Poverty Area*.mp. OR residential.mp. OR residence.mp.) AND (exp Intervention/ OR intervention*.mp. OR pilot*.mp. OR randomi?ed controlled trial*.mp. OR	((Natural disaster*.mp. OR emergency preparedness.mp. OR emergency management.mp. OR disaster plan*.mp. OR disaster prepar*.mp. OR accident*.mp. OR avalanche*.mp. OR cyclone*.mp. OR drought*.mp. OR earthquake*.mp. OR flood*.mp. OR landslide*.mp. OR tidal wave*.mp. OR tsunami*.mp. OR tornado*.mp. OR wildfire*.mp. OR bush fire*.mp. OR bushfire*.mp. OR heatwave*.mp. OR heat wave*.mp. OR hurricane*.mp. OR climate change.mp. OR global warming.mp. OR ecosystem*.mp.	((Education.sh. OR social capital.mp. OR improved education.mp. OR access education.mp. OR education access.mp. OR better education.mp. OR increased education.mp. OR Indigenous population*.mp. OR Indigenous knowledge.mp. OR Indigenous culture*.mp. OR Aboriginal knowledge.mp. OR Aboriginal culture*.mp. OR ((social support*.mp. OR social connection*.mp. OR social network*.mp.) AND (old* adult*.mp. OR old*	(Mental Disorder*.mp. OR Mental Health.mp. OR mental illness.mp. OR depress*.mp. OR Major Depression.mp. OR Postpartum Depression.mp. OR Anxiety.mp. OR Anxiety Disorders.mp. OR Affective Disorder*.mp. OR mood disorder*.mp. OR Bipolar Disorder*.mp. OR Schizophrenia.mp. OR Psychosis.mp. OR common mental disorder*.mp. OR severe mental disorder*.mp. OR Substance Related and Addictive Disorders.mp. OR alcoholism.mp. OR	(Systematic Review.mp. OR Meta Analysis.mp. OR review.mp.)	Limiters - Publication Year: 2012-2022

bisexual*.mp. OR queer.mp. OR non-binary.mp. OR transgender.mp. OR Social Norms.mp. OR gender norm*.mp.) AND (exp Intervention/ OR intervention*.mp. OR pilot*.mp. OR randomi?ed controlled trial*.mp. OR RCT*.mp. OR non-randomi?ed controlled trial*.mp. OR program*.mp. OR natural experiment*.mp. OR trial*.mp.))		RCT*.mp. OR non-randomi?ed controlled trial*.mp. OR program*.mp. OR natural experiment*.mp. OR trial*.mp.))	OR biodivers*.mp. OR violence.mp. OR war*.mp. OR conflict*.mp. OR riot*.mp. OR radiation exposure.mp. OR chemical exposure.mp. OR refugee*.mp. OR migrant*.mp. OR asylum seeker*.mp.) AND (exp Intervention/ OR intervention*.mp. OR pilot*.mp. OR randomi?ed controlled trial*.mp. OR RCT*.mp. OR non-randomi?ed controlled trial*.mp. OR program*.mp. OR natural experiment*.mp. OR trial*.mp.))	people.mp. OR old* person*.mp. OR elderly.mp. OR senior*.mp. OR old* age.mp.)) OR ((Academic Settings.sh. OR school*.mp.) AND (bully*.mp. OR social emotional learning.mp. OR social skill*.mp. OR emotional skill*.mp. OR socioemotional.mp. OR social and emotional.mp.))) AND (exp Intervention/ OR intervention*.mp. OR pilot*.mp. OR randomi?ed controlled trial*.mp. OR RCT*.mp. OR non-randomi?ed controlled trial*.mp. OR program*.mp. OR natural experiment*.mp. OR trial*.mp.))	addiction.mp. OR substance abuse.mp. OR substance misuse.mp. OR epilepsy.mp. OR dementia.mp. OR Stress.mp. OR Trauma.mp. OR Stress and Trauma Related Disorders.mp. OR PTSD.mp. OR posttraumatic stress disorder.mp. OR post traumatic stress disorder.mp. OR Developmental Disabilities.mp. OR developmental disorder*.mp. OR behavi?r* disorder*.mp. OR Adjustment Disorder*.mp. OR attention deficit.mp. OR ADHD.mp.)		

Scopus logic grid (#1 AND #2 AND #3 AND Limiters/Filters)

#1a (Demographic)	#1b (Economic)	#1c (Neighbourhood)	#1d (Environmental events)	#1e (Sociocultural)	#2	#3	
Intervention	**Intervention**	**Intervention**	**Intervention**	**Intervention**	**Outcome**	**Study type**	**Limiters / Filters**
TITLE-ABS-KEY (({Intimate Partner Violence} OR {gender-based violence} OR {Child Abuse} OR {Childhood Adversity} OR {adverse childhood} OR {child maltreatment} OR {child neglect} OR Racism OR {racial discrimination} OR Xenophobia OR {men's health} OR {men's mental health} OR {male mental health} OR {Sexual Minority} OR {sexual minorities} OR	TITLE-ABS-KEY (({Economic Security} OR {financial security} OR {economic stability} OR {financial stability} OR {economic status} OR {Economic Inequality} OR {income inequality} OR {income equity} OR {income equality} OR {income inequity} OR {Economic Disadvantage} OR poverty OR {socioeconomic status} OR {Social	TITLE-ABS-KEY((House OR housing OR home OR {Community Facility} OR {community facilities} OR {recreation area} OR {recreation areas} OR {recreational area} OR {recreational areas} OR Neighborhood* OR Neighbourhood* OR {urban environment} OR {urban environments} OR {rural environment} OR {rural environments} OR sanitation OR {waste management} OR recycling OR	TITLE-ABS-KEY(({natural disaster} OR {natural disasters} OR {emergency preparedness} OR {emergency management} OR {disaster planning} OR {disaster plan} OR {disaster preparation} OR {disaster preparations} OR avalanche* OR cyclone* OR drought* OR earthquake* OR flood* OR landslide* OR {tidal wave} OR {tidal waves} OR tsunami* OR tornado* OR wildfire* OR {bush fire} OR {bush fires} OR bushfire* OR	TITLE-ABS-KEY(({social capital} OR {improved education} OR {access education} OR {education access} OR {better education} OR {increased education} OR {Indigenous population} OR {Indigenous populations} OR {Indigenous knowledge} OR {Indigenous culture} OR {Indigenous cultures} OR {Aboriginal knowledge} OR {Aboriginal culture} OR {Aboriginal cultures} OR	TITLE-ABS-KEY({Mental Disorder} OR {mental disorders} OR {Mental Health} OR {severe mental disorder} OR {severe mental disorders} OR {mental illness} OR Depression OR Depressive OR {Mood Disorder} OR {mood disorders} OR {affective disorder} OR {affective disorders} OR Stress OR Anxiety OR Schizophrenia OR {Bipolar Disorder} OR {Psychological Trauma} OR PTSD OR {Psychotic Disorder} OR Dementia OR Epilepsy OR Alcoholism OR {substance abuse} OR {substance misuse} OR addiction OR {Developmental Disability} OR {Developmental disabilities} OR {Adjustment Disorder} OR {adjustment disorders} OR {Attention Deficit})	TITLE-ABS-KEY({systematic review} OR review OR meta-analysis OR {meta analysis})	Published 2012 – 2022 Run the search then "Filter by" and "Limit to" each of the years from 2012 to 2022.

{Gender Identity} OR LGBT* OR lesbian* OR gay OR bisexual* OR queer OR non-binary OR transgender OR {Social Norms} OR {gender norm} OR {gender norms}) AND (intervention* OR pilot OR {randomised controlled trial} OR {randomised controlled trials} OR {randomized controlled trial} OR {randomized controlled trials} OR RCT OR {non-randomised controlled trial} OR {non-randomised controlled trials} OR {non-randomized controlled trial} OR {non-randomized controlled trials}	protection system} OR {social protection systems} OR employment OR {cash transfer} OR {cash transfers} OR {income grant} OR {income grants}) AND (intervention * OR pilot OR {randomised controlled trial} OR {randomised controlled trials} OR {randomized controlled trial} OR {randomized controlled trials} OR RCT OR {non-randomised controlled trial} OR {non-randomised controlled trials}	{open space} OR {open spaces} OR {public space} OR {public spaces} OR residential OR residence) AND (intervention* OR pilot OR {randomised controlled trial} OR {randomised controlled trials} OR {randomized controlled trial} OR {randomized controlled trials} OR RCT OR {non-randomised controlled trial} OR {non-randomised controlled trials} OR {non-randomized controlled trial} OR {non-randomized controlled trials} OR program* OR {natural experiment} OR {natural experiments} OR trial*))	heatwave* OR {heat wave} OR {heat waves} OR hurricane* OR {climate change} OR {global warming} OR ecosystem* OR biodivers* OR war OR warfare OR conflict OR riot OR {radiation exposure} OR {chemical exposure} OR refugee* OR migrant* OR {asylum seeker} OR {asylum seekers}) AND (intervention* OR pilot OR {randomised controlled trial} OR {randomised controlled trials} OR {randomized controlled trial} OR {randomized controlled trials} OR RCT OR {non-randomised controlled trial} OR {non-randomised controlled trials}	(({social support} OR {social supports} OR {social connection} OR {social connections} OR {social network} OR {social networks}) AND ({old adults} OR {older adults} OR {old people} OR {older people} OR elderly OR senior* OR {old age} OR {older age})) OR (({Academic Setting} OR {academic settings} OR school*) AND (bully* OR {social emotional learning} OR {social skills} OR {emotional skills} OR socioemotional OR {social and emotional}))) AND (intervention*			

OR program* OR {natural experiment} OR {natural experiments} OR trial*))	trials} OR {non-randomized controlled trial} OR {non-randomized controlled trials} OR program* OR {natural experiment} OR {natural experiments} OR trial*))		OR {non-randomized controlled trial} OR {non-randomized controlled trials} OR program* OR {natural experiment} OR {natural experiments} OR trial*))	OR pilot OR {randomised controlled trial} OR {randomised controlled trials} OR {randomized controlled trial} OR {randomized controlled trials} OR RCT OR {non-randomised controlled trial} OR {non-randomised controlled trials} OR {non-randomized controlled trial} OR {non-randomized controlled trials} OR program* OR {natural experiment} OR {natural experiments} OR trial*))			

Contacting experts:

We contacted all authors of the Lund et al. (2018) review (n = 16 experts), as well as the corresponding author for each included review (n = 86 experts), to request any additional studies that we may have missed. Thirteen experts could not be reached and, after one month, 61 did not respond, 10 responded confirming no new suggestions, eight responded with suggestions which were not eligible for inclusion (or had already been included/excluded in the process), and 10 experts responded with 12 new suggestions which were eligible for inclusion (one which had been previously excluded by title and abstract).

Supplementary File 3. Studies excluded at full-text stage, with reasons (n = 554)

Excluded due to study design (did not use a systematic methodology, including a systematic search and selection of studies)

- Abeldaño RA, Fernández R. Community Mental Health in disaster situations. A review of community-based models of approach. Cien Saude Colet. 2016;21(2):431-42.
- Abreu RL, Black WW, Mosley DV, Fedewa AL. LGBTQ Youth Bullying Experiences in Schools: The Role of School Counselors Within a System of Oppression. Journal of Creativity in Mental Health. 2016;11(3-4):325-42.
- Ai AL, Foster LJ, Pecora PJ, Delaney N, Rodriguez W. Reshaping child welfare's response to trauma: Assessment, evidence-based intervention, and new research perspectives. Research on Social Work Practice. 2013;23(6):651-68.
- Alaimo K, Beavers AW, Crawford C, Snyder EH, Litt JS. Amplifying Health Through Community Gardens: A Framework for Advancing Multicomponent, Behaviorally Based Neighborhood Interventions. Curr Environ Health Rep. 2016;3(3):302-12.
- Alvarez K, Cervantes PE, Nelson KL, Seag DEM, Horwitz SM, Hoagwood KE. Review: Structural Racism, Children's Mental Health Service Systems, and Recommendations for Policy and Practice Change. J Am Acad Child Adolesc Psychiatry. 2022;61(9):1087-105.
- Anne Pearlman L. Restoring Self in Community: Collective Approaches to Psychological Trauma after Genocide. Journal of Social Issues. 2013;69(1):111-24.
- Ashida S, Schafer EJ. Social networks, social relationships, and their effects on the aging mind and brain. The Wiley Handbook on the Aging Mind and Brain. 2017:17-36.
- Atwool N. Intensive intervention with families experiencing multiple and complex challenges: An alternative to child removal in a bi- and multi-cultural context? Child and Family Social Work. 2021;26(4):550-8.
- Augusterfer EF, Mollica RF, Lavelle J. A review of telemental health in international and post-disaster settings. Int Rev Psychiatry. 2015;27(6):540-6.
- Ayalon L, Perel-Levin S, Georgantzi N, Lima CDM. Participation of Older Persons With Mental Health Conditions and Psychosocial Disabilities in the Labor Market. American Journal of Geriatric Psychiatry. 2021;29(10):1033-7.
- Badland H, Pearce J. Liveable for whom? Prospects of urban liveability to address health inequities. Soc Sci Med. 2019;232:94-105.
- Baranov V, Cameron L, Contreras Suarez D, Thibout C. Theoretical Underpinnings and Meta-analysis of the Effects of Cash Transfers on Intimate Partner Violence in Low- and Middle-Income Countries. Journal of Development Studies. 2021;57(1):1-25.
- Başoğlu M. Control-Focused Behavioral Treatment: A brief intervention for survivors of war and torture. Torture. 2022;32(1-2):251-63.
- Bauer A, Garman E, McDaid D, Avendano M, Hessel P, Díaz Y, et al. Integrating youth mental health into cash transfer programmes in response to the COVID-19 crisis in low-income and middle-income countries. The Lancet Psychiatry. 2021;8(4):340-6.
- Beck AF, Cohen AJ, Colvin JD, Fichtenberg CM, Fleegler EW, Garg A, et al. Perspectives from the Society for Pediatric Research: interventions targeting social needs in pediatric clinical care. Pediatric Research. 2018;84(1):10-21.
- Bertulies-Esposito B, Sicotte R, Iyer SN, Delfosse C, Girard N, Nolin M, et al. [Early Detection and Intervention for Psychosis: Why and How?]. Sante Ment Que. 2021;46(2):45-83.
- Blay-Tofey M, Lee BX. Preventing gender-based violence engendered by conflict: The case of Côte d'Ivoire. Social Science and Medicine. 2015;146:341-7.
- Bonar EE, DeGue S, Abbey A, Coker AL, Lindquist CH, McCauley HL, et al. Prevention of sexual violence among college students: Current challenges and future directions. J Am Coll Health. 2022;70(2):575-88.
- Borgi M, Collacchi B, Correale C, Marcolin M, Tomasin P, Grizzo A, et al. Social farming as an innovative approach to promote mental health, social inclusion and community engagement. Ann Ist Super Sanita. 2020;56(2):206-14.
- Bothe DA, Olness KN, Reyes C. Overview of Children and Disasters. J Dev Behav Pediatr. 2018;39(8):652-62.

- Bowman S, McKinstry C, McGorry P. Youth mental ill health and secondary school completion in Australia: time to act. Early Interv Psychiatry. 2017;11(4):277-89.
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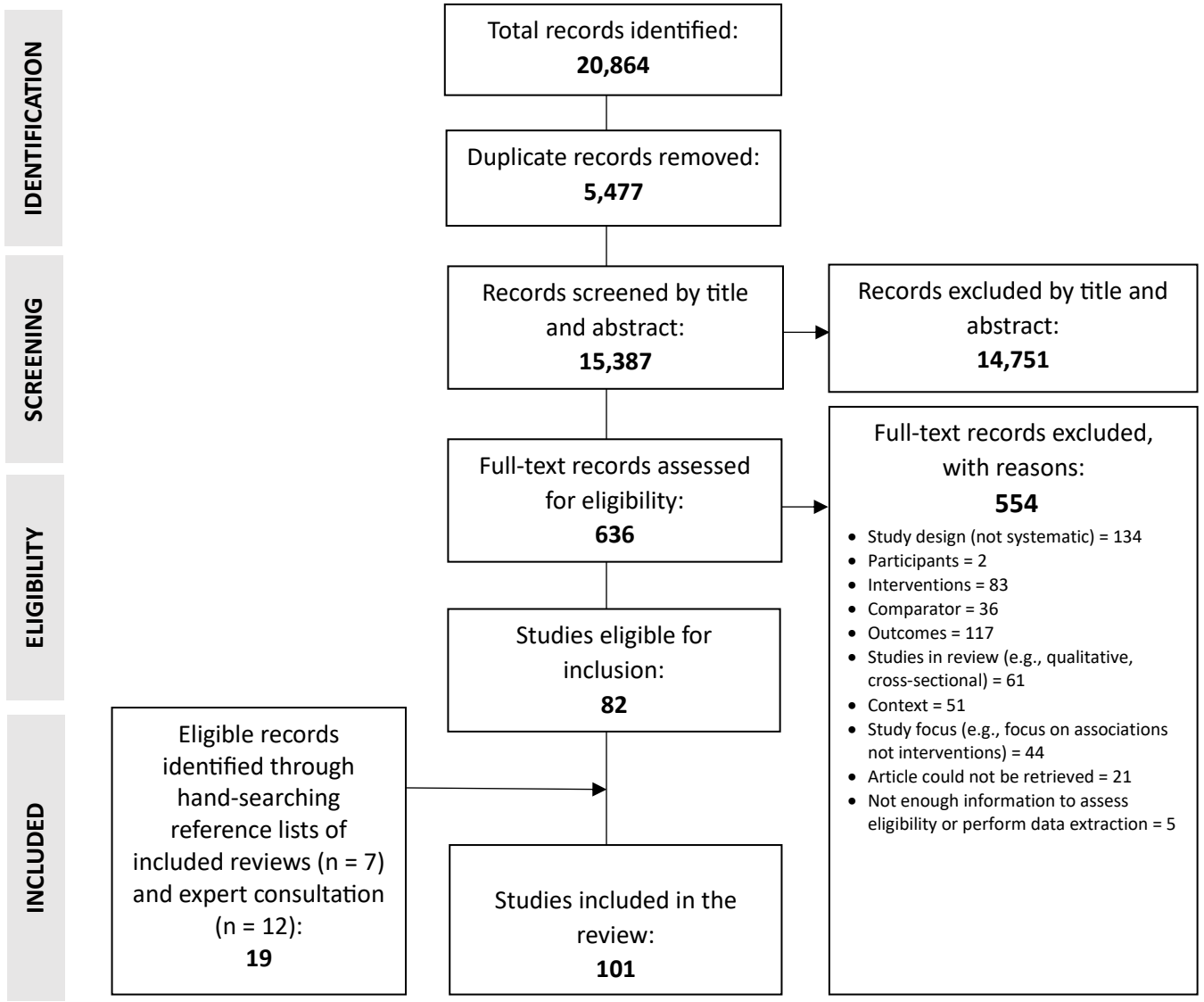
Supplementary File 4. PRISMA flow diagram for study identification, screening, and selection



Supplementary File 5. Detailed description of all included reviews (N = 101)

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
DEMOGRAPHIC DOMAIN (15 reviews)										
Asgary R, Emery E, Wong M. Systematic review of prevention and management strategies for the consequences of gender-based violence in refugee settings. Int Health. **2013**;5(2):85-91.	Systematic review; Preventing or managing the consequences of gender-based violence in displaced populations; 0/0; Not applicable	Refugees or displaced persons; Not applicable; Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	The authors did not find any publications that evaluated strategies to prevent and/or manage gender-based violence in displaced populations	Not applicable; Low confidence
Branco, M. S. S., Altafim, E. R. P., & Linhares, M. B. M. (**2021**). Universal Intervention to Strengthen Parenting and Prevent Child Maltreatment: Updated Systematic Review. Trauma, Violence, and Abuse.	Systematic review; Preventing child maltreatment; 6/18; RCTs (3), Quasi-experiments (3)	Parents and children; N = 1131 I = 635 C = 496; Brazil (1), Liberia (1), UK (1), USA (3)	All interventions were face-to-face group-based universal parenting programs to strengthen parenting skills and prevent maltreatment of children	Waiting list (4), usual care (1), unclear (1)	Child behaviour (SDQ, IBQ, CARE Index, ECBI, CABI); Mental health (CESD, EPDS, STAI, PSWQ)	Intervention effects were mixed, and effect sizes were not reported. Reduced child externalising and internalizing symptoms were reported in 2 studies. Improved emotional and behavioural regulation of children was reported in 1 study. Parental stress improved in 1 study, but no intervention effect was found in 3 studies. Reduction in parent's worry and depression levels was reported in one study, but not in 2 others. One study reported reduced anxious parenting.	Some studies showed improvement in parental outcomes – improved couple relationships, co-parenting, coping ability, and communication, and reduced physical violence and conflict. Improvements in caregiver-child positive interactions were reported in one study, but no significant difference in caregiver-child communication.	Parenting programs support positive relationships between parents and parent-child and increase parental skills to prevent maltreatment of children. Programs aim to improve outcomes of parents + children through improve parental knowledge and understanding of child development, reduced parental stress and improvement of positive parenting practices which resultantly improves child emotional and behavioural functioning and regulation.	Selection bias, poor blinding, and issues with data collection methods in the included studies.	High quality (1), moderate quality (2), weak quality (3); Low confidence
Chen M, Chan KL. Effects of Parenting Programs on Child Maltreatment Prevention: A Meta-Analysis. Trauma Violence Abuse. **2016**;17(1):88-104.	Meta-analysis; Reducing child maltreatment; 8/31; RCTs (8)	Parents; N = 1817 I = 959 C = 858; Reported for whole review (n unknown): Australia, Canada, Iran, New Zealand, Thailand, UK, USA	Reported for whole review: Primary, secondary, or tertiary prevention programs that particularly focused on child maltreatment, including home visiting service or parent training.	Reported for whole review: Treatment as usual	Parental depression (BDI, BSI, CESD, CIDI, DASS, SCL-90-R).	Parenting programmes were found to have only a small (and non-significant) positive effect on reducing parental depression. The effect size on the reduction of parental depression was very small (n=8, random effect size 0.026 (95% CI -0.078-0.129), p=0.565). The test of heterogeneity demonstrated that there was little variance between the tests of parental depression ($I^2 = 0$).	Parenting programmes were found to successfully reduce child maltreatment reports (n=31, random effect size 0.296, 95% CI 0.177-0.416, p<0.01).	In this study, parental depression was seen as a variable on the pathway between parenting programmes and child maltreatment, rather than an outcome itself. Parenting programmes are believed to reduce modifiable parental risk factors associated with child maltreatment (including parental depression).	It was not possible to draw conclusions about the impact of parenting programmes over time, as few studies conducted follow-up evaluations	Quality varied for relevant studies. On a modified version of the CONSORT checklist (where 12 points was highest quality), 1 study = 6 points, 1 study = 7 points, 2 studies = 8 points, 1 study = 10 points, 3 studies = 11 points; Low confidence

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
Drew RJ, Morgan PJ, Pollock ER, Young MD. Impact of male-only lifestyle interventions on men's mental health: A systematic review and meta-analysis. Obes Rev. **2020**;21(7):e13014.	Systematic review and meta-analysis; Men's mental health; 6/9; RCTs (6)	Males aged 18 to 65 years old; N = 1057; Australia (1), Canada (1), Finland (1), UK (2), USA (1)	Lifestyle behaviour change interventions that explicitly targeted physical activity, diet, or sedentary behaviour for general health and well-being or weight loss. Examples of gender tailoring were shown in the setting (e.g., sporting venues and male-dominated workplaces), program materials (e.g., men's health literature and gender-specific strategies), and methods of communication that men are thought to prefer (e.g., frank and direct approach and thoughtful use of humour).	No intervention	Mental health (MHC-SF, RAND-36), Psychological health (DASS-21), Psychological distress (K-10), Stress (cortisol), Depression (CES-D), Mood (POMS), and Negative affect (PANAS).	Male-only behaviour change programs can improve men's mental health in some circumstances, however, intervention effects on mental health outcomes were mostly small, and the majority were not significantly different from changes in the control groups. Three sports-focused interventions were based on the Football Fans in Training program, tested in different populations. In 2 studies, no significant intervention effects on negative affect were reported, while in one study significant between-group results were found at 12 weeks for negative affect, remaining significant at 12-month follow-up (effect size unknown). In one workplace study for men in the Navy, significant group-by-time effect indicated an improvement in depressive symptoms favouring the intervention group. In 2 university/clinic-based interventions, no statistically significant intervention effects were detected for MH outcomes. 3 studies were included in a meta-analysis looking at negative affect as the outcome. A significant effect favouring control conditions was detected for negative affect, although it did not reach practical significance (SMD = −0.15; 95% CI, −0.29 to −0.02; Z = 2.32 [p = .02]; Heterogeneity I2 = 0%).	Positive intervention effects were detected for weight and other lifestyle behaviours (e.g., physical activity and diet).	Observational research suggests that men with mental health concerns often report using lifestyle behaviour change as a way of managing their condition. Behaviour change programs may be particularly appealing for men who align to traditional forms of masculinity, as studies suggest they are less likely to seek help for psychological concerns.	In all studies, mental health indicators were examined as secondary outcomes. The current evidence could be further strengthened with more studies specifically targeting mental health, providing power calculations for mental health outcomes, and including long-term post-intervention follow up.	Overall, the risk of bias associated with the mental health outcomes was generally low; Low confidence
Efevbera Y, McCoy DC, Wuermli AJ, Betancourt TS. Integrating Early Child Development and Violence Prevention Programs: A Systematic Review. New Directions for Child and Adolescent Development. **2018**;2018(159):27-54.	Systematic review; Preventing violence against children; 4/6; RCT (1), cluster-RCT (1), factorial design (1), quasi-experiment (1)	General population or families at risk for child maltreatment in a LMIC, defined by World Bank classification; N = 617 I = 279 C = 338; Chile (1), Jamaica (1), Mozambique (1), Turkey (1)	Early childhood development plus violence prevention interventions were reviewed. Interventions varied widely, including: (1) A home-visiting program for first-time pregnant adolescent females in Chile (parent education program), (2) The Incredible Years Teacher Training Program in Kingston, Jamaica (pre-school teacher training), (3) The International Child Development Program in Maputo, Mozambique (Parenting Program), and (4) The Turkish Early	It is unclear what the control groups entailed.	Child development (Psychomotor Development Scale), Behaviour (Conduct Problems Prevention Research Group scales, SDQ), Cognitive development (Stanford-Binet Intelligence Test, Weschler intelligence tests, Children's Embedded Figures Test), Emotional	Most studies reported mental health outcomes which favoured the intervention group. One study found no significant difference between control children and children whose adolescent mothers participated in a parenting education intervention on child development (e.g., psychomotor, social, language development). One study found significantly higher IQ scores (F(1,215) = 11.6, P <0.001) and general cognitive ability scores (F(1,212) = 3.8, P <0.05) for children in mother-trained intervention groups compared to children in control groups. One study found significantly lower conduct problems among children whose caregivers attended an educational course, compared to children in a control group (M=1.49 vs M=2.42, P <0.05, Cohen's d = -0.5). Another study found significantly improved behaviour	Child maltreatment, abuse, and punishment reduced to a greater extent in intervention groups across most studies.	Integrated early childhood development and violence prevention interventions may improve multiple child outcome domains while leveraging limited resources in LMICs. Early childhood development and violence prevention approaches may lead to increased positive development and reduced adversity, resulting in better child wellbeing.	The absence of other caregivers such as fathers, grandparents, and other family members in interventions could highlight an opportunity for future work. There was variability in the design of each intervention and the instruments, used to measure a variety of outcomes, further complicating comparison. Moving forward, the use of strong experimental designs is needed to provide internally valid estimates of the potential effectiveness of interventions across diverse contexts. Cost-benefit analyses would also be useful, particularly given integrated programs that streamline service delivery may prove to be more cost-effective	Quality of evidence was not assessed by original authors; Critically low confidence

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			Enrichment Program (Parent education program).		Problems (PARQ).	among children whose teachers participated in an early childhood development + violence prevention intervention, compared to children in control classes (B for regression of effect of intervention (controlling for initial score and school) = 5.72, p = 0.018; p-value of difference between treatment and control classrooms at follow-up using non-parametric Mann-Whitney U test <0.0001).			and scalable than siloed programming.	
Emezue C, Chase JAD, Udmuangpia T, Bloom TL. Technology-based and digital interventions for intimate partner violence: A systematic review and meta-analysis. Campbell Systematic Reviews. **2022**;18(3).	Systematic review and meta-analysis; Reducing intimate partner violence; 17/17; RCTs (17)	Participants of diverse sexual orientations, racial/ethnic backgrounds, and ages were included who were experiencing or had experienced IPV. All participants were female, aged 19 - 41.5 years and predominantly white; N = 4590; Australia (1), Canada (1), China (1), Kenya (1), New Zealand (1), USA (12)	Digital interventions designed to reduce IPV exposure, adverse mental health, and victimization outcomes, deployed via mHealth, eHealth, and telehealth modalities, including personalized digital platforms (videos, smartphone apps, text messaging, chatbots, social media, and email). Digital interventions may be used for safety planning, digital consultation, referral-to-care, psychoeducation, and decision support. Interventions with digital-only or digital plus traditional hybrid models were included.	Control conditions varied across studies and included usual care (UC), intervention-as-usual (IAU), waitlist controls, or an active placebo control group format. Examples of control conditions included enhanced control groups, such as the control participants receiving modular IPV psychoeducation but not in a digital format, and participants receiving a smartphone app or website containing non IPV information, or face-to-face	Depression (CES-D, CESD-R, BDI, DASS, IDAS, PANAS), PTSD (PCL-5, PCL-17, PSS-I), and anxiety (BAI, GAD-7, PHQ-9, DASS, FDAS).	Between 0- and 3-months post-intervention, IPV survivors who received technology-based interventions exhibited a small but significant reduction in depression. However, this effect faded after 3 months and was highest immediately post-intervention. Nine RCTs provided data for a pooled effect size for depression, demonstrating a small, but statistically significant reduction in depression (SMD = −0.10, 95% CI = −0.18 to −0.01; I2 =58%). Heterogeneity was significant. Digital interventions reduced anxiety among survivors. This effect size was small and significant up to 3 months postintervention. Four RCTs provided data for a pooled effect size of anxiety, demonstrating a small significant reduction in anxiety between 0 and 3 months (SMD = −0.27, 95% CI = −0.42 to −0.13; survivors = 714; studies = 4; I2 = 25%). No significant heterogeneity was noted. Digital interventions reduced PTSD among IPV survivors. The effect was small and non-significant between 3- and 6-months post-intervention compared to controls. Four RCTs provided data to calculate a pooled effect for PTSD for 3–6 months post-intervention, demonstrating interventions had a small but non-significant negative effect (reduction in) PTSD (SMD = −0.04, 95% CI = −0.14 to 0.06; survivors = 1428; studies = 4; I2 = 0%). No significant heterogeneity was observed.	Digital Interventions reduced survivors' physical violence victimization, although treatment effect sizes were small but significant from 0 to 6 months post-intervention.	While the underlying theories across anti-IPV interventions are explicit, the mechanism of action (i.e., theory of change) showing causal linkages for improving survivors' mental health appears less so. The theoretical frameworks used in IPV digital intervention design varied across studies. However, since some of these proprietary apps were based on the myPlan app, most were theoretically grounded in Dutton's empowerment model.	The authors found little evidence that digital interventions are being adapted for ethnically, culturally and linguistically diverse survivors - more evidence-based, age-appropriate, language and culturally congruent interventions are needed. Further, accessing technology-based interventions might pose a challenge in low-tech or no-tech settings, innovative approaches are warranted in these contexts. Many service providers must consider digital interventions as an add-on to usual services, as many IPV survivors lack access to technologies. A limitation to this field of work is the ethical and safety concerns with truly randomizing IPV survivors into control conditions, making trials unpopular with IPV survivors. The modest effect sizes in this report demonstrate the difficulty in stopping violence by involving survivors alone.	High risk of bias (4), unclear risk of bias (11), and low risk of bias (2); Moderate confidence

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				counselling (i.e., enhanced usual care) by a health care provider.						
Fang Z, Barlow J, Zhang C. Parenting Programs That Address Physical Abuse in Childhood for Families of Children With Developmental Disabilities in Mainland China: Systematic Review and Meta-Regression. Trauma Violence Abuse. **2022**;23(2):457-75.	Systematic review and meta-regression; Reducing child maltreatment; 31/31; RCTs (30), quasi-experiments (11)	Families of children aged 0–18 years of age with developmental disabilities in mainland China; N = 2410 primary caregivers; China (31)	Parenting interventions were delivered to adult primary caregivers of children with developmental disabilities aimed at (1) reducing physical abuse in childhood, (2) improving parent–child relationships or creating healthy parent–child attachment, or (3) reducing child emotional and/or behavioural problems, by increasing parental knowledge of CEBP, improving parenting skills, changing parental attitudes, cultivating empathy, reducing parental stress, improving parental self-efficacy, or play.	The TAU conditions can be classified into three broad categories: regular services only (16 studies); medication only (9 studies), providing children of parents in both treatment and control groups with the same dose of medication; and a combination of both (6 studies).	Child emotional and behavioural problems (CBCL, FES-CV, CBRS-P, FAD, PEP, ABC, EMBU, SNAP-IV, ATEC, PSI/SF, DCS, MBRS, PHCSS, PedsQL, DBDRS).	Overall, compared to families in control conditions, those in the parenting interventions reported reduced child emotional and behavioural problems (CEBPs). This was statistically significant when CEBPs were parent-reported (effect size unclear), but not when they were child-reported. For CEBPs, the parenting interventions had more significant effects for families with child(ren) with autism and epilepsy, than for ADHD and Tourette's. Programs with components to increase parental knowledge of child emotional and behavioural problems, reduce parental stress, and cultivate empathy were associated with greater success; the use of positive reinforcement in LMICs has not shown the expected effects and might need further sociocultural adaptations. Programs with the following delivery features tend to have stronger effects: a longer duration, an institutional setting, efforts to build rapport, a combination of group and individual sessions, and ongoing communication. 30 studies were included in a meta-analysis. Parent-reported data showed that parenting programs were more effective than control groups at post-intervention for reducing CEBPs (g = −1.37, 95% CI [−2.03, −0.71]). There was substantial heterogeneity (I2 = 75.40%, Q = 1,262.86, df = 58, p < .0001). For child-reported scales, there was no statistically significant group difference for CEBP (g = −0.68, 95% CI [−1.82, 0.46]; I2 = 90.06%, Q = 35.81, df = 4, p < .0001).	One trial measuring child abuse indicated that parents who received the parenting program were less likely to verbally or physically punish their children than parents in the control group at post-intervention (Risk Ratio = 0.51, 95% CI [0.28, 0.92]). Analysis showed a small effect favouring the parenting programs at post-intervention for parent-child relationship quality, as reported by parents (g= 0.47, 95% CI [0.21, 0.73]).	Parenting programs directed at parents of children with developmental disabilities incorporate helpful principles from a number of other sources: (1) behavioural interventions characterized by applied behavioural analysis which is grounded in operant learning theory; (2) child development theories, which lead to a focus on skill acquisition and inform the creation of developmentally appropriate learning experience; and (3) educational frameworks, which encourage the development of individualized treatment plans and a structured teaching environment, to maximize learning opportunities.	The small number of studies and participants could have underpowered the subgroup analyses and meta-regression models. Cultural differences in the use of positive reinforcement may have impacted outcomes in the Chinese setting.	Risk of bias varied across studies. All studies were judged high ROB for performance and detection bias. More than half were high ROB for allocation concealment and other sources of bias. Most studies were low ROB for attrition bias and reporting bias; Critically low confidence
Goldstein Z, Rosen B, Howlett A, Anderson M, Herman D. Interventions for paternal perinatal depression: A systematic review. Journal of Affective	Systematic review; Improving paternal mental health; 14/14; N = 2220	Fathers recruited via hospital settings, prenatal programs and neonatal intensive care unit;	Paternal perinatal depression interventions including father-focused interventions (6), couple-focused interventions (4), and family-focused	Control group descriptions not provided.	Depression symptoms (HADS-D, BDI-II, EPDS, CES-D, SDS)	Six out of 14 studies demonstrated that fathers in the intervention group compared to a control group had a small but statistically significant reduction in depression scores (effect sizes not reported). Of the six studies with significant results, four of the studies provided a brief intervention to	Not reported.	The authors discussed that the quality of parent-child relationship and couples' relationships could mediate the relationship between paternal perinatal depression and child development. Therefore, improvement in these mediating factors could help to mitigate the	The review did not address the potential impacts of the interventions on other mental health outcomes such as anxiety disorders, which may also carry significant burden on families. No meta-analysis could be conducted due to variability in	Quality appraisal not conducted by original study authors; Critically low confidence

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Disorders. **2020**;265:505-10.	RCTs (14)	I = 1162 C = 1058; Australia (4), China (2), England (1), France (1), Iran (1), Singapore (1), USA (4)	interventions (4). The interventions were primarily psychoeducational in nature and included material around one or more of the following: childbirth, breastfeeding, new-born care, transitioning to parenthood, co-parenting, improving couple communication and wellbeing, and understanding the new triadic relationship.			the fathers only. This included all three studies that taught fathers to massage their partner or new-born or maintain skin-to-skin contact after birth, as well as the only intervention to focus exclusively on men's lifestyle and well-being. No trials found an increase in depression scores following the interventions.		impact of depression on families. Effective maternal depression treatment techniques and interventions could be adapted and applied to treat fathers.	the methodologies, outcome measures and length of follow-ups of included studies. Quality appraisal was not conducted by original study authors.	
Linde DS, Bakiewicz A, Normann AK, Hansen NB, Lundh A, Rasch V. Intimate Partner Violence and Electronic Health Interventions: Systematic Review and Meta-Analysis of Randomized Trials. J Med Internet Res. **2020**;22(12):e22361.	Systematic review and meta-analysis of randomised trials; Reducing domestic/intimate partner violence; 5/14; RCTs (5)	Women exposed to any type of IPV by a current or former partner at any point in life; N = 1840; Australia (1), New Zealand (1), USA (3)	All types of eHealth interventions (e.g., videos, text messages or social media interventions) were included. Interventions included online safety decision aids (3), telephone support (1), email or face to face module with telephone support (1).	Comparison groups included use of a control website (3) or standard care (2).	Depression (CES-D, PHQ, PROMIS, HADS), PTSD (DSM, PCL)	There was no evidence that eHealth interventions reduced depression (SMD –0.13; 95% CI –0.37 to 0.11; I2=78%) or PTSD (n = 3 studies; MD –0.11; 95% CI –1.04 to 0.82; I2=0%) compared with no eHealth intervention in this population.	No evidence that eHealth interventions reduced physical, sexual, or psychological violence compared with no eHealth intervention. The authors explored if the effect of eHealth interventions varied between type of intervention or the IPV scale used in subgroup analyses but found no differences.	eHealth is defined as the use of information and communication technologies for health. It is a diverse concept that encompasses the sub-areas mobile health (mHealth) and telehealth. It has been hypothesized that eHealth interventions have potential to reduce IPV exposure and its health-related consequences as the technology provides a safe and flexible space for the target population compared with traditional face-to-face approaches.	The types of outcomes and how they were measured were heterogenous across trials, which limited the possibility of pooling results and identifying patterns across studies. More high-quality trials are needed, and the authors recommend harmonizing outcome reporting in IPV trials by establishing core outcome sets.	Risk of bias using Cochrane risk of bias tool reported that 2 RCTs had low risk of bias. Other studies were not given overall ratings but had issues with random sequence generation, allocation concealment, blinding of participants, blinding of outcome assessments, and selective reporting; Moderate confidence
Rivas C, Ramsay J, Sadowski L, Davidson LL, Dunne D, Eldridge S, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. Cochrane Database Syst Rev. **2015**;2015(12):Cd005043.	Systematic review; Reducing intimate partner violence; 8/13; RCTs (8)	Women aged 15 years and over who have experienced intimate partner abuse; N = 727 I = 392 C = 335; Australia (1), China (2), USA (5)	One-on-one advocacy support interventions were provided. They were defined as brief (<12 hours) or intensive (>12 hours). Most interventions involved an element of counselling support and were underpinned by empowerment theories to enhance women's independence and control. Interventions generally involved safety planning and education about accessing community resources. Some interventions included a focus on children, such	Control groups mostly received usual care which varied considerably (e.g., usual shelter care, standard social care available to all community residents (if any), information sheets/cards including details for family	Psychological distress (BSI, PSS, SCL-90-R), Depression (CES-D, EPDS, C-BDI-II), PTSD symptoms (DTS), mental health (DSM-IV SCID).	Overall, there is inconsistent evidence that advocacy has a beneficial impact on mental health outcomes in women. The type of outcome measure used (e.g., continuous vs dichotomous data) also appears to impact findings. For example, pooled continuous data from 2 studies looking at depression found there was no evidence that women receiving brief advocacy reported lower levels of depression than women in the control group (SMD − 0.17, 95% CI −0.43 to 0.08, I2 = 0%; n = 239). A meta-analysis of dichotomous data from 2 studies showed that significantly fewer women developed depression (NNT = 4) if they received a brief advocacy intervention (OR 0.31, 95% CI 0.15 to 0.65, I2 = 24%; n = 149). Of three intensive advocacy interventions measuring depression as a continuous	There was no evidence that brief advocacy leads to a reduction in physical abuse when this outcome is expressed as a continuous measure (n = 5 studies). One study measuring physical abuse as a dichotomous variable found that women were less likely to be experiencing physical abuse at the end of the brief advocacy intervention period (OR 0.42, 95% CI 0.23 to 0.75; n = 306). For	Advocacy interventions are based around the concept of empowerment: talking through potential solutions with the woman rather than being prescriptive and telling her what she ought to do, helping the woman to achieve the goals she has set rather than being directive and setting the goals for her, and helping her to understand and make sense of the situation and her responses to it.	There was little consistency between studies, with variations in the amount of advocacy given, the type of benefits measured, and the lengths of follow-up periods. As a result, it was hard to combine the results, and the authors cannot be certain of how much advocacy interventions benefit women or the impact of the type of advocacy, the place it was given, or the severity of the abuse experienced by the women receiving the intervention.	For the whole review, 5 studies were deemed high risk of bias, 5 moderate, and 3 low risk of bias; High confidence

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			as advocacy interventions to build confidence in children of abused mothers, and antenatal monitoring.	violence services), and one study included a control group which received 6 phone calls over 3 months by a trained community health worker.		measure at 12 months follow-up, meta-analysis revealed no evidence that intensive advocacy reduces depression (SMD − 0.14, 95% CI − 0.33 to 0.05, I2 = 27%; n = 446). One study suggested that an advocacy intervention led to significantly lower levels of perceived stress compared with women in the control condition (MD − 0.56, 95% CI − 1.09 to − 0.03; n = 53). For a brief advocacy intervention, there was significant evidence that advocacy reduced psychological distress at three to four months follow-up (MD − 0.56, 95% CI − 1.09 to − 0.03; n = 53). Two intensive advocacy interventions showed no statistically significant effect on psychological distress post-intervention.	intensive advocacy interventions, 2 studies reported no significant effect of intervention on physical abuse at 12 months follow-up, but significantly less physical abuse in intervention compared to control groups at 2 years follow-up. Advocacy interventions did not lead to statistically significant reductions in sexual abuse. Six out of seven studies reported no statistically significant reductions in emotional abuse following advocacy interventions. One antenatal-based study reported a statistically significant reduction in emotional abuse at 16 to 34 weeks after receipt of a single, brief session of advocacy (change score MD − 4.24, 95% CI − 6.42 to − 2.06; n = 110; moderate quality evidence).			
Spencer CM, Stith SM, King EL. Preventing Maltreatment at Home: A Meta-Analysis Examining Outcomes From Online Programs. Research on Social Work Practice. **2021**;31(2):138-46.	Meta-analysis; Reducing intimate partner violence; 3/6; RCTs (3)	Participants included psychology college students in romantic relationships in one study, individuals with alcohol use disorder and elevated trait anger in one study, and individuals who sought help for aggression in intimate adult	Interventions were online relationship education programs targeting IPV or anger management. They generally included communication skills/techniques, reducing bias interpretations, and emotion-regulation and conflict-resolution techniques.	Comparison groups varied: 1 = viewing healthy habit videos, 1 = viewing a general presentation about psychoeducation and relationship problems, 1 = no treatment.	Depression (measures used not specified).	The results from the meta-analysis indicate that online relationship education programs and online anger management programs had a significant, large effect on decreasing levels of depression between pre-test and post-test or follow-up scores for the intervention group compared to the control group (d = -.93, p < .05).	These online programs produced significant, medium effects on decreasing levels of anger (d = -.60, p < .001), emotional IPV perpetration (d = -.59, p < .05), and physical IPV perpetration (d= -.51, p < .05).	It may be argued that, because individuals who participated in the included studies were volunteers and wanted relationship help, their results were more positive in reducing IPV perpetration. This highlights the potential utility of online anger management and relationship programs for couples who are motivated to improve their relationships but are experiencing situational violence or increased conflict in their relationships. These online programs may benefit individuals facing other barriers to in-person services, including those living in resource-sparse communities,	Very few studies were identified in this review, indicating more research is needed. Quality appraisal was not conducted by original study authors.	Not assessed by original review authors; Critically low confidence

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		relationships in one study; N = 198 I = 98 C = 100; Unclear						individuals lacking insurance or other financial resources needed to obtain traditional care, and those who lack time or transportation to attend in-person programs or treatment. Online programs may work well to supplement work done with clinicians.		
Stephens-Lewis D, Johnson A, Huntley A, Gilchrist E, McMurran M, Henderson J, et al. Interventions to Reduce Intimate Partner Violence Perpetration by Men Who Use Substances: A Systematic Review and Meta-Analysis of Efficacy. Trauma Violence Abuse. **2021**;22(5):1262-78.	Systematic review and meta-analysis; Reducing intimate partner violence; 7/9; RCTs (7)	Adult heterosexual males who use substances; N = 971 I = 473 C = 490; India (1), the Netherlands (1), USA (5)	Five trials involved integrated IPV and SU interventions, while two involved IPV interventions with adjunct SU interventions. Three interventions were delivered in a group format and four were delivered individually. Cognitive behavioural and motivational interviewing therapies were the most common approaches.	Control groups were mostly treatment as usual, such as standard interventions in community clinics, psychoeducation material, and pharmacotherapy.	Substance use (TLFB interview, onsite toxicology screens, Quick drinking screen, Daily Drinking Questionnaire, Drinking Norms Rating Form, Severity of Alcohol Dependence Questionnaire, URICA).	Data from individual trials showed a reduction in SU outcomes in the short term (<=3months; n = 2 trials) for interventions compared with TAU. Meta-analysis of integrated IPV and SU interventions (n = 3 trials) showed no difference in abstinence from overall SU at 8–12 weeks compared to TAU. Rather, a direction of effect in favour of the SU TAU group was found (MD = 2.07, CI [0.00, 4.13], p = .05, I2 = 0%). However, it is important to note that this analysis was dominated by one trial as illustrated by the 0% heterogeneity.	Data from the CTS-2 physical violence subscale were combined from four trials at 4–12 weeks. The combined MD was 0.1 (CI -0.37, 0.57), p = .68). This analysis was subject to moderate heterogeneity (I2 = 51%).	A coordinated response that prioritizes the needs of victims and survivors while concurrently addressing the behaviour of perpetrators is likely to be more effective in preventing future violence. Robust evidence supports an association between substance use (SU; i.e., alcohol and drug use) and IPV, with a consensus that SU can increase both the frequency and severity of violence.	There was heterogeneity in terms of the interventions studied as well as differences in comparison groups, delivery approach, length of follow-up, and assessment methods in determining IPV and SU behaviours. A number of trials excluded potential participants due to mental health diagnoses. There is a need to develop and evaluate evidence-based interventions for men who use substances and abuse their partners.	Original authors stated that the trials were conducted with low risk of bias; Low confidence
Van Parys, A. S., Verhamme, A., Temmerman, M., & Verstraelen, H. (**2014**). Intimate partner violence and pregnancy: a systematic review of interventions. PLoS ONE, 9(1), e85084. https://doi.org/10.1371/journal.pone.0085084	Systematic review; Reducing intimate partner violence; 5/9; RCTs (5)	Pregnant women of any age and/or women who had given birth in the past year (plus their partners/ children if the intervention involved them); N = 643 families + 818 individuals I = 373 families + 441 individuals C = 270 families + 377 individuals; Australia (1), Hong Kong (1), USA (3)	Interventions addressed intimate partner violence. Interventions included: (1) home visits by paraprofessionals to provide direct services and linked families to community resources; (2) 12-month support from non-professional mentor mothers; (3) a brief empowerment intervention (30-minute session including advice and brochure); (4) Individual sessions over 4 weeks before birth of baby and 1 session within 2 weeks of delivery (based on interpersonal psychotherapy, emphasizing social support).	Control groups included standard medical care / treatment as usual with educational resources, free developmental screening, and referral for children + usual care.	Mental health, anxiety, depression symptoms, drug and alcohol use, child behavioural and emotional regulation, and PTSD symptoms (EPDS, PSI-SF, LIFE, Davidson trauma scale, criterion A from PTSD module of the SCID-NP).	Findings were mixed across interventions. One study in which women were visited by paraprofessionals reported a significantly better mental health among intervention participants (101.21 vs. 99.16, P=0.03) than control participants. A brief empowerment intervention study reported that significantly fewer women in the intervention group reported postnatal depression at follow-up (RR 0.36, 95% CI, 0.15–0.88). An intervention involving individual sessions with women over 4 weeks did not significantly reduce the likelihood of a major depressive episode or post-traumatic stress disorder (PTSD). They found a trend towards decrease during pregnancy but not during postpartum. The intervention involving mentor mothers reported a trend favouring the intervention regarding depression (19/85 vs 14/43; AdjOR 0.42, 95% CI 0.17–1.06) scores, but no observed effect on parenting stress.	Following one of the home visiting programs, no adjusted statistically significant effects were reported on the experience of physical partner violence in the intervention group versus the control group (14.2% vs. 13.6%, P= 0.88, OR 1.05, 95% CI not reported) at approximately 3.5 years follow-up. In another 3-year home visiting program, intervention women reported a lower, albeit statistically marginally non-significant, adjusted rate of IPV victimization [Incidence Rate Ratio (IRR) 0.86, 95% CI,	Adverse mental health consequences and behavioural risks including depression, anxiety, PTSD, suicide attempts alongside physical health issues are associated with IPV during time of pregnancy. Perinatal care is ideal window of opportunity to address IPV as it is often the only moment in lives of couples where there is regular contact with health care providers.	The results should be interpreted with caution and within the light of methodological challenges. According to the authors, researching violence is inherently associated with numerous ethical and safety issues, making it very difficult to produce strong evidence. They identified considerable variation in categorizing certain behaviour as IPV, research settings, study populations, sample sizes, content of the intervention, and length of follow-up. Intrinsic to the difficulties associated with the study subject sample sizes are small, there is a considerable loss to follow-up, and it is impossible to blind respondents. Moreover, few studies adjusted their analysis for confounding factors (e.g., childhood abuse), which can create an oversimplified image of reality.	Low risk of bias = 2 studies, unclear risk of bias = 3 studies; Low confidence

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							0.73–1.01] and a significantly lower rate of perpetration (IRR 0.83, 95% CI, 0.72–0.96) than the control group. Intervention women showed significantly lower rates of physical assault victimization (IRR 0.85; 95% CI, 0.71–1.00) and significantly lower perpetration (IRR 0.82, 95% CI, 0.70–0.96). Although rates of overall IPV victimization and perpetration were also lower after 9 years, these results were not statistically significant. Authors of the mentor mothers intervention reported evidence of a true difference in mean abuse scores at 12 months follow-up (15.9 vs. 21.8, AdjDiff28.67, 95% CI, 216.2–21.15, P= 0.03). Authors of the brief empowerment intervention reported statistically significant less psychological [Mean Difference (MD) 21.1, 95% CI, 22.2 to 20.04)] (but not sexual) abuse and significantly less minor (MD 21.0, 95% CI, 21.8 to 20.17) (but not severe) physical violence in the intervention group.			

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							The individual sessions intervention did not significantly reduce the likelihood of IPV during pregnancy or up to three months postpartum.			
Waid J, Cho M, Marsalis S. Mental health targets in child maltreatment prevention programs: A systematic review of randomized trials. Children and Youth Services Review. **2022**;136.	Systematic review of randomized trials; Preventing child maltreatment; 33/33; RCTs (33)	Families from the general population (i.e., primary prevention) or those exhibiting early risk factors for maltreatment (e.g., secondary prevention). Families of children who previously experienced maltreatment (tertiary prevention) were excluded; Not reported; Not reported	Child maltreatment prevention strategies included home visiting (n = 22), group parenting (n = 7), online (n = 2), and outpatient (n = 2) approaches. All interventions engaged primary caregivers in activities.	All studies had a comparison group – but details were not reported consistently.	Parent mental health including depression, anxiety, substance use, and stress. Child behaviour, mental development, and mental health (depression, attention, hyperactivity). Measures used not reported.	Mental health outcomes were mixed across studies. 18 studies reported treatment group improvements to mental health, while 15 reported no improvements to mental health. Programs which resulted in improvements to mental health included home visiting (12), group parenting (3), a combination of home visiting and a parenting component (1), an outpatient approach (1), and an online approach (1). Across programs reporting changes to mental health, the most commonly reported improvements were to child behaviour (n = 8) and parent stress (n = 6). The magnitude of change was not reported.	15 studies reported improvements to maltreatment prevention in treatment groups. Programs which resulted in maltreatment prevention included home visiting (6), group parenting (5), a combination of home visiting and a parenting component (1), an outpatient approach (1), and online approaches (2). These studies utilised self-reported measures of maltreatment risk, structured observation, child protective service records, and hospital records.		The most commonly reported mental health improvement was to children's behaviour, suggesting children's behaviour may be a particularly important target in child maltreatment prevention efforts. Studies also reported improvements to parent outcomes, indicating support for continued focus on both parent and child dimensions of mental health promotion in maltreatment prevention efforts. Only one study in this review reported caregivers' experiences with maltreatment as a child at baseline. Most programs focused on mothers with younger children, and no programs explicitly targeted relative caregivers. Parent self-reports of child maltreatment is a limitation - there is a need for more objective measures. The authors argue that prevention programs may benefit by incorporating components which move beyond the individual and interpersonal dimensions of abuse and neglect and address the systemic contributors to mental illness and child maltreatment, including socioeconomic and structural inequalities.	The authors reported that the internal validity for the studies was "good" (n = 27) or "fair" (n = 6). External validity for the studies was reported to be "good" (n = 29) or "fair" (n = 4); Low confidence
Walsh K, Zwi K, Woolfenden S, Shlonsky A. School-based education programmes for the prevention of child sexual abuse. Cochrane Database Syst Rev. **2015**(4):Cd004380.	Systematic review; Preventing child sexual abuse; 5/24; RCT (1), cluster-RCT (4)	Children (aged 5 to 12 years) and adolescents (aged 13 to 18 years) attending primary (elementary) or secondary (high) schools; N = 2463; China (1), USA (4)	Interventions were school-based education programmes focusing on knowledge of sexual abuse and sexual abuse prevention concepts, or skill acquisition in protective behaviours, or both. Although a wide range of programmes were used, there were many common elements,	No intervention or the standard school curriculum.	Anxiety/fear (fear survey, STAIC, FATS).	There was no evidence of increases or decreases in anxiety and fear in intervention participants compared to control participants. 3 studies were meta-analysed (N total = 795 (I = 456; C = 339)). The SMD for anxiety/fear was -0.08 (95% CI -0.22 to 0.07). This result reveals evidence of no increases or decreases in anxiety or fear in intervention participants. There was no heterogeneity (I2 = 0%, P value = 0.79).	This review found evidence that school-based sexual abuse prevention programmes were effective in increasing participants' skills in protective behaviours and knowledge of sexual abuse prevention concepts (measured	The authors report: Although not yet rigorously researched, it appears that school-based programmes may also work to enhance community capacity for sexual abuse prevention by raising awareness and delivering information to multiple members of children's social systems, via provision of information packages to parents, training for teachers, and family participation in homework activities. School-based	Studies have not yet adequately measured the long-term benefits of programmes in terms of reducing the incidence or prevalence (or both) of child sexual abuse in programme participants.	The quality of the evidence was classified as moderate; High confidence

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			including the teaching of safety rules, body ownership, private parts of the body, distinguishing types of touches and types of secrets, and who to tell. Programme delivery formats included film, video or DVD, theatrical plays, and multimedia presentations. Other resources used included songs, puppets, comics, and colouring books. Teaching methods used in delivery included rehearsal, practice, role-play, discussion, and feedback.				via questionnaires or vignettes). Knowledge gains (measured via questionnaires) were not significantly eroded one to six months after the intervention for either intervention or control groups. Children exposed to a child sexual abuse prevention programme had greater odds of disclosing their abuse than children who had not been exposed, however we were more uncertain about this effect when the analysis was adjusted to account for the grouping of participants in classes or schools.	sexual abuse prevention programmes focus on children and adolescents as prevention targets. They seek to prevent child sexual abuse by providing students with knowledge and skills to recognise and avoid potentially sexually abusive situations, and with strategies to physically and verbally repel sexual approaches by offenders. They endeavour to minimise harm by disseminating messages about appropriate help seeking in the event of abuse or attempted abuse. Interventions aim to transfer the knowledge and skills learned by the child or adolescent in the classroom to real-life situations. Interventions work by capitalising on principles used by classroom teachers, most notably social cognitive learning theories, which stress the social context of learning via the use of instruction, modelling, rehearsal, reinforcement, and feedback (Wurtele 1987).		
ECONOMIC DOMAIN (24 reviews)										
Audhoe S, Hoving J, Sluiter J, Frings-Dresen M. Vocational interventions for unemployed: effects on work participation and mental distress: a systematic review. J Occup Rehabil **2010**;20:1–13.	Systematic review; Reducing unemployment through the promotion of re-employment; 3/5; RCTs (1), non-RCT (1)	Participants were unemployed and between 18 and 65 years old; N = 3195 I = 1940 C = 1255; Australia (1), Finland (1), USA (1)	All interventions applied group training techniques aimed at promoting re-employment and/or improving mental health. The duration of the interventions varied from 1 week to 6 months. The interventions focused on acquiring job-search skills, maintaining paid work, personal development and preparedness against setbacks during the job-search process. The programs were varied: (1) ''Skillshare'' work preparation program (combination of occupational skills training and personal development) aimed to provide unemployed participants necessary	The control groups varied: (1) Waiting-list unemployed individuals who were eligible for training programs. (2) Controls received a booklet briefly by mail describing job search methods and tips equivalent to three single spaced pages of text.	Psychological distress (GHQ-12, or with an unspecified 18-item index).	There was limited reporting on evidence that vocational interventions to improve work participation could reduce mental distress for the unemployed. In the Skillshare study, the intervention group had a statistically significant lower psychological distress score, compared to the control group, at time-point 2 (10.47 vs. 15.80, p = .01). Between time-point 1 and 2, the intervention group improved on psychological distress scores (p<.05). At time-point 3, there was no statistically significant difference in psychological distress scores between the intervention and control groups. Changes over time, between the groups, were not clearly reported. In the JOBS II study, psychological distress symptoms were lower in the high-risk intervention group compared to the control group (p<.01). Changes over time, between and within the groups, were not clearly reported.	The review indicates that there is weak evidence to support the use of vocational interventions to improve work participation. The Skillshare program reported no significant difference in employment rate between intervention and control participants. Following the JOBS II program, re-employment was significantly higher for intervention participants (both low and high risk) than for control participants (p<.05). The difference in re-employment rate	Programs are based on theories of active learning process, social modelling, gradual exposure to acquiring skills, practice through role playing and providing preparedness against setbacks during the job search process.	Very few studies were identified, and the methodological quality of these studies was not strong. The studies were conducted across a variety of different countries, each with different labour markets, welfare systems, and mental health care, making it difficult to directly compare results. The authors note that it would be interesting to evaluate whether more attention to mental health concerns would boost the effects of re-employment programs for the unemployed.	The methodological quality of the studies ranged from good to poor; Low confidence

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			skills to obtain and maintain paid work. (2) JOBS II intervention focused on enhancing the sense of mastery through acquisition of job search and problem-solving skills and decision-making group processes, and on preparedness against setbacks. JOBS II was intended to prevent poor mental health and promote high quality re-employment. (3) Tyohon job-search training workshop, based on theories of active learning process, social modelling, gradual exposure to acquiring skills, practice through role playing and preparedness against setbacks.	(3) Controls received a literature package, which corresponded to the basic themes in job-search training and included four guides.		In the Tyohon study, psychological distress symptoms were lower in the intervention group compared to the control group ($p<.05$). Changes over time, between and within the groups, were not clearly reported.	was higher for intervention participants, ranging from 5 – 12% higher than comparison groups. In the Tyohon study, re-employment rate between the intervention and control groups was not significantly different.			
Bond GR, Drake RE, Pogue JA. Expanding Individual Placement and Support to Populations With Conditions and Disorders Other Than Serious Mental Illness. Psychiatr Serv. **2019**;70(6):488-98.	Systematic review and meta-analysis; Reducing unemployment; 8/9; RCTs (8)	People with a disability other than serious mental illness; N = 2745; Denmark (1), Norway (2), Sweden (1), USA (4)	Individual Placement Support (IPS) interventions were assessed, including: Standard IPS (3), Modified IPS (1), Enhanced IPS (1), IPS + Cognitive Behavioural Therapy (CBT) (1), Modified IPS + group intervention (1), and IPS at methadone clinic (1).	Comparison groups varied: Compensated work therapy (2), stepwise job services (2), list of job resources (1), traditional vocational rehabilitation (1), waitlist (1), group intervention (1).	Depression symptoms, anxiety symptoms, PTSD symptoms, psychological distress - unclear what measures were used.	Findings on mental disorder symptom reduction were inconsistent. Three RCTs reported reductions in depression symptoms in IPS groups compared to comparison groups and one reported no difference in depression symptoms between the groups. Reductions in anxiety symptoms (1 RCT), PTSD symptoms (1 RCT) and psychological distress (1 RCT) were reported in IPS groups compared to comparison groups. The magnitude of change was not reported.	In eight studies, results for competitive employment rates significantly favoured IPS. Meta-analysis yielded an overall weighted odds ratio of 2.23 (95% confidence interval=1.53–3.24, p,.001).	Not reported.	Different national policies in different countries could be a confounding variable. For example, in Scandinavia, where several studies were conducted, national policies foster high job security and generous welfare benefits, which provide disincentives to working and suppress employment rates, for both IPS and control participants. Another possible source of confounding is the augmentation of IPS with CBT in some studies. Another issue is that several studies had substantial attrition in self-reporting of non-vocational outcomes.	Overall, the methodological quality was adequate. The most common methodological weakness was a lack of detail in the description of the intervention and of the process used to recruit the sample; Critically low confidence
Charzyńska K, Kucharska K, Mortimer A. Does employment promote the process of recovery from schizophrenia? A review of the existing evidence. Int J Occup Med Environ Health. **2015**;28(3):407-18.	Systematic review; Reducing unemployment; 10/18; RCTs (5), clinical controlled trial (4), cross-sectional comparison (1)	People with schizophrenia; N = 3521; Not reported	A range of employment interventions were assessed: Supported Employment (4; involves getting individuals into employment first, then training them on the job), Individual Placement and Support (2; a type of supported	Not reported.	Schizophrenia symptoms (PANNS, BPRS), Depression symptoms (CDSS, HDRS), Mental health (12-item short form health survey), Cognition	Results were not presented for all of the measured outcomes. Most studies that measured symptoms found a reduction in symptoms in the intervention compared to the control groups, but the effect sizes and clinical/practical significance were not reported. Findings regarding the relationship between being in employment and neurocognitive functioning were inconclusive.	Not reported.	Work improves self-esteem and provides individuals with a sense of accomplishment, self-identity, and satisfaction with being able to provide a financial contribution to the household.	The majority of the studies published on this topic focus on the effectiveness of different employment programs for vocational outcomes. Only a few focus on clinical outcomes.	Quality of evidence was not formally assessed by original authors. Weaknesses identified were that the majority of studies had small sample sizes and used non-randomised approaches;

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			employment in which employment specialists work closely with clinicians to find individuals a job that matches their abilities and preferences), and Competitive Employment (4; involves prevocational training).		(WAIS-III, Stroop Test, WCST, CVLT, Verbal learning test, Digit span, LNST, Digital symbol test, Verbal fluency test, Bergen n-back test, Grooved pegboard test).					Critically low confidence
Evans, L., Lund, C., Massazza, A., Weir, H., & Fuhr, D. C. (**2022**). The impact of employment programs on common mental disorders: A systematic review. International Journal of Social Psychiatry.	Systematic review; Improving access to employment; 5/5; RCTs (3), non-RCT (1), retrospective cohort (1)	Adults were the target population in all studies with mean age ranging from 17 to 36 years; N = 2747; Bangladesh (1), Democratic Republic of the Congo (1), UK (1), USA (2)	Interventions involved multiple components and 8 different programs were presented in 5 studies. Program components included: Microcredit common supplement (3), skills-based training component 5), hands-on work placements (2), psychoeducation group sessions with matched savings program + financial literacy group sessions (1).	Control groups not clearly outlined.	Depression and anxiety (HSCL, PHQ-9; BDI, BAI).	Two studies (40%) measuring depressive symptoms as an outcome found a significant positive effect ($\beta = -.8$, $p < 0.001$; $d = -0.06$, $p < .05$) and three studies (60%) found no intervention effect. One of these studies also found a significant effect on major depressive disorder ($d = .49$, $p < .05$), favouring the IPS group. Within the two studies that measured anxiety, one (50%) found a positive effect ($d = 0.15$, $p < .05$) and one (50%) reported no effect. The different employment components yielded conflicting results on mental health outcomes. Of the interventions with a skill-based component, 3/5 (60%) had a significant positive effect on outcome measures, while 2/5 (40%) had no effect. Both interventions with a placement and a skills-based training component also found no effect on mental health. Studies with retrospective, and non-randomized experimental designs all reported null effects.	Not reported.	People living in poverty suffer from increased prevalence and severity of common mental disorders (CMDs) through aspects like food insecurity, low socio-economic status, limited education and financial stress. Interventions addressing these social determinants can have positive impact on mental health. While many employment programs are not created with the intent to prevent or treat CMDs; by addressing poverty, financial stress, and other social determinants of CMDs a reduction in prevalence, incidence, and severity of these disorders may occur.	The search was not complemented by qualitative studies for analysis of participants reactions to programs. There was high heterogeneity in included studies and it was therefore difficult to form wider claims about nature of employment programs, impacts on CMDs and calculate pooled estimates. Authors reported concerns around allocation concealment, blinding of participants and personnel, and incomplete outcome data in the included studies.	Three RCTs had low-unclear risk of bias. Two cohort studies had high risk of bias; Moderate confidence
Frederick, D. E., & VanderWeele, T. J. (**2019**). Supported employment: Meta-analysis and review of randomized controlled trials of individual placement and support. PLoS ONE, 14(2), e0212208.	Systematic review and meta-analysis of randomised controlled trials; Improving access to employment; 8/25; RCTs (8)	Individuals with or without severe mental illness or other types of disabling conditions (target population unclear); N = 3104 I = 1549 C = 1555; Not reported	Individual placement and supported employment interventions were assessed. Those with serious mental illness or other disabilities receive aid searching for competitive employment and mental health/other treatments concurrently.	Treatment as usual or self-placement.	Mental health outcomes (Brief psychiatric rating scale, positive and negative syndrome scale, mental component of short-form health survey).	While mental health outcomes favoured Individual Placement Support interventions, this was not statistically significant ($d = 0.03$, 95%CI = [-0.15, 0.21]).	IPS compared to usual treatment had better vocational outcomes, including: obtained any competitive employment (RR = 1.63, 95%CI = [1.46, 1.82]), greater job tenure ($d = 0.55$, 95%CI = [0.33, 0.79]), greater job length ($d = 0.46$, 95%CI = [0.35, 0.57]), greater income ($d = 0.48$, 95%CI = [0.36, 0.59]).	Working may be associated with improved aspects of wellbeing such as mental health. How we go about and think about work (job crafting) may impact level of work engagement, which is associated with increased levels of meaning. Work -directly or indirectly- appears to be significantly related to the modification of individual's wellbeing, and unemployment can be associated with mental health negative outcomes.	Mental health effects were heterogeneous across studies - examining further and understanding that heterogeneity may be essential in developing further improvements in supported employment interventions.	Quality of the evidence was not clearly assessed by original study authors; Critically low confidence

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
Gayed A, Milligan-Saville JS, Nicholas J, Bryan BT, LaMontagne AD, Milner A, et al. Effectiveness of training workplace managers to understand and support the mental health needs of employees: a systematic review and meta-analysis. Occup Environ Med. **2018**;75(6):462-70.	Systematic review and meta-analysis; Improving employment conditions; 5/10; RCTs (2), cluster-RCTs (2), quasi-experiment (1)	Managers and employees; N = 1378; Japan (4), UK (1)	Interventions were mental health education/training delivered to managers which, overall, aimed to support managers to be better equipped to promote positive mental health, gain early awareness of and responses to their employee's mental health, improve mental health literacy and be able to support employees returning to work. Interventions were delivered online and in-person and varied from a few hours to 10 weeks.	No comparison group descriptions were provided.	Employee psychological distress (BJSQ-57, BJSQ-32, GHQ-12, WEMWBS-14, BJSQ-18, WHO HWPQ, JPC WMHSI).	Workplace interventions for managers with an emphasis on the mental health of employees reporting directly to them were not found to have significant effects on employees' psychological distress (SMD=−0.08; 95%CI −0.21 to 0.06; p=0.28). There was no evidence of heterogeneity for this outcome (Q=1.77; I2=0%; p=0.78). To examine the longer-term effects of managers training, a meta-analysis was also conducted for employee outcomes with a follow-up period of 3 months or more. The pooled estimate for the overall mean difference for employees' self-reported levels of psychological distress in studies with a follow-up period of 3 months or greater was not significant (SMD=0.08; 95%CI −0.23 to 0.38; p=0.62). Both delivery formats, face to face (SMD=−0.12; 95%CI −0.30 to 0.06; p=0.180) and online (SMD=−0.09; 95%CI −0.36 to 0.18; p=0.514) did not show to have significant effects on employee distress. Similarly, the review also found no significant effects across the different types of training provided to managers (awareness, skill building or a combination of the two), and location of the studies.	Not reported.	The authors suggested that it was not possible, based on the current review, to determine what impact, if any, manager training has on employee's wellbeing. The benefits of manager training may in part be dependent on various proximal/ workplace factors (e.g., workplace job security/ insecurity, other organisational changes that occur during the intervention and evaluation period).	Limited follow-up period (maximum 3 months) may potentially prevent managers from having an opportunity to demonstrate newly acquired skills during the allocated time frame of the research. Organisational stability was not captured in the included studies, therefore it was not known whether these factors may have, if any, effected the outcomes. Other limitations include: small number of studies and sample size. To detect the true effect of mental health training for managers on employees' outcomes, larger trials with longer follow-up times are needed.	For all of the included studies, 4 were rated as good quality, 3 as fair quality and 1 as poor quality; Low confidence
Little MT, Roelen K, Lange BCL, Steinert JI, Yakubovich AR, Cluver L, et al. Effectiveness of cash-plus programmes on early childhood outcomes compared to cash transfers alone: A systematic review and meta-analysis in low- and middle-income countries. PLoS Med. **2021**;18(9):e1003698	Systematic review and meta-analysis; Poverty alleviation; 3/17; Cluster-RCTs (3)	Infants and young children (aged 0 – 59 months old) in low-middle income countries as defined by the World Bank; N = 6250; Colombia (1), Mexico (1), Niger (1)	Overall, the interventions had to contain at least 2 parts: (1) Cash transfer that provided financial assistance at individual / household level, was non-contributory, and a grant aimed to reduce impact of/vulnerability to poverty, disbursed in consistent and predictable intervals. (2) At least 1 plus intervention targeting SDG 2 (no hunger), SDG 3 (good health and wellbeing) SDG 4 (education) or SDG 16 (violence prevention). In the relevant studies, the intervention was characterised as	Studies had to include at least (1) one group receiving the cash-plus intervention and (2) one group receiving cash-only.	Cognitive development (Bayley Scale of Infant Development, McCarthy Scales of Children's Abilities– General Cognitive Index).	After standardising the measures, meta-analysis suggests that Cash + Psychosocial Stimulation programmes may not be more effective than cash transfers alone in promoting overall cognitive development (d = 0.16 (−0.25, 0.57), p = 0.24, I2 = 85%), although there is substantial heterogeneity among the studies.	Not reported.	There are two dominant theories about how these cash-plus programmes work: (1) The intervention works by improving mediating outcomes on the pathway to impact (e.g., increasing knowledge), while also addressing the structural deprivations impacting health and development potential; and (2) Supply-side and demand-side interventions must occur in tandem to meet population needs (e.g., providing health services when health checks are a cash condition).	The main limitation of this review is the few study numbers that were retrieved. Findings from this review should be viewed as preliminary evidence and serve as a guide for future research, particularly given the potentially high heterogeneity in the meta-analyses. There are limited and mixed impacts on different and vulnerable subgroups.	The three studies were rated as having low risk of bias; High confidence

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			'psycho-social intervention'.							
Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J, et al. Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. The Lancet. **2011**;378(9801):1502-14.	Systematic review; Poverty alleviation; 4/5; RCT (1), cluster-RCTs (3)	Individuals in low-middle income countries; N = 4479 individuals + 1124 families; Ecuador (1), Mexico (2), South Africa (1)	Interventions were included if they aimed to improve an individual's poverty status, and included: cash transfers, microfinance, loans, social insurance, debt management, and financial services.	Control conditions varied: no loan offered (1), median of cumulative cash transfers (1), delayed receipt of cash transfer (2), recreation services, counselling, provision of food aid (1).	Depression (CES-D, PSS-10), child cognitive development (Woodcock-Munoz cognitive development test, Wechsler abbreviated scale of intelligence), behavioural problems (SDQ).	The mental health effect of these poverty alleviation interventions was varied. In children, conditional cash transfer evaluations after 10 years comparing early recipients and later recipients of the Oportunidades programme in Mexico showed a small but significant effect on reduction of behavioural problems (behaviour problems score (intervention vs control), β=–0·14 (95% CI –0·27 to –0·01), p=0·03), and no significant effect on cognitive scores. When the same intervention was assessed as a continuous outcome (total amount of cash received), a doubling of cash transfers was associated with significant improvements in all cognitive assessments after 5 years: long-term memory (intervention vs control), β=0·12‡ (95% CI 0·04 to 0·19), p=0·002; short-term memory, β=0·13 (95% CI 0·07 to 0·19), p<0·001; visual integration, β=0·08 (95% CI 0·01 to 0·14), p=0·02. The small loans intervention in South Africa was associated with an increase in stress levels among programme participants 6 months after the end of the intervention: high stress symptoms, treatment versus non-treatment regression coefficient, β=0·78† (CI 0·13 to 1·43), p<0·05. Results for depressive symptoms were non-significant in the same trial. The evaluation of the unconditional cash transfer programme in Ecuador did not note any significant effects of the programme on children's cognitive and behavioural outcomes or caregivers' depression indices after 2 years.	Not reported.	Two principal causal pathways have been postulated. According to the social causation hypothesis, conditions of poverty increase the risk of mental illness through heightened stress, social exclusion, decreased social capital, malnutrition, and increased obstetric risks, violence, and trauma. Conversely, according to the social selection or social drift hypothesis, people with mental illness are at increased risk of drifting into or remaining in poverty through increased health expenditure, reduced productivity, stigma, and loss of employment and associated earnings.	The findings suggest that intervention effects are greatly dependent on the precise nature of the intervention (e.g., whether the intervention is a loan, a conditional cash transfer, or an unconditional cash transfer; the level of input, for example amount of cash; and the level of active involvement required from participants), the mental health outcome being assessed, and the context. The interventions in this review suffer from a problem common to many prevention interventions, namely that they target all people identified as poor within a population, and only intervene with one facet of poverty, primarily finance. In the context of multifaceted poverty and the complex relationship between poverty and mental ill health, such interventions are unlikely to have an effect on mental health unless they address more specific mechanisms of the association between poverty and mental health and target a specific vulnerable subgroup of the population.	According to the original authors, some studies were found to have high risk of bias in some domains, but these risks did not substantially compromise the validity of the findings; Low confidence
Marshall T, Goldberg RW, Braude L, Dougherty RH, Daniels AS, Ghose SS, et al. Supported employment: assessing the evidence. Psychiatr	Literature review; Reducing unemployment; 10/17; RCTs (10)	Adults (aged 18 years +) with mental disorders or with co-occurring mental and substance use disorders. Studies generally recruited adults	Interventions were all based on the Individual Placement Support (IPS) model of supported employment. The primary goal of IPS is to help participants achieve competitive employment, which is	Comparisons differed across studies but generally included: other training (group skills	Mental health outcomes were referred to as 'non-vocational outcomes' and included psychiatric symptoms, mental health	Eleven RCTs of IPS consistently found no effects on 'non- vocational outcomes.' Secondary analysis of data from four RCTs of IPS suggested that competitive employment may be associated with greater improvement over time in symptom control, compared with no employment. Although one Mental Health Treatment	Compared with control conditions, supported employment demonstrates consistent evidence for high rates of competitive employment, more	Not reported.	More work needs to be done on subgroup and other adaptations to the IPS model. Mental health outcomes were not clearly measured in this review, so it is difficult to draw accurate conclusions.	The authors rated the level of evidence as 'high' for supported employment. High level evidence was assigned where there were three or more well-designed RCTs

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Serv. **2014**;65(1):16-23.		who were interested in receiving supported employment in outpatient mental health settings. In almost all studies, participants were unemployed at the time of study admission; N = 3515 I = 1817 C = 1898; Studies were conducted across a wide range of socioeconomic and cultural contexts. Countries unclear.	defined as jobs paying at least minimum wage that are located in socially integrated community settings and that are held by consumers directly and not reserved for individuals with disabilities or held by provider agencies.	training, train-place model, placements, sheltered workshops), vocational rehabilitation, psychosocial rehabilitation, or usual care.	status, clinical functioning. Measures not clearly specified.	Study found that supported employment participants had significantly improved mental health status, and reduced in- patient hospital use and psychiatric crisis visits, the supported employment model for this study was complemented by systematic medication management.	hours worked, more weeks worked per year, higher wages, and fewer days to the first competitive job.			evaluating the service; Critically low confidence
McGuire J, Kaiser C, Bach-Mortensen AM. A systematic review and meta-analysis of the impact of cash transfers on subjective well-being and mental health in low- and middle-income countries. Nat Hum Behav. **2022**;6(3):359-70	Systematic review and meta-analysis; Alleviate financial hardship; 31/45; RCTs (9), cluster-RCTs (12), instrumental variable design (2), regression discontinuity (2), propensity score matching (2), difference in difference estimation (1), propensity score matching and difference in difference estimation (2), sample restriction (1).	Individuals in low- and middle-income countries, as defined by the World Bank; N = 77,353; Cambodia (1), China (1), Ecuador (2), Ethiopia (1), India (1), Kenya (7), Liberia (1), Malawi (4), Mali (1), Mexico (4), Nicaragua (1), Nigeria (1), Paraguay (1), Peru (1), Rwanda (1), South Africa (2), Uganda (1).	Interventions included unconditional cash transfers (n = 21), conditional cash transfers (n = 8), or both conditional and unconditional cash transfers (n =2). Across the whole review, the average time from the start of the cash transfer to follow-up was two years. The average monthly payment was $38 adjusted for purchasing power parity. A quarter of the cash transfers were implemented as predominantly a lump sum (n = 13). All other cash transfer programmes (n = 32) were paid out monthly or bi-monthly.	Not detailed.	Mental health measures for depression, anxiety, worry, and distress (CESD-10, CESD-20, GDS-15, GHQ-12, SF-12 (MH), SRQ-20, MHI-5, K-10). For mental health measures that are not a validated psychometric instrument, they refer to the broad state they seek to capture (for example, worry and anxiety). Instruments that combine measures of depression, anxiety or general psychological distress are classified as	Cash transfers, on average, have a consistent positive effect on mental health among recipients. An average improvement in mental health outcomes of about 0.07 SD. was reported. Unconditional cash transfers (d = 0.110; d.f. = 27; P < 0.001; 95% CI 0.086, 0.134) appear to have a larger effect than conditional cash transfers (d = 0.069; d.f. = 13; P = 0.005; 95% CI 0.025, 0.113), but the difference in effect sizes is only marginally statistically significant (Δd = 0.041; d.f. = 40; P = 0.088; 95% CI −0.006, 0.089). A statistically significant intercept was obtained in almost all specifications - this suggests that cash transfers have an effect independent of cash transfer type, context, size, as well as the study type and outcome measure. This may be interpreted as a pure effect from being enrolled in a cash transfer. The authors observed that the effects of cash transfers appear to slowly dissipate over time and that the effect size of cash transfers is positively moderated by both their absolute size and their size relative to previous incomes.	Not reported.	Cash Transfers may impact MH and SWB through mechanisms operating in both the short- and long-term. In the short-term, Cash Transfers may improve food security and reduce the stress associated with financial instability and hardship. In the long-term, Cash Transfers can provide a feeling of economic security to help foster improved social relationships (for example, via improving the capacity of recipients to contribute resources), to better allow access to education and to focus on future investments (for example, via reducing time discounting). Thus, by being protected against future economic shocks, recipients are enabled to focus on long-term goals rather than immediate survival needs.	The results were consistent across a battery of robustness tests and the observed effects did not vary significantly according to study design (RCT and quasi-experimental), country context, payment mechanism or risk of bias. A limitation arises from the paucity of longitudinal follow-ups. There was only one study in our sample that followed up more than five years after the cash transfer intervention began.	According to the original authors, 24 of the relevant studies were rated as having moderate bias and seven were rated as having serious bias; High confidence

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					'Mental health indices'.	The effect of cash transfers on subjective wellbeing was significantly larger than on mental health outcomes. The average estimated effect on SWB (d = 0.134; d.f. = 24; P < 0.001; 95% CI 0.092, 0.176) was clearly larger than the average effect on MH (d = 0.069; d.f. = 28; P < 0.001; 95% CI 0.050, 0.088), and this difference was statistically significant (Δd = 0.065; d.f. = 40; P = 0.005; 95% CI 0.021, 0.110).				
Moore TH, Kapur N, Hawton K, Richards A, Metcalfe C, Gunnell D. Interventions to reduce the impact of unemployment and economic hardship on mental health in the general population: a systematic review. Psychol Med. **2017**;47(6):1062-84.	Systematic review; Reducing impact of job loss, debt, and financial difficulties; 6/11; RCTs (6)	All relevant studies included unemployed adults (mixed gender). Some participants were also experiencing debt. There were more white participants than individuals from other ethnic backgrounds; N = 4624; Finland (1), UK (1), USA (4)	Five studies looked at Job Club interventions which involved job skills training seminars to improve job seeking. One study looked at a debt advice intervention, which included a telephone call from trained advisors from 'National Debtline'.	Comparison groups received: written material (4), no intervention (1), or usual services, which involved a state Government job service and community referral programme or a usual job centre service.	Anxiety (HSCL-90 subscale, STAI State, STAI Trait, STAI-6), depression (HSCL-90, CIDI MDEf, GDS), and psychological symptoms (GHQ-12).	There is reasonably consistent evidence from large RCTs that short, 1- to 2-week 'job club' interventions can reduce depressive symptoms in high-risk, unemployed people up to 2 years. Effects were small but strongest among those at increased risk of depression at baseline (improvements of up to 0.2–0.3 S.D. in depression scores). Evidence of improvement in depressive symptoms in intervention group participants coincided in some studies with higher levels of re-employment and reduced financial strain (mediating factors). An RCT of debt advice found no effect but had poor uptake.	Not reported.	Some studies looked for aspects of the intervention that might contribute to the change in outcome (mediating effects). There was some evidence that reduced depressive symptoms were associated with re-employment, reduction of financial strain, and job search preparedness (self- efficacy and inoculation against setbacks).	The authors reported a number of quality issues with the included studies, particularly a lack of information needed to assess bias and issues around participant blinding. Recent research into suicides occurring during a period of recession indicated that those whose suicide appeared to be related to consequences of recession were largely still in work, and cohabiting with financial dependents, but had no contact with secondary-care psychiatric and little recent contact with primary-care services. This suggests the need for research into how best to (a) identify those at risk of adverse mental health outcomes during recession, and (b) intervene to reduce risk among those not in contact with services.	Most studies were assessed as at high or unclear risk of bias; High confidence
Nieuwenhuijsen K, Verbeek JH, Neumeyer-Gromen A, Verhoeven AC, Bültmann U, Faber B. Interventions to improve return to work in depressed people. Cochrane Database Syst Rev. **2020**;10(10):Cd006237.	Systematic review and meta-analysis; Improving employment engagement; 11/45 RCTs (10), cluster-RCTs (1)	Adult (over 17 years old) workers (employees or self-employed); N = 1481 Denmark (1), Norway (1), Sweden (1), The Netherlands (5), USA (3)	Work-directed interventions aim to ameliorate the consequences of depressive disorders on the ability to work. These types of interventions either target the work itself, by modifying the job task, or (temporarily) reduce the working hours. Work-directed interventions can also support the worker in dealing with the consequences of their depression at the workplace. The work-directed interventions	Comparison conditions included various care as usual conditions (psychiatric clinical management, primary care), other work-directed interventions, or no intervention.	Depression (4DSQ, BDI CES-D, DSM-IV criteria, HADS HAM, HRSD PHQ, PHQ-9, StIDS-SR)	A combination of a work-directed intervention and a clinical intervention may reduce depressive symptoms (SMD -0.25, 95% CI -0.49 to -0.01; 8 studies, low-certainty evidence). When considering work-directed interventions alone, there is probably no effect on depressive symptoms (SMD -0.10, 95% -0.30 CI to 0.10; 4 studies, moderate-certainty evidence) within the first year of follow-up and there may be no effect on depressive symptoms beyond that time (SMD 0.18, 95% CI -0.13 to 0.49; 1 study, low-certainty evidence).	A combination of a work-directed intervention and a clinical intervention probably reduces sickness absence days within the first year of follow-up (SMD -0.25, 95% CI -0.38 to -0.12; 9 studies; moderate-certainty evidence). The intervention does not lead to fewer persons being off work beyond one year follow-up (RR 1.08, 95% CI 0.64 to 1.83; 2 studies, high-certainty evidence).	Work-directed interventions are deemed to reduce work disability by creating a work environment better suited for a depressed worker, such as modifying work tasks or working hours. Moreover, the worker can be supported in dealing with the depression at work by a gradual return to work program or by enhancing skills to cope with work situation.	More research is needed on the addition of work-directed interventions to the clinical care provided; the number of studies evaluating these types of interventions is still limited.	Certainty of the evidence for depression outcomes was low and moderate. Moderate confidence.

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			assessed involved a range of approaches including: (1) support from occupational therapists, (2) work coaching and modification, care coordination, and CBT strategies, (3) exposure-based return to work, (4) collaborative care including OT support, manual-guided self-help, workplace intervention, with ongoing psychiatric consultation. Of the 11 relevant studies, 8 looked at work-directed interventions combined with clinical interventions and 4 looked at work-directed interventions alone.							
Pachito DV, Eckeli AL, Desouky AS, Corbett MA, Partonen T, Rajaratnam SM, et al. Workplace lighting for improving alertness and mood in daytime workers. Cochrane Database Syst Rev. **2018**;3(3):Cd012243.	Systematic review; Improved work environment; 5/5; RCTs (3), CBA studies (2)	Daytime indoor workers in office and hospital settings; N = 282; Europe (4), North America (1)	Lighting interventions in the workplace were assessed. This included: use of cool-white light known as high correlated colour temperature (CCT), different proportions of indirect and direct light, individually applied blue-enriched light, and individually applied morning bright light.	Comparison conditions included standard illumination, different proportions of indirect and direct light, no treatment, and afternoon bright light.	Mood (SIGH-SAD, HDRS-17, SAD subscale, BDI-II, PANAS).	Cool-white light (CCT) does not improve mood in daytime workers. Changing the proportions of direct and indirect light in the workplace may not affect mood. Glasses with mounted LEDs (light emitting diode) providing blue-enriched light may improve mood in workers compared to no treatment (MD -4.80, 95%CI -9.46 to -0.14). Personal exposure to bright light during the afternoon improves mood just as well as personal exposure to bright light in the morning in people exhibiting symptoms that are not severe enough for the diagnosis of seasonal depression.	Not reported.	Light is important in many biological functions, such as the regulation of sleep, and it may influence a person's state of mood and level of alertness. Daytime workers who spend most of the time indoors may be exposed to low light levels during daytime. This may lead to decreased levels of alertness and mood disturbances.	All the included studies were conducted in the Northern hemisphere, so it was not possible to estimate whether the findings of these studies could be extrapolated to tropical or subtropical regions, where natural light is intense even in the winter. No studies focused on blue collar workers. Randomised controlled trials with more rigorous methodological quality are needed.	Quality of the evidence was graded as low by original review authors; High confidence
Pega F, Pabayo R, Benny C, Lee EY, Lhachimi SK, Liu SY. Unconditional cash transfers for reducing poverty and vulnerabilities: effect on use of health services and health outcomes in low- and middle-income countries. Cochrane Database of Systematic Reviews. **2022**;2022(3).	Systematic review; Reducing poverty; 7/34; c-RCTs (5, covering 7 studies)	Children (0 to 17 years) and adults (18 years or older) residing in low- and middle-income countries, as defined by the World Bank; N = 9,487 households + 6236 older adults + 4924 children / adults I = 3755 households + 3230	Unconditional cash transfer (UCT) programs for reducing poverty or vulnerabilities, featuring the following characteristics: "in-hand" cash payment, unconditional (no de facto conditions attached to receipt), non-contributory (not a payment from a social insurance system that recipients have previously contributed to), provided by a	Control groups received no unconditional cash transfer.	Depression (CES-D, GDS).	The evidence is very uncertain about the effect of a UCT on depression. Three c-RCTs of individual study participants reported a decrease in level of depression, one c-RCT of households reported an increase in level of depression, and one c-RCT with an unclear population reported a decrease in level of depression, as measured using the CES-D or GDS score.	One study reported that a UCT led to a very large increase in the likelihood of owning a goat or sheep, compared with no UCT, when followed up at 36 months into the intervention (RR 2.15, 95% CI 1.45 to 3.21; 1 study, 371 participants (effective sample size); moderate-certainty evidence).	The primary causal pathway through which UCTs impact health is through income. There is some evidence suggesting that cash transfer programmes reduce the depth or severity of income poverty in children and adults in LMICs. his reduced risk of income poverty in the recipient household may improve health outcomes all by itself. More specifically, income from publicly-funded cash transfers may impact health at the individual level through five types of causal effects: Direct consumption effects, direct status	The authors did not identify any harms of UCTs. The relative effectiveness of UCTs compared with conditional cash transfers (CCTs) also remains uncertain. More evidence from experimental studies is required to improve this currently limited and overall relatively uncertain body of evidence. For UCTs for which experimental study designs are not financially, operationally, or otherwise feasible, quasi-experimental studies present promising options for epidemiological and	Quality of the evidence for depression outcome was graded as very low by original review authors; High confidence

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		older adults + 530 children / adults C = 3938 households + 3096 older adults + 256 children / adults (I and C unclear for one study); Ecuador (2), Kenya (2), Malawi (1), Nigeria (1), Zambia (1)	formal institution or as part of a scientific study, disbursed to an individual or household (not community), and is provided regularly over extended periods of time (i.e. twice or more over a one-year period). The unconditional cash transfer programs provided cash of a value equivalent to 1.3% to 53.9% of the annualised gross domestic product per capita.				Another study reported no evidence for an effect of a UCT, compared with no UCT, on the likelihood of owning any livestock at 24 months into the intervention (RR 1.00, 95% CI 0.29 to 3.44; 1 study, 909 participants (effective sample size); low-certainty evidence). Five studies (all C-RCTs), with an effective sample size of 9184 households, assessed the effect of a UCT on the likelihood of being extremely poor at 24 or 36 months into the intervention. In relative terms, the point estimate showed that the UCT led to a large reduction in risk, with the 95% CI suggesting that the effect may be between a very large and a small reduction in the risk (RR 0.92, 95% CI 0.87 to 0.97; I2 = 63%; 6 cluster-RCTs, 3805 participants; low-certainty evidence).	effects, combined consumption and status effects, employment effects, and reduced financial risk.	econometric health impact evaluations. Randomised controlled trials (RCTs) of individual participants would be preferable over RCTs of clusters of individuals. All future experimental studies of the impact of UCTs on health or health-related outcomes should always publish comprehensive a priori study protocols. Future experimental studies should also comprehensively assess contamination (e.g., by using spill-over control groups) to reduce risk of bias from contamination. Since the current body of evidence is primarily for the Americas and Africa, more research is also needed particularly for the Eastern Mediterranean, South-East Asian and Western Pacific regions.	
Puig-Barrachina V, Giró P, Artazcoz L, Bartoll X, Cortés-Franch I, Fernández A, et al. The impact of Active Labour Market Policies on health outcomes: a Scoping review. Eur J Public Health. **2020**;30(1):36-42.	Scoping review; Increasing employment; 12/36; Experimental (9), quasi-experimental (3)	Adults of working age, in their respective country, who were unemployed and participating in an Active Labour Market Policy (ALMP); N = 13115; Australia (2), Finland (3), Ireland (1), USA (6)	ALMPs are oriented towards creating employment and promoting labour reintegration. Twelve studies assessed job search assistance (with a psychological component) as an intervention, with one also including job training.	Unclear.	Depressive symptoms (BDI, SCL-11, SCL-90), psychological distress (GHQ-12), anxiety (SCL-90).	Findings were mixed. Three studies reported no statistically significant intervention effect for mental health outcomes. Ten studies reported at least one improvement in mental health outcome, favouring the intervention group. Six of these studies highlighted that intervention effects were greatest for participants who had bad health or were at high risk of poor mental health at baseline. Improvements in mental health were often mediated by re-employment and reduced financial strain for intervention participants.	Individuals in interventions were more likely to be re-employed or in training at follow-up, report reduced financial strain, and increased mastery and job preparedness. These factors contributed to reduced depression/distress.	The most significant knowledge gaps are the mechanisms involved in achieving mental health improvements, and above all the differential health impacts according to axes of inequality and welfare state. Individual well-being relies on five fundamental needs: time structure, social contacts, collective effort or purpose, social identity or status and regular activity. These needs can be met by numerous activities, and participating in the labour market may satisfy these needs. An individual's subjective well-being	It would be desirable to undertake new evaluations of the effects of ALMPs with a gender, class, intercultural, and international perspective. A recent branch of literature has stressed that, in the context of high precariousness, getting an insecure job does not necessarily lead to health improvement. In this sense, eventual improvements in health and wellbeing due to the ALMP may dissipate quickly after the transition to precarious employment. This possibility	Quality of the evidence was not assessed by the original review authors; Critically low confidence

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								depends on feeling that they are in control of their life course, as well as economic matters. Some types of ALMPs, such as education or some forms of labour market activity can fulfil some of the needs met by employment, both the psychosocial needs and the sense of control.	must be taken into account when implementing welfare-to-work polices in an ALMP.	
Ridley M, Rao G, Schilbach F, Patel V. Poverty, depression, and anxiety: Causal evidence and mechanisms. Science. **2020**;370(6522):eaay0214.	Systematic review and meta-analysis; Poverty alleviation; 30/30; RCTs (30)	Individuals in low- and middle-income countries; Not reported; Afghanistan (1), Bangladesh (1), Burkina Faso (1), Democratic Republic of the Congo (1), Ecuador (1), Ethiopia (1), India (1), Kenya (5), Liberia (1), Malawi (3), Mali (1), Mexico (1), Multiple (1), Nepal (1), Nicaragua (1), Philippines (1), South Africa (1), Uganda (2), Zambia (2).	Multifaceted antipoverty interventions (n = 10 studies) and cash transfer interventions (n = 20 studies) were included. "Multifaceted antipoverty programs" refers to interventions that aimed to lift people out of poverty by providing a range of elements, typically including asset transfers, skills training, cash support, and access to savings and health care opportunities. "Cash Transfers" refers to studies of unconditional cash transfers to low-income households, with the exception of 2 studies that examined conditional cash transfer programs.	Not clearly reported.	Mental health was the broad construct presented in the review. The outcomes vary across studies and include screening instruments to detect common mental illnesses (GHQ-12) and symptoms of depression (CES-D, APAI-R), indices of psychological well-being (PWB), and a perceived stress scale (PSS).	Anti-poverty programs are associated with improved mental health. Positive treatment effects imply better mental health. The overall average treatment effect of anti-poverty programs was 0.094 SD (95% CI: 0.040, 0.147). For cash transfers the average treatment effect was SD = 0.067 and for multifaceted antipoverty programs the average treatment effect was SD = 0.138.	Not reported.	Poverty leads to worry, physical health problems, early-life conditions, violence and crime, and impacts social status. These factors can lead to mood and anxiety disorders which in turn impact productivity, labour supply, preferences and beliefs about the self, economic decision-making, women's empowerment, and childhood development. These factors once again feed into increased poverty. Anti-poverty programs help to break this cycle.	The worries and uncertainty that come with living in poverty seem to be an important driver of mental illness, as do the effects of poverty on childhood development and one's living environment. We have more limited causal evidence for other plausible channels, including worsening of physical health caused by poverty, increased exposure to violence or crime, and the effects of low relative social status and social isolation. Understanding which of these mechanisms are important may have implications for policy choices. For example, if worries and uncertainty play a major role, then providing health and unemployment insurance may be crucial, whereas if early-life conditions are the key drivers, then cash transfers to parents of young children could be the most appropriate policy response.	Quality of the evidence was not assessed by the original review authors; Critically low confidence
Ruotsalainen JH, Verbeek JH, Mariné A, Serra C. Preventing occupational stress in healthcare workers. Cochrane Database of Systematic Reviews. **2014**(4).	Systematic review and meta-analysis; Improving working conditions for healthcare workers; 21/58; RCTs (12), cluster-RCTs (4), controlled clinical trials (3), cluster-randomised cross-over non-inferiority trial (1), CBA study (1).	Healthcare workers who had not actively sought help for conditions such as burnout, depression, or anxiety disorder; N = 4764; Belgium (1), Canada (3), France (1), Iran (1), Japan (1), The Netherlands (3), Sweden (2), Taiwan (1), Turkey (1), UK (4), USA (4)	Organisational interventions were assessed. They aimed at changing working conditions in 20 studies, improving support or mentoring in six studies, changing content of care in four studies, improving communication skills in one study, and improving work schedules in two studies.	Most studies compared an organisational intervention to no intervention. One compared to care as usual, one to feedback only, and one compared shorter vs longer working schedules.	Stress (PSS, DeVilliers Carson Leary Stress Scale, Organization & Stress Scale, Nursing Stress Scale), Burnout (MBI, Oldenburg Burnout Inventory, other study created scales), Psychological distress (HADS, CES-D, QPS Nordic, GHQ, SCL-90-R, SF-36).	Shorter or interrupted work schedules (with a weekend break instead of a continuous schedule) reduced stress levels in two studies (Std Mean Diff (95% CI) = -0.55 (-0.84, -0.25); Test for overall effect: Z=3.59(P=0), Heterogeneity: Tau2=0; Chi2=0.28, df=1(P=0.59); I2=0%). There was no clear benefit of any of the other organisational interventions (e.g., Peer-support schemes, communication skills, extra care training, use of telemedicine).	Not reported.	Organisational interventions can prevent stressful events from occurring or the feeling of stress or burnout from developing by adjusting work practices so that they match and make use of workers' capabilities better. Better theoretical underpinning is needed of how organisational interventions would lead to an individual stress reduction.	Many interventions, such as organising peer support groups or mentoring schemes, are difficult to classify as either person- or work-directed interventions. Randomised trials of better quality are needed. Studies should have at least 60 participants in each arm to avoid a small-studies effect. Cross-over studies are best avoided because it is unclear if a washout period can prevent contamination and how long such a period should be. Cluster-randomised trials should adjust their results for the clustering effect and report the cluster-coefficients. Attrition bias should be avoided by reducing dropout and by the use of better	In general, most studies were of low methodological quality, with at least several items that we judged to put them at a high risk of bias; High confidence

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									methods of imputation of missing values. Follow-up time should be at least one year, to be sure that results of the intervention are lasting. Studies in physicians are lacking. Interventions could also be more focused on specific stressors such as work schedules. The quality of reporting (random number generation, allocation concealment, blinding) should be improved.	
Suijkerbuijk YB, Schaafsma FG, van Mechelen JC, Ojajärvi A, Corbière M, Anema JR. Interventions for obtaining and maintaining employment in adults with severe mental illness, a network meta-analysis. Cochrane Database of Systematic Reviews. **2017**;2017(9).	Network meta-analysis; Increasing employment; 7/48; RCTs (7)	Adults aged between 18 and 70 years who had been diagnosed with severe mental illness and were unemployed due to severe mental illness; N = 3206 I = 1608 C = 1606; China (1), the Netherlands (1), mixed Europe (1), USA (4)	The interventions could be classified in main groups: supported employment, augmented supported employment, prevocational training, transitional employment, and psychiatric care only.	Comparison groups could be other types of vocational rehabilitation, no intervention, or psychiatric care only.	Mental health (SFHS, PANSS, BPRS, HADS, MHI).	Seven RCTs produced end-score data with mental health instruments and all of them had a follow-up duration of more than one year. Only two comparisons showed significant results. In one study, the participants in the prevocational training group scored significantly lower on all scales of the PANNS: positive symptoms (SMD -2.48, 95% CI -3.95 to -1.01) negative symptoms (SMD -1.61, 95% CI -2.99 to -0.23) and general psychopathology (SMD -1.86, 95% CI -3.09 to -0.63), compared to those receiving psychiatric care only. In another large trial, a significant difference in SFHS end scores in favour of supported employment compared to psychiatric care only was found (SMD 2.88, 95% CI 1.78 to 3.98).	Supported employment and augmented supported employment are more effective than the other interventions in obtaining and maintaining competitive employment for people with severe mental illness without increasing the risk for hospital admissions. The difference in effectiveness between supported employment and augmented supported employment is small.	Prevocational training assumes that people with severe mental illness need to learn certain skills before they can hold a competitive job. In a protective environment, and in a stepwise way, people with severe mental illness are gradually exposed to 'normal' working conditions and routines. These types of interventions focus on helping and empowering the individual. A key component of supported employment is the integration of employment services and a mental health treatment team.	Most RCTs were conducted in North America. The authors did not find any trials from low- or middle-income countries. The results of this review could be less applicable for these countries because their mental health care systems are less developed or community-based, or both, and are not integrated with vocational rehabilitation programmes.	Original authors rated the quality of evidence as moderate-to-low; High confidence
Suto, M., Balogun, O. O., Dhungel, B., Kato, T., & Takehara, K. (**2022**). Effectiveness of Workplace Interventions for Improving Working Conditions on the Health and Wellbeing of Fathers or Parents: A Systematic Review. Int J Environ Res Public Health, 19(8).	Systematic review; Improving working conditions; 7/7; RCTs (5), quasi-experimental (2)	Working population from various sectors including healthcare, service and welfare, information. Included males and females; N = 3489 I = 1364 C = 1285 (Final I and C unclear for one study);	Five types of different interventions were assessed: (1) Reduced weekly working hours; (2) Self-rostering/ flexibility; (3) Supervisory/ employee training - managing work-family interface; (4) Workplace parenting intervention - managing work-family interface; (5) Individualised counselling to employees.	Comparison conditions varied: no intervention, other active arms, placebo groups, waiting lists, or usual practice.	Worry, stress / perceived stress (DISE, Teacher Occupational Stress Factor Questionnaire), mental distress, workplace distress (CGPWOS), somatic symptoms (Symptom checklist-90), depression (PHQ, DASS), anxiety (DASS, GAD-2), alcohol	No negative effects were reported in the seven studies in terms of mental distress, depression, anxiety, and stress. For interventions in which weekly working hours were reduced by 25% (work reduction), intervention participants experienced decreased stress on work days (estimate -0.243 (-0.356, -0.130); p<0.01) and on days off (estimate -0.224 (-0.338, -0.110); p<0.01). Specifically, men were shown to have benefitted more from worktime reduction, as compared with women, while male and female employees with children living at home reported somewhat lower levels of perceived stress on workdays, as compared to those without children.	Six studies reporting on social wellbeing, work-life balance, marital conflict, parent-child relationships, and parental satisfaction and efficacy found positive intervention effects or no statistically significant difference. Four studies assessed intervention effects on job performance, and statistically significant effects were reported for	Work life conflict is known to have a potentially negative impact on personal effectiveness, marital relations, parent-child relationships, and even child development. Work-related stressors are also linked to decreased job and life satisfaction, stress-related outcomes like psychological disorders, exhaustion, and alcohol abuse. Providing interventions for improving working conditions is promising for improving aspects of psychological health, through improving physical health and quality of sleep, for example.	The included studies had high heterogeneity, with differences in intervention types and variations in study design, setting and populations limiting comparability. In some studies that included both parents and childless employees, it was not clear if all included male employees had children, so generalisations specific to fathers is not possible. Keywords used in search strategy to identify eligible studies may have been narrow and excluded publications in occupational health that may have included fathers. All included studies were from high-income countries,	According to the review authors, 2 studies had low risk of bias, 4 studies had unclear risk of bias, and 1 study had high risk of bias; High confidence

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		Australia (3), Denmark (1), Sweden (1), USA (2)			use disorders (AUDIT), child negative and positive affect (PANAS), child problem behaviours (ECBI, SDQ).	For interventions which involved self-rostering (work flexibility) and gave participants choice over their work activities, intervention participants experienced reduced somatic symptoms (estimate -0.104 (-0.19, -0.022); p = 0.013) and reduced mental distress (estimate -0.131 (-0.23, -0.032); p = 0.010) at 12-month follow-up. For interventions focussing on supervisory/employee training (designed to reduce work-family conflict), intervention participants experienced reduced negative affect (B = -0.11 (-0.18, -0.03), ES = 0.24) and increased positive affect (B = 0.43 (0.32, 0.55), ES = 0.30). Several interventions looked at workplace parenting interventions, such as the Workplace Triple P program (aiming to reduce work-family conflict and improve family functioning). In a study of teachers, intervention participants experienced reduced work stress (Cohen's d = 0.70 (0.08, 0.79)), depression symptoms (Cohen's d = 0.58 (0.21, 1.06)), and anxiety symptoms (Cohen's d = 0.57 (0.46, 1.33)), with findings maintaining at 4-month follow-up. In another study of the Workplace Tripe P program, which included only fathers with children aged 2-9 years at home, there was no intervention effect on work stress, but intervention participants reported significantly reduced child behaviour problems (behaviour problems: F (1, 27) = 4.25 (p = 0.05), which maintained at 4-months follow-up. In another study of the Triple P program, involving fathers with children aged 1 – 16 years living at home, intervention participants reported significantly lower parental distress (DASS total: Cohen's d = 0.64, p = 0.002) but not work stress at 8-week follow-up. There did not appear to be an intervention effect on child behaviour outcomes (measured by SDQ). Employee assistance programs (offer individualized counselling to support employees to identify effective coping	job satisfaction, workplace commitment, and self-efficacy at work post intervention.		restricting generalizability of findings.	

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						strategies for personal and professional stressors) did not significantly reduce workplace distress or at-risk alcohol use in intervention participants, but did lead to reduced symptoms of depression (b -1.098 (SE 0.463), *b* = -0.100; *t* = -2.37 (-2.009 to -0.187) and anxiety (b -0.327 (SE 0.158), *b* = -0.092; *t* = -2.06 (-0.638 to -0.016).				
van Rijn RM, Carlier BE, Schuring M, Burdorf A. Work as treatment? The effectiveness of re-employment programmes for unemployed persons with severe mental health problems on health and quality of life: a systematic review and meta-analysis. Occup Environ Med. **2016**;73(4):275-9.	Systematic review and meta-analysis; Increasing employment; 13/16; RCTs (13)	Participants were unemployed, aged between 18 and 65 years, and had mental health problems; N = approximately 1,961; Canada (1), Hong Kong (1), The Netherlands (1), Switzerland (1), UK (2), UK/EU mix (1), USA (6)	The intervention was mostly Individual Placement and Support (IPS). IPS emphasises integration of vocational and healthcare services, rapid job finding, obtaining competitive employment that corresponds to the clients' preferences and clinical and rehabilitative needs, and follow-along support at the job. Some studies used a derivate of IPS like Compensated Work Therapy (CWT), Assertive Community Treatment with Individual Placement Support (Act-IPS) or integrated supported employment combined with work-related social skills training.	In all studies, the control group received traditional vocational rehabilitation which consists of pre-employment training and medical care as usual.	Mental health / psychiatric symptoms (PANSS, HADS, BPRS, MHI-5).	Mental health outcomes were mixed across studies. For six studies measuring psychiatric symptoms, using comparable scales, no statistically significant pooled intervention effect was reported. Six studies measured psychiatric symptoms and the pooled effect size was 0.20 (95% CI −0.23 to 0.62). The meta-regression analysis showed that studies with over 50% of male participants had a lower effect size of mental health (β −1.43, 95% CI −2.12 to −0.74).	Within studies which were included in the mental health meta-analysis, the percentage of competitive employment ranged from 13% to 55% in the intervention groups compared to 2% to 28% in the control groups.	Re-employment of unemployed persons may be a powerful intervention to reduce health inequalities.	Research should focus on establishing the effectiveness of re-employment programmes for health based on the place-and-train model, by conducting RCTs with a larger sample size, with health outcomes as their primary outcome measure, and with longer follow-up periods.	Risk of bias was low for most assessment items. A high risk of bias was found with regard to blinding. It was unclear across most studies whether co-interventions were avoided, or whether these were similar in the intervention group as well as in the control group; Critically low confidence
Walton MT, Hall MT. The Effects of Employment Interventions on Addiction Treatment Outcomes: A Review of the Literature. Journal of Social Work Practice in the Addictions. **2016**;16(4):358-84.	Review of the literature; Improving employment; 8/12; RCTs (8)	Adult participants (18 years of age or older) who met diagnostic criteria for substance dependence (USA only); N = 955 I = 515 C = 429 USA (8)	Most studies tested some form of simulated employment (n = 7). Simulated employment refers to an experimental employment intervention administered in a controlled setting for the purpose of testing its effects on substance use. Fewer studies looked at competitive employment (n = 1), interventions that measure the effects of participants securing competitive employment	Other types of simulated employment, inactive control, or usual care.	Substance use (toxicology screens/samples, ASI, HCQ, ACSB, DSM-IV checklist for cocaine, opioid, and alcohol dependence), Psychological distress (BSI).	Participants in almost all employment interventions (n = 7 studies) showed greater abstinence from a range of substances (alcohol, cocaine, opiate) and fewer substance-use-related problems than participants in control conditions. In some studies, individuals who engaged in employment services used substances at nearly half the rate of individuals who did not receive such services. One study showed that participants who improved the quality of their employment (e.g., higher pay, more interesting work) over the study period showed less substance use than those with poorer quality jobs. Only one study showed no significant intervention effect.	Participants in some employment interventions also experienced fewer episodes of homelessness, better employment-related outcomes, and decreased criminal behaviour.	Employment provides income, but also offers a consistent and (ideally) positive social environment, as well as daily structure. For individuals in recovery from substance use disorders, employment might be beneficial in this general sense as well, but also valuable for sustained recovery. Jobs require individuals to delay gratification and to manage frustration and other negative emotions in healthy ways, and afford them with avenues to feel a sense of achievement. Employment and vocational services enhance treatment for substance-using clients by providing a gateway into a healthier and more productive	Evidence suggests that some working fields might not be advisable for people in early recovery due to a higher prevalence of substance abuse among workers; the construction industry is such an example. Similarly, high-stress fields might not be advisable job placement sites because they leave clients more prone to relapse. Future research is needed to determine which industries or job roles are most conducive to anchoring treatment gains for clients in recovery. Future research should explore whether type of work has differential effects on client outcomes. For example, does placement in low-skilled work	Quality of the evidence was not assessed by the original review authors; Critically low confidence

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			(conventional jobs in the US labour market) in a non-experimentally controlled setting. Competitive employment interventions focused on helping participants interview for and succeed in jobs.					social network. Stable employment allows access to income, which can then be spent on stable housing, which is correlated with better mental and physical health, demonstrating that ancillary benefits begin to accumulate and further embed the gains made in substance abuse treatment.	achieve similar short-term outcomes as placement in positions that more accurately match a client's interests and abilities? Studies with hiring managers related to the employment possibilities of individuals with alcohol use disorders reveal substantial misconceptions and stereotypes.	
Wollburg C, Steinert JI, Reeves A, Nye E. Do cash transfers alleviate common mental disorders in low-and middle-income countries? A systematic review and meta-analysis. Plos one. **2023**;18(2):e0281283 .	Systematic review and meta-analysis; Poverty alleviation; 17/17; RCTs (3), cluster-RCTs (14)	Adults and adolescents, who live in poverty and receive cash transfers in low-and middle-income countries as defined by the World Bank; N = 26,794; Bangladesh (1), Ecuador (1), Kenya (4), Malawi (3), Mali (1), Nicaragua (2), South Africa (2), Uganda (1), Zambia (2)	Conditional (n = 5 studies) and unconditional (n = 10 studies) cash transfer programs (CTPs) targeted at households living in poverty in low-and middle-income countries. Two studies compared the effects of conditional and unconditional transfers. Conditions focused on school attendance (6 studies), health check-ups (2 studies), and/or the development of a business proposal (3 studies). Transfer values varied between US$144 and US$1,525 over the length of the program, which is equivalent to approximately 9%–23% of participants monthly consumption. Most CTPs provided payments on a monthly or bimonthly basis over a period of nine months to four years. Three programs delivered one-time lump sums.	Participants in inactive control groups, who received no cash transfers or were enrolled at a later stage (waitlist control), served as comparison group.	Depression (CES-D, GHQ, PHQ-9, CDI), anxiety (GHQ, CMAS), stress (PSS).	Meta-analysis (of 11 studies and pooling data from 22,488 participants) showed that cash transfers significantly reduced depression and anxiety of recipients (dpooled = -0.10; 95%-CI: -0.15, -0.05; p<0.01). However, improvements may not be sustained 2–9 years after program cessation (dpooled = -0.05; 95%-CI: -0.14, 0.04; ns). Meta-regression indicates that impacts were larger for unconditional transfers (dpooled = -0.14; 95%-CI: -0.17, -0.10; p<0.01) than for conditional programs (dpooled = 0.10; 95%-CI: 0.07, 0.13; p<0.01). Effects on stress were insignificant and confidence intervals include both the possibility of meaningful reductions and small increases in stress (dpooled = -0.10; 95%-CI: -0.32, 0.12; ns). No harmful effects were reported.	Not reported.	Findings align with evidence from high-income countries suggesting a causal effect of positive income shocks on mental health.	It is important to note that due to the limited number of studies, further research is needed to equip practitioners and policymakers with a better understanding of the role of conditionality in CTPs for mental health. Such studies could further analyse the potential of soft conditionality in the form of labelling and messaging, which may suffice to achieve desired goals without putting as much strain on participants. Although restricting eligibility to randomized trials increases confidence in causal effects, there are important shortcomings of RCT designs. Smaller-scale, controlled experiments have limited generalizability to larger contexts, due to, e.g., unanticipated equilibrium-effects or implementation challenges at scale. Additional analysis of quasi-experimental research and longitudinal studies may improve estimates of the effects of CTPs at larger scale. Policies aiming to address the poverty-mental health cycle should therefore consider unconditional, longer-term support to populations living in poverty.	Following GRADE-criteria, the overall confidence is judged to be moderate at post-intervention and low at longer-term follow-up, due to some indication of publication bias and since meta-analysed trials carried intermediate to high risk of bias; High confidence
Zaneva M, Guzman-Holst C, Reeves A, Bowes L. The Impact of Monetary Poverty Alleviation Programs on Children's and Adolescents' Mental Health: A Systematic Review and Meta-Analysis Across Low-,	Systematic review and meta-analysis; Poverty alleviation with cash; 14/14;	Children and adolescents, aged 0 - 19 years old; N = 16750 (at follow-up); Africa (8), Asia (2), Central America	Monetary transfer interventions that aimed to alleviate poverty or socioeconomic inequalities. The majority of studies were cash transfer programs with cash typically dispensed to adult	Comparison conditions varied: Life Skills and Red Cross training (1), received welfare as usual (1), or did not	Externalising and internalizing symptoms, encompassing aggressive behaviours, hyperactive behaviours, delinquent	Poverty alleviation interventions providing monetary transfers are generally effective in improving the mental health of adolescents. However, some programs, particularly conditional interventions, may actually be harmful for adolescent girls in low- and middle-income countries, as they can increase responsibilities and create stress.	Not reported.	It is important to consider the differential gender effects of cash transfer interventions in general. One proposed mechanism for this may relate to economic autonomy. Although it is established in adults that women and men in low-income countries have different levels of economic agency and ability to make financial decisions,	In the context of high-risk settings, such as armed conflict or extreme deprivation, monetary transfer programs are limited in their effectiveness on their own. Integrated poverty alleviation interventions, combining cash and social care, appear more impactful for improving outcomes for	The authors found low risk of bias in the included studies overall and concluded that causal inferences can be made; Moderate confidence

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Middle-, and High-Income Countries. J Adolesc Health. **2022**;71(2):147-56.	RCTs (5), cluster-RCTs (7), pseudo-RCTs (2)	(1), South America (1), USA (2)	caregivers, and sometimes to children themselves. These were either unconditional cash transfers (UCTs) or conditional cash transfers (CCT). In CCT programs, participants needed to comply with certain conditions such as school attendance or healthcare visits to receive their cash. Two programs provided grants in the form of larger lump sums. Three programs were integrated with social care and also provided training or coaching components. Cash amounts ranged from $1 to $468, or could be a proportion of the caregivers' wage, and were paid monthly, quarterly, or as lump sums.	receive any intervention (12).	behaviours, depressive symptoms, anxiety symptoms, trauma, and mental distress (SDQ, CES-D, GHQ-12, CRIES-8, SSQ, BPI, BASC, SMFQ).	8 studies were meta-analysed and suggest a small positive effect of the intervention on adolescent mental health (10 - 19-year-olds). Internalizing problems were significantly reduced post-intervention compared to post-control conditions (OR = 0.72, 95% CI 0.59-0.88, p< .01; I2 = 67%, p < .01). This is a population-level effect and small effects from public health interventions would produce greater net benefit than large changes in small segments of the population.		this is less clear in younger populations. It is possible that boys have more autonomy and are more likely to spend transferred money as they like, while girls may feel pressure to contribute to the family budget.	adolescents. Cash transfer programs may produce adverse mental health outcomes for those who are left out. The presently available evidence base is limited, and this is perhaps in part due to the fact that mental health is a secondary outcome for monetary poverty alleviation programs. Evidence is severely lacking for high-income countries, externalizing symptoms, and young children.	
Zimmerman A, Garman E, Avendano-Pabon M, Araya R, Evans-Lacko S, McDaid D, et al. The impact of cash transfers on mental health in children and young people in low-income and middle-income countries: a systematic review and meta-analysis. BMJ Glob Health. **2021**;6(4).	Systematic review and meta-analysis; Reducing poverty; 11/12; RCTs (2), cluster-RCTs (6), quasi-experiments (3)	Children, adolescents, and young adults aged below 25 years in low- and middle-income countries; N = 43861 (for whole review); Cambodia (1), Ecuador (1), Kenya (2), Malawi (2), Mexico (1), Nicaragua (1), Liberia (1), South Africa (1), Uganda (1)	Interventions were (A) 'targeted' anti- poverty interventions, defined as anti- poverty policies that strive to target poor people as the direct beneficiaries to reduce monetary poverty (income or consumption poverty) and/or some dimension of poverty (e.g., education, employment or housing materials) and (B) involved a direct cash transfer, such as and including: conditional and unconditional cash transfers, microfinance, loans, debt management and economic strengthening using matched savings. Six studies assessed conditional cash transfer interventions	No cash transfer.	Depression (CES-D-10, SMFQ-12, CDI-11, CDI-27, Beck Hopelessness Scale-20), psychological distress (GHQ-12), behavioural problems (Denver Developmental Screening Test, BPI, McCarthy Tests), anxiety (SMFQ-12, CMAS-R-28), PTSD symptoms (PTSD checklist-28).	Findings were mixed. Seven included studies reported improvements in at least one mental health outcome of interest (depression, psychological distress, behavioural problems PTSD symptoms, or anxiety). Seven studies reported no change in at least one mental health outcome of interest (depression, behavioural problems, anxiety). 100% of studies with transfers at $20 or higher per month reported a positive effect on mental health, whereas only 60% of studies with transfers lower than $20 reported a positive effect. No study found a negative impact on any mental health outcome. Seven studies were included in a meta-analysis assessing impact on depressive symptoms. There was no impact of cash transfers on depressive symptoms (0.02, 95% CIs: −0.19 to 0.23; p=0.85). However, 95% of the variation across estimates was due to heterogeneity between studies (I^2=95.2). This suggests that treatment effect differences across studies are not random, which	Not reported.	Existing frameworks suggest that there is a 'vicious cycle' whereby poverty increases the risk of mental illness, while mental illness increases the risk of future poverty. Cash transfer programs may reduce poverty, by providing financial resources to alleviate poverty in households, while at the same time stimulating behavioural change and human capital investment. Cash transfers increase household income and may thus directly reduce financial strain and increase economic security. They may reduce family conflict associated with poverty and financial stress, thus reducing mental health risks for all family members. Cash transfers may also reduce child labour and related exposures that place young people at risk of mental health disorders.	These programmes often involve relatively small cash benefits, which may be insufficient to generate changes in mental health. Improvements in the financial situation of the household may not translate into quality of life improvements for children and young people, thus having limited effects on their mental health. In addition, conditional cash transfers may increase family stress associated with the pressure to meet conditionalities. Further research should investigate whether the impact of cash transfers on youth mental health differs with cash volume, as this has important implications for policy. Addressing the indirect mechanisms of cash transfers improving mental health through increasing household income, and directly through reducing child labour is an important area for future research. Longitudinal qualitative methods should be	The overall risk of bias was judged to be moderately high; High confidence

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			(receiving cash was conditional on other factors, such as school attendance, health visits), while 6 assessed unconditional cash transfer interventions. The amount of money received ranged from $2 to $20 a month.			compromises the validity of the summary estimate.			applied alongside RCTs to provide in-depth understanding of how cash transfers impact the mental health and stress of recipients and their children.	
ENVIRONMENTAL EVENTS DOMAIN (19 reviews)										
Al-Tamimi, S. A. G. A. and G. Leavey (**2022**). "Community-Based Interventions for the Treatment and Management of Conflict-Related Trauma in Low-Middle Income, Conflict-Affected Countries: a Realist Review." Journal of Child and Adolescent Trauma 15(2): 441-450.	Realist review; Alleviation of trauma/stress associated with conflict; 14/29; RCTs (14)	Communities in low/lower-middle-income countries affected by or currently in conflict; school children/ adolescents in some studies (some of these participants were former combatants); Unknown; For the whole review: Africa (13), Asia (5), multi-country (8), South America (1)	Twenty-one unique community-based interventions were found out of 29 sources. Prominent interventions included: group delivered trauma focused CBT (5), narrative exposure therapy (4), common elements treatment approach (2), group delivered TF-CBT as component of broader program theory (3).	Unclear.	Trauma associated symptoms; 11 studies used customised assessment tools independently or with widespread tools including HTQ, DSM framework for PTSD, UCLA PTSD-reaction index. Tools for studies involving children were CPSS and SCARED. HTQ was most prevalently used.	Community based interventions were seen to be effective in improving mental health outcomes including, PTSD symptoms, anxiety, and depression. The magnitude of changes was not clearly reported in the review.	Economic security / empowerment was mentioned in the review, but no results presented.	Task-shifting interventions had psychosocial interventions delivered by lay community psychosocial workers who were integrated within the community. They incorporated the community as the intervention deliverer thus improved cultural acceptability. Transdiagnostic elements in interventions overcame barriers of varied symptom presentation and helped the interventions to be adaptable in treating different mental health symptoms. Customisation of outcome assessment tools based on the context in which the intervention is being delivered was key.	The results don't answer the question of which community-based interventions are most effective for the treatment and management of conflict-related trauma in low- and middle-income countries. The study did not cover frequency of intervention delivery or duration of individual sessions, which impacts effectivity and sustainability of interventions. There was no assessment of long-term effectiveness and absence of role of gender.	Quality of evidence not assessed by original review authors; Critically low confidence
Alzaghoul, A. F., et al. (**2022**). "Post-traumatic stress disorder interventions for children and adolescents affected by war in low- and middle-income countries in the Middle East: systematic review." BJPsych Open 8(5).	Systematic review; Alleviation of trauma/stress in children and adolescents exposed to conflict; 6/6; RCTs (6)	Participants were between 9 and 18 years old and had been exposed to conflict; N = 1099 Jordan (1), Lebanon (1), Palestine (4)	Three group-based psychosocial interventions were identified and evaluated: 'teaching recovery techniques', 'writing for recovery' and 'advancing adolescents'.	Waitlist.	PTSD symptoms (CRIES, Harvard Trauma Questionnaire, Gaza Traumatic Event checklist), depression (DSRS), peritraumatic dissociation (peritraumatic dissociative experience scale), anxiety (revised children manifest anxiety scale and screen for	The Teaching Recovery Techniques (TRT) intervention was effective in decreasing PTSD symptom scores in 3 studies. It was the only programme associated with statistically significant reduction in PTSD scores. In one TRT study, pre-intervention post-traumatic stress levels were significantly higher in the intervention group. Fifty-three students (63.9%) in the intervention group exceeded the diagnosis cut-off based on CRIES-8 scores, whereas 25 students (50%) had similar scores in the control group. After the intervention, 28 (33.7%) students in the intervention group and 22 (44%) students in the control group exceeded diagnosis cut-off. In another TRT study, pre-intervention post-traumatic stress levels were equal in the intervention and control groups. Average CRIES-8	Positive experiences and improved social skills were indicated following most interventions, qualitatively and quantitatively. There was a small effect of reduced impact of trauma on school performance (d=0.35), and students in one of the TRT studies expressed a positive experience; they felt relaxed and optimistic and had improved social communication, self-awareness, and self-	Focusing more broadly on psychological interventions, especially those that are trauma-focused, may treat PTSD effectively or beneficially impact PTSD symptoms and other psychological problems like depression and anxiety. Previous studies suggest that TRT helped normalise experiences, teaching coping techniques (breath control), and improve understanding of experiences. In conflict settings, support and connectedness are important for building self-esteem that can be protective in face of psychological concerns.	Several studies had unclear reporting. Selection bias, randomisation methods, and allocation concealment were the main areas of concern. In face-to-face psychological intervention research, blinding of teachers, therapists, and researchers is often not possible. Methods to deal with missing data, such as replacing missing data with median or using estimation method, are needed. There is also potential for bias when high risk methods of randomisation (e.g., gender-based randomisation or use of consecutive numbers to determine group allocation) are conducted.	According to the original review authors, 4/6 studies were low risk of bias; Moderate confidence

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					childhood anxiety related disorders), psychological distress (SDQ, human insecurity and human distress scale).	scores were high in both groups (intervention: 25.59; control group: 24.67). A clinically significant difference was found at post-test in the intervention group, in which the mean decreased to 18.57 compared with 24.16 in control group. Twenty-nine (41%) students in the intervention group no longer met the diagnostic criteria for PTSD, compared with nine (13%) students in control group. the three groups (TRT + Parenting component, TRT alone and waitlist) had the same score for avoidance and arousal symptoms at baseline; however, the TRT + Parenting group had higher intrusive symptoms score (TRT: P = 0.042; waitlist: P = 0.015). The TRT + Parenting group demonstrated significant reductions in intrusive symptoms at time point 2 (P = 0.001) and time point 3 (P < 0.001), avoidance symptoms at time point 3 (P < 0.001) and arousal symptoms at time points 2 and 3 (all P < 0.001), compared with the waitlist group. The TRT group demonstrated significant reductions in intrusive and avoidance symptoms at time point 3 (P < 0.001 and P = 0.049), and arousal symptoms at time points 2 (P = 0.001) and 3 (P < 0.001), compared with the waitlist group. The TRT + Parenting group showed significantly greater decreases in PTSD symptoms, particularly avoidance symptoms, than the TRT-only group. In a final TRT study, post-traumatic stress symptoms were markedly higher in the intervention group: 64% of students in the intervention group and 43% of students in the control group had clinically significant post-traumatic stress symptoms. At follow-up, this had increased to 45% in the control group and remained unchanged in the intervention group. Depression symptoms were also reduced by TRT interventions. In one TRT study, there was a significant reduction in depression score in the intervention group at follow-up (d = 1.24). In another TRT study, no significant reduction was observed in the intervention group post-intervention (P = 0.746). However, the	responsibility. Some students reported improvement in psychosocial well-being post-intervention, increased trust, and had made more friends.			

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						control group experienced an increase in depression scores (increase in mean from 14.71 to 16.2). This increase was significantly related to gender, where authors observed a statistically significant increase in female depression scores in the control group ($P < 0.01$). In a third TRT study, a significant reduction in depression scores were identified at both time points 2 and 3 for both TRT + parenting component groups (time points 2 and 3: $P < 0.001$) and TRT alone (time point 2: $P = 0.003$; time point 3: $P = 0.032$), whereas no such change was reported for the waitlist group. In the same study, average anxiety scores were high (above the clinical cut-off of 34) in all three groups at baseline, decreasing at time point 2, then increasing at time point 3 in the waitlist group. Although there was a slight increase between time points 2 and 3 in the TRT group, the overall decrease between time points 1 and 3 was significant ($P < 0.001$). The TRT + parenting component group demonstrated the most robust improvement across the three time points ($P < 0.001$). Psychological distress was high in all three groups at baseline and there were no significant changes overall in psychological distress. There were no treatment effects in studies implementing the Advancing Adolescents or Writing for Recovery programmes.				
Brown FL, de Graaff AM, Annan J, Betancourt TS. Annual Research Review: Breaking cycles of violence - a systematic review and common practice elements analysis of psychosocial interventions for children and youth affected by armed conflict. J Child Psychol Psychiatry. **2017**;58(4):507-24.	Systematic review; Improving the mental health of conflict-affected children and youth; 15/28; RCTs (11), controlled trials (4)	Children or youth (24 years old or younger) who lived or are living in an area affected by recent or ongoing conflict (post-World War II), including former child soldiers; N = 3313; Burundi (1), Democratic Republic of Congo (5), Indonesia (1), Palestine (6), Sri	Interventions included: Trauma-Focused Cognitive Behavioural Therapy (5), Classroom-based interventions (4), Narrative Exposure Therapy (1), Writing for Recovery (1), Group Interpersonal Psychotherapy (1), Crisis group intervention (1), Peer-led school-based mediation intervention (1), Family-focused psychological intervention (1).	Comparison conditions varied and included: Waitlist (7), Treatment as usual (2), No treatment (2), Creative play intervention + waitlist (1), Reintegration (1), Child friendly spaces + control (1), Psychoeduc	PTSD (CRIES-13, PSS-I, PTSD-RI, CPSS, CPTS-RI), depression (DSRS, APAI, AYPA, CDI), anxiety (APAI, AYPA, SCARED, RCMAS), conduct problems (APAI, AYPA), aggression: (AAS, CASP, MAQ), traumatic grief (TGIC), mental health (SDQ), distress (AYPA,	The results were mixed, however the overall picture is one of a reduction in mental disorder symptomatology in the treatment groups vs comparison groups. Thirteen of the 15 studies reported on interventions that produced a treatment effect in at least one outcome. The magnitude of these effects was not reported.	Greater school performance (1 RCT), closeness to combatants (1 RCT), social support (1 RCT) and friendship quality (1 controlled trial) were found in intervention groups compared to comparison groups.	When looking at the successful interventions, access promotion, psychoeducation for children and parents, insight building, rapport building techniques, cognitive strategies, use of narratives, exposure techniques and relapse prevention were reported to be efficacious components of psychosocial interventions among children and youth in conflict-affected settings.	As many studies did not report on treatment fidelity, there may have been differences in treatment delivery. There is a lack of long-term follow-up data and lack of data on implementation issues such as therapist recruitment, training, and supervision.	According to original review authors, the studies had several methodological weaknesses that may introduce bias, most commonly: Failure to blind assessors and/or participants, failure to select highly representative samples, not reporting whether concurrent interventions were received by participants, not reporting fidelity to the intervention

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		Lanka (1), Uganda (1).		ation about symptoms + control (1).	SDQ), emotional functioning (SSIS), intrusion and avoidance (CRIES-8), behavioural/ emotional problems (CBCL-parent), internalising problems (CBCL-parent), externalising problems (CBCL-parent).					protocol, and not reporting the number of participants completing the full intervention; Critically low confidence
Brown, R. C., Witt, A., Fegert, J. M., Keller, F., Rassenhofer, M., & Plener, P. L. (**2017**). Psychosocial interventions for children and adolescents after man-made and natural disasters: a meta-analysis and systematic review. Psychol Med, 47(11), 1893-1905.	Systematic review and meta-analysis; Improving psychological wellbeing of children who have experienced man-made/natural disasters; 17/35; RCTs (17)	All participants were under 18 years of age and had experienced either natural or man-made disaster; N = 1803 I = 955 C = 848 Africa (1), Asia (8), Europe (2), Middle East (5), North America (1).	Psychological interventions including CBT (4), eye movement desensitisation and reprocessing (4), narrative exposure therapy for children (KIDNET) (1), and classroom interventions (9).	Waitlist control / active control (details not specified).	PTSD (CPSS, CRIES-13, PROPS, UCLA scale, CRIES-8, UPID, PTSD-RI), Grief (TGIC).	Overall, treatments were more effective in reducing PTSD symptoms than respective control groups (g = 0.44 (medium effect size), 95% CI 0.18–0.69). However, there was a significant heterogeneity between studies (Q = 119.69, p < 0.0001). Classroom-based interventions contributed most to the variance (44.69%), followed by studies on EMDR (14.05%), one study on calligraphy (10.94%), CBT (10.47%) and KIDNET (1.70%). Effects were moderated by type of profession (higher level of training led to higher effect sizes). CBT, EMDR, KIDNET and classroom interventions were equally recommended.	Not reported.	Cognitive behavioural approaches include elements like psychoeducation which affect expression and modulation, cognitive coping, creating trauma narratives, and managing dysfunctional behaviours, which can aid persistent psychopathology over time.	The studies were heterogenous in terms of different sample sizes, types of control groups, use of assessment tools, and the timeframe of when therapy started after traumatic events. The latter was not accounted for because it was not reported consistently in studies. The quality of studies was not assessed. Some possible moderators could not be explored due to small number of studies reporting data and the heterogeneity between them. Analyses underpowered due to small number of studies.	The quality of the studies was not assessed systematically; Critically low confidence
Coombe J, Mackenzie L, Munro R, Hazell T, Perkins D, Reddy P. Teacher-mediated interventions to support child mental health following a disaster: A systematic review. PLoS Currents. **2015**;7(DISASTERS).	Systematic review; Supporting children / adolescents after disasters; 9/18; Quasi-RCT (4), quasi-experimental cluster-RCT (1), CBA studies (4)	School students who experienced a natural or man-made disaster and their teachers; N = 3393 I = 1477 + 7 school classes C = 1460 + 8 school classes Former Yugoslavia (1), Israel and Gaza Strip (4), Lebanon (1), Sri Lanka (1), Turkey (1), Uganda (1)	Seven interventions followed man-made disasters and two followed natural disasters. Interventions were school--based, teacher--mediated interventions to support child and adolescent recovery after a disaster. The interventions ranged in content and duration, but generally included psychoeducation presentations, CBT techniques, coping skills training, learning through play, group activities, drama and games, education on ethnic bias, human rights, and peaceful	Comparison conditions were waitlists (4) or unclear (5).	PTSD severity /symptoms, depression (BDI), anxiety symptoms, and stress/mood (measurement tools not specified).	In all studies, students in the intervention conditions had improved outcomes compared to students in control conditions, at least in the short-term. This included decreased PTSD in all 9 studies, decreased depression in 2, decreased anxiety in 3 and decreased stress in 1. The magnitude of change or clinical significance is unclear.	Not reported.	Schools play a key role in the aftermath of a disaster and are typically one of the first organisations to resume operations after a disaster. They can provide students with a sense of returning to normality. Through their existing network of teachers, parents, peers and students, schools provide a non-stigmatising setting for seeking and receiving psychological support.	The greatest disparity evident between interventions responding to natural versus man-made was commencement time. Natural disaster interventions commenced immediately to 15 months after the disaster, while interventions targeted at man-made disasters were implemented across a broader timeframe. Due to the difficulty of implementing and evaluating interventions in a post-disaster environment there may be interventions with successful and positive outcomes that have not been reported in the peer-reviewed literature.	More than half of the studies were categorised as high or unclear risk in the domains of sequence generation and allocation concealment, primarily due to their study design. In the domain of 'other sources of bias' unclear risk was given to all studies. All studies were scored either low or unclear risk on the remainder of the risk of bias domains; Critically low confidence

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			living, and homework exercises.							
Doherty, A., Benedetto, V., Harris, C., Boland, P., Christian, D. L., Hill, J., Bhutani, G., & Clegg, A. J. (**2021**). The effectiveness of psychological support interventions for those exposed to mass infectious disease outbreaks: a systematic review. BMC Psychiatry, 21(1), 592.	Systematic review; Improving psychological support offered to and psychological wellbeing of individuals exposed to mass infectious disease outbreak; 22/22; RCTs (22)	General populations exposed to mass infectious disease outbreak (COVID-19, SARS); N = 3826 I = 1930 C = 1896 Belgium (1), Canada (1), China (6), Hong Kong (1), Iran (3) Italy (3), Oman (1) Serbia (1), Spain (1), Sweden (2) Turkey (2), Multi-country study (1).	Interventions reviewed varied, including: Therapist-guided therapy (1), online counselling (1), 'Emotional Freedom Techniques' (1), mobile phone apps (2), brief crisis intervention (1), psychological-behavioural intervention (1), Cognitive Behavioural Therapy (3), progressive muscle relaxation (2), emotional-based directed drawing (1), psycho-educational debriefing (1), guided imagery (1), Eye Movement Desensitization and Reprocessing (EMDR) (1), expressive writing (2).	Comparison group conditions varied: Automatic weekly self-help information (1), waiting list (3), no intervention (2), brief written information about mental healthcare of healthcare workers (1), routine care (10), mandala drawing intervention (1), trauma focused CBT (1), neutral writing task (1), health education information (1), unclear (1).	Depression (HAMD-17, DASS-21, PHQ-9, HADS-S, BDI-II), anxiety (GAD-7, PANAS, STICSA, STAI-1, HADS-A, short health anxiety inventory, Spielberger state-trait anxiety inventory, GAD-7, SCAS), distress (SUD), mental health (Warwick-Edinburgh mental wellbeing scale, BSI), behaviour (behaviour assessment scale for children), PTSD (checklist for DSM-V).	The meta-analyses conducted suggests that different psychological support interventions have shown potential effectiveness to reduce levels of anxiety (SMD: -0.72; 95% CI: − 1.03 to − 0.40) and depression (SMD: -0.40; 95% CI: − 0.76 to − 0.03) in those exposed to mass infectious disease, but not for levels of stress (SMD: 0.16; 95% CI: − 0.19 to 0.51).	Not reported.	Not a clear causal pathway. Individual directed psychological interventions need a more holistic approach which includes personalised interventions + organisational level / societal structural changes to decrease stressors of mass outbreak. Prior to mass outbreak, mental health service provision was already lacking, and COVID-19 exacerbated this, so wider public mental health provision should be included in national preparedness and emergency response plans for mass infectious disease outbreaks.	Some studies had small sample sizes. Challenges regarding recruitment and retention of representative samples of participants were reported. Lack of follow-up made it difficult to estimate longer term effects of interventions. There were some issues around potential reporting and selection bias across the studies. There was a lack of RCTs from low- and middle-income countries.	Twelve studies were classified as high risk of bias, eight as some concern, and two as low risk of bias. Studies showed shortcomings due to either their randomisation process, deviations from their intended interventions, missing outcome data, their measurement of outcomes, or selective reporting; High confidence
Fu C, Underwood C. A meta-review of school-based disaster interventions for child and adolescent survivors. J Child Adolesc Ment Health. **2015**;27(3):161-71.	Meta-review; Supporting children / adolescents after disasters; 11/11; RCTs (5), quasi-experiments (6)	Children and adolescents, 18 years or younger, who have experienced a natural or man-made disaster; N = 6081; Armenia (1), Bosnia (1), China (1), Indonesia (1), Israel (1), Kosovo (1), Lebanon (1), Nepal (1), Sri Lanka (1), Turkey (1), USA (1)	Universal school-based interventions conducted after natural or man-made disasters were examined. The interventions were delivered by teachers, teen/young adult volunteers, paraprofessionals, or counsellors. Interventions incorporated physical exercises, art therapy, the use of narrative in reconstructing memories of life before, during and after the event, psychoeducation, reprocessing traumatic	Unclear (wait lists and no treatment).	PTSD symptoms (UCLA PTSD Index for DSM-IV, Child PTSD Reaction Index, CPSS, DICA-R, CBCL).	Overall, school-based, universal programmes that are conducted by teachers or local paraprofessionals are effective in reducing PTSD symptoms in children and adolescents. Three out of 4 studies in post-natural disaster settings reported a reduction in PTSD symptoms among intervention participants, while one found no significant differences between intervention and control groups. The average effect for PTSD change among interventions in post-natural disaster settings was found to be small (standardised mean difference [SMD] −0.308, 95% CI = −0.54 to −0.07 z = −2.58, p = 0.010). The heterogeneity was very high (I2 = 87.5%). Four out of seven interventions in conflict-affected areas reported a	Not reported.	Schools, if left intact and functioning, may be an appropriate setting for implementing psychosocial interventions because outside of the home, school is the most natural support system for children and youth. The implementation of interventions through schools is considered a practical approach for public health initiatives because they are able to reach the most children and target larger populations than clinic-based referrals. Universal mental health and psychosocial support interventions in school which reach all children regardless of perceived risk may help to prevent the medicalisation of	RCTs are not an option in most post-disaster situations, particularly in the immediate wake of the event, and are unethical if it means excluding some individuals, children in this instance, from interventions that have been shown to have plausible causal effects. As is often the case with donor funded public health interventions, only three studies were able to evaluate long-term impact and test whether short-term effects were sustained beyond one year.	Quality of the evidence was not assessed by original review authors; Critically low confidence

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
			experiences, stress management skills and group-based exercises using music/dance and drama.			reduction in PTSD symptoms among intervention participants, while three detected no statistically significant changes between groups. Among studies in conflict-affected areas, the average effect for PTSD change among interventions was medium — a standardised mean difference [SMD] of −0.514, 95% CI = −0.80 to −0.23, z = −3.57, p < 0.001). Heterogeneity was lower at I2 = 41%.		normal reactions to traumatic stress and lower feelings of stigma among children. School-based interventions are also able to reach children at their developmental age level and provide ample opportunities for teachers to follow-up with students.		
Gillespie S, Banegas J, Maxwell J, Chan ACY, Darawshy NA, Wasil AR, et al. Parenting Interventions for Refugees and Forcibly Displaced Families: A Systematic Review. Clin Child Fam Psychol Rev. **2022**;25(2):395-412.	Systematic review; Supporting displaced families/ caregivers within the humanitarian context; 4/24; RCTs (3), quasi-experimental design (1)	Displaced families and caregivers of children aged 6 months to 19 years old; N = 581; Bosnia (1), Lebanese refugee camps (2), Uganda (1).	Parenting program interventions were defined as those which influence parenting behaviours such as nurturing, discipline, teaching, monitoring and management. Many studies looked at selective prevention interventions, targeting parenting based on their children's age, their migration history, or ability to complete the program.	Waiting list controls.	Caregiver and child mental health outcomes were measured through standardised, self-report measures. Specific measures were not detailed.	The parenting intervention in Bosnia for internally displaced Muslim families reported no intervention effect for maternal wellbeing, but an intervention effect for improved child cognitive performance (ES = 0.48). The parenting intervention for internally displaced Acholi people in Uganda reported an intervention effect on improved maternal mental health (Effect sizes: Sadness =− 0.62, Irritability =− 0.38, Somatic complaints =− 0.46). One parenting intervention set in a Lebanese refugee camp reported an intervention effect on improved child language development (ES = 0.53), but no intervention effect on maternal wellbeing or child difficulties. Another study in a Lebanese refugee camp reported an intervention effect on maternal psychological distress (ES = -0.70) but no effect on child psychological wellbeing.	Parenting programs for forcibly displaced families did not show to have treatment effects on child maltreatment. However, a number of studies reported positive effects on outcomes such as parenting knowledge, discipline, and parent-child relationships.	Models of family stress and social interaction learning, which centres parenting as the mechanism through which stressful contexts impact child development. These findings are also highly consistent with parenting intervention research across the world, which demonstrates that parenting practices are malleable to intervention.	Most of the included studies were conducted in humanitarian settings, however researchers were all based in high-income countries. Future research should explore how innovations developed in high income countries can reach families in humanitarian settings. Strengthening the research infrastructure within LMICs will enable interventions and their rigorous evaluations to be led by researchers from the home country and/or population. Traditional parenting programs may need to be adapted to address specific barriers to parenting and threats to parent mental health that may be experienced by this population of displaced families. Parenting prevention programs conducted in HICs have demonstrated that improvements from prevention (in contrast to treatment) programs grow over time; these effects, also known as cascading effects, spread across the family system over time. In the studies reviewed here, however, the assessments were limited to just a short follow up period (4 months maximum) providing no indication of longer-term change. Only a small number of RCTs have been conducted in this area, which makes it challenging to generalise the review findings. Small sample size, large range of child ages, and diverse outcomes measured also create limitations.	Four of the relevant included studies were coded as having only preliminary evidence. Findings about program effectiveness from these trials should be interpreted cautiously due to small sample sizes and some of the studies being underpowered to detect small or medium effect sizes; Moderate confidence
Gwozdziewycz N, Mehl-Madrona L.	Meta-analysis;	Refugees living in refugee camps;	Interventions assessed were Narrative	Comparison groups	Mental Health symptoms	NET interventions are adequately effective at treating refugees' mental	Not reported.	Authors suggested that the effectiveness of narrative exposure	Quality assessment was not conducted by the original review	Quality assessment was not conducted

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Meta-analysis of the use of narrative exposure therapy for the effects of trauma among refugee populations. Perm J. **2013**;17(1):70-6.	Supporting people with vulnerabilities within the humanitarian context; 4/7; RCTs (4)	N = 377 I = 156 C = 221; Rwanda (1), Sri Lanka (1), Uganda (2)	Exposure Therapy methods or KIDNET (which is Narrative Exposure Therapy for children). With this intervention, patients talk about the worst part of the trauma and re-experience thoughts and emotions paired with it. The therapist will ask patients about emotional, physiologic, cognitive, and behavioural reactions. Interventions were delivered by lay and trained counsellors instead of health professionals. Three studies evaluated the effectiveness of NET methods and one study evaluated KIDNET in comparison to a meditation-relaxation intervention.	included: meditation-relaxation technique, trauma-counselling, monitoring group, supportive counselling, psychoeducation, interpersonal psychotherapy.	(PTSD Diagnostic Scale, International Diagnostic Interview, UCLA PTSD Index, DSM, CAPS, MINI depression score, Hamilton Score, Guilt Score, HSCL, CIDI).	health, in comparison to treatment as usual, interpersonal therapy and other treatment techniques. The total average effect size was d = 0.63 (medium) for all interventions. The meta-analysis found an average effect size of d = 0.53 (medium) for studies using physicians, trained graduate students, or both to deliver the intervention, and an average effect size of d = 1.03 (large) for studies that used refugee counsellors to deliver the intervention. It appears as though a range of mental health outcome measures were combined for the meta-analysis.		therapy treatments could be due to specific characteristics of the intervention - focusing on making use of the person's own life story and the duration (short term). Given the appropriate tools and training, local refugees may be able to deliver treatment, making it cost-efficient.	authors. The authors noted that all included studies used different scales to measure outcomes, and the number of outcome measures also varied from study to study. Spontaneous remission of symptoms was a factor that many included studies could not control for. The authors suggested the need for future research to pay attention to migration issues if they plan to collect follow-up measurements.	by the original review authors; Critically low confidence
Kiss L, Quinlan-Davidson M, Pasquero L, Tejero PO, Hogg C, Theis J, et al. Male and LGBT survivors of sexual violence in conflict situations: A realist review of health interventions in low- and middle-income countries. Conflict and Health. **2020**;14(1).	Systematic review; Supporting people with vulnerabilities (male and LGBT survivors of sexual violence) within the humanitarian context; 6/26; RCTs (6)	Male and LGBT survivors of sexual violence in various humanitarian or conflict settings in low-and-middle-income countries; N = 1534 I = 998 C = 536; Democratic Republic of Congo (2), Iraq (3), Thailand (1)	A range of Psychosocial Interventions were used. These were defined as any non-pharmacological interventions which aims to improve mental health, functioning or wellbeing of participants. Interventions could be provided on an individual, group or community basis. These interventions must also be related to sexual violence in conflict settings. Some studies (2) used more than one intervention type. Interventions included: Cognitive Processing Therapy (4), Trauma-focused Cognitive-based Therapy (CBT) (1), Common Elements Treatment Approach (CETA) (2), trauma-	Comparison group conditions: wait-list control, individual psychosocial support.	Mental health outcomes, including depression, anxiety, trauma symptoms, conduct problems, aggression (HSCL-25, HTQ, Inventory of traumatic grief, locally developed Function Scale, UCLA PTSD Reaction Index, African YPAI)	Psychosocial interventions that included men and boys were effective in reducing symptoms of depression, anxiety, PTSD, dysfunction, or post-traumatic grief. For depression, statistically significant intervention effect sizes were medium to large (e.g., d = 0.40 for cognitive processing therapy vs waitlist control; d = 1.82 for common elements treatment approach compared to waitlist control). For anxiety, statistically significant intervention effect sizes were small to large (e.g., d = 0.27 for cognitive processing therapy compared to waitlist control; d = 1.60 for common elements treatment approach compared to waitlist control). Some studies combined depression and anxiety outcomes, mostly revealing statistically significant large effect sizes (e.g., d = 1.6, six months after group CBT compared to individual support; d = 2.45 for trauma-focused CBT compared to waitlist control).	For female-specific interventions, group therapy or group counselling sessions were associated with greater social connectedness and support networks, compared to individual support interventions. Improvements in participants social capital were also found for participants who received a group-based CBT intervention, over an individual support condition.	There is currently limited evidence on which intervention components are most effective to improve mental health. The author suggested that mental health interventions would benefit from gender-relevant approaches. Interventions should address the unique differences that male survivors might experience. Culturally appropriate interventions are necessary as cultural contexts can affect survivors, communities and providers attitudes and behaviours that could have pose significant implications on the effectiveness and feasibility of the intervention itself. Models of care that are gender-sensitive and integrated to local resources are promising avenues to promote the health of male and LGBT survivors of CRSV.	No data on effect-size by gender were published in these evaluations. Therefore, it is unclear whether the interventions were equally effective for female and male survivors, or whether they were effective at all among male survivors. No intervention evaluation focussed on LGBT survivors. Services are not tailored to male and LGBT survivors of sexual violence, and survivors of sexual violence in conflict situations may not seek mental health support due to stigma and discrimination associated with doing so. Many studies weren't able to complete follow-ups due to lack of time, participants returning to their home country, and changing circumstances. Access and effectiveness of mental health interventions also depend on whether the basic needs of conflict survivors are being addressed.	Quality of evidence was not assessed by the original review authors; Critically low confidence

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			informed intervention (1), Brief Behavioural Activation Treatment for Depression (1).			For PTSD/trauma/grief symptoms, statistically significant intervention effect sizes were small to large (e.g., d = 0.35 for PTSD symptoms for trauma-informed intervention vs control; d = 2.40 for trauma symptoms for common elements treatment approach compared to waitlist control). For conduct problems, one study comparing trauma-focused CBT to waitlist control reported a large statistically significant intervention effect size of d = 0.95. For aggression, one study comparing common elements treatment approach to a waitlist control condition reported a medium statistically significant intervention effect size of d = 0.58. However, no data on effect-size by gender were published in these evaluations. Therefore, it is unclear whether the interventions were equally effective for female and male survivors, or whether they were effective at all among male survivors. Studies with female survivors of sexual violence in conflict/humanitarian settings found that mental health interventions which aim to promote social connectedness, safety, and security can improve participants mental health. No intervention evaluation focussed on LGBT survivors.				
Le Roux IH, Cobham VE. Psychological Interventions for Children Experiencing PTSD After Exposure to a Natural Disaster: A Scoping Review. Clin Child Fam Psychol Rev. **2022**;25(2):249-82.	Scoping review; Supporting children after natural disasters; 9/15; Quasi control series design (2), quasi-RCT (4), non-equivalent control group pre-test post-test quasi-experimental design (3)	Children (under 18 years old) who were exposed to a natural disaster; N = 964; Armenia (2), China (1), India (1), Sri Lanka (1), Thailand (1), Turkey (1), USA (2)	A range of group and individual treatments were used across the studies. Psychological interventions which aim to target symptoms of PTSD were included, such as: trauma focused-CBT (TF-CBT) (2), TF-CBT with Psychopharmacology (1), Eye Movement Desensitisation and Reprocessing Treatment (EMDR) (1), trauma and grief focused psychotherapy (2), and 3 studies did not report following a specific treatment or theoretical	Comparison conditions varied. Control groups were those who did not receive treatment, were on waitlists, or participants who were not screened.	PTSD symptoms (CPTSD-RI, KRI, CRI, CPTSDRI, CAPS, UCLA PTSD Index, CRIES-13, Thai Version of CRIES, PTSD-RI).	Psychological interventions, irrespective of type, were associated with statistically significant, clinically meaningful, and sustained reductions in PTSD symptoms (exact magnitude of changes not clearly described). Treatments were found to reduce physiological and psychological reactivity to trauma reminders. While there was no clear, high-quality evidence comparing the effectiveness of individual and group treatments, results indicated that participants who received group treatment were significantly more likely to complete treatment than those receiving individual treatments. No conclusion can be drawn on the influence of provider training on treatment efficacy. Interventions delivered in schools were	Not reported.	The author hypothesised that services delivered in schools were found to be most effective because schools represent a (mostly) accessible, convenient, and affordable environment for providing mental health services to children. However, the authors also highlighted that school-based interventions could exclude children who are unable to attend schools due to a range of reasons.	The majority of included studies are retrospective field research designed and implemented in response to the urgent need for mental health support in the aftermath of a natural disasters. Research conducted in such contexts face limitations such as treatment selection, implementation, capacity, and resource constraints. Due to the heterogenous nature of the sample populations, intervention designs, diagnostic measurement tools, and characteristics of treatment application, direct comparisons between intervention type and treatment efficacy were not feasible. Many studies did not	Quality of evidence was not assessed by the original review authors; Critically low confidence

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			framework but instead used a combination of strategies including culturally targeted group interventions, emotional identification, meditative practices, art techniques, and counselling.			found to be the most effective to accomplish mass screening, treatment, and monitoring of a large group of children. However, no studies evaluated whether treatment location influenced treatment efficacy. While psychological interventions were found to be more effective at alleviating PTSD symptoms at post-intervention, than control groups, it did not result in complete remission of PTSD in all participants. Many children remained symptomatic at follow-up.			measure for pre-existing or comorbid mental health conditions and previous trauma exposures that participants could have. Critical appraisal and risk of bias assessments were not conducted.	
Li, G., Shi, W., Gao, X., Shi, X., Feng, X., Liang, D., Li, C., Phillips, M. R., & Hall, B. J. (**2022**). Mental health and psychosocial interventions to limit the adverse psychological effects of disasters and emergencies in China: A scoping review. The Lancet Regional Health - Western Pacific.	Scoping review; Support responses following disasters in China; 25/63; RCTs (25)	Children, adolescents, adults, and elderly individuals post-disaster/post-emergency in China; N = 4919 I = 2685 C = 2234; China (24), Taiwan (1)	Mental health and psychosocial interventions in response to disasters/ emergencies were assessed, including: play therapy, Chinese calligraphic handwriting training (1), CBT (3), dancing training (1), physical exercise (1), Chinese qigong (1), interpersonal psychotherapy (2), Chinese herbal formula (1), structured intervention (1), web-based intervention (1), narrative exposure therapy (1), critical incident stress debriefing + cohesion training (1), resilience intervention (1) peer to peer live streaming app (1), physical exercise (aerobics) + mindfulness / meditation or mental health education / counselling (3), acceptance and commitment therapy + aerobics (1), self-affirmation writing exercise (1), wise intervention (1), mindfulness (2), group reminiscence therapy + physical exercise (1), outward bound training (1).	Comparison groups included no treatment, treatment as usual, mental health education, waiting lists.	PTSD, anxiety (SAS, HAMA, GAD-7), general mental health (SCL-90-R), depression (SDS; PHQ-9; HAMD-17), alcohol use, overall psychological wellbeing, positive/ negative emotion, psychological distress (structured questionnaires)	Overall, interventions resulted in improvement in all psychological outcomes assessed (e.g., anxiety, suicide risk, depression, PTSD). Statistical significance and the magnitude of effects was not always reported. The authors indicate that most effect sizes were not large. • Play therapy led to significantly lower anxiety and suicide risk in children. • Chinese calligraphic writing training significantly decreased PTSD in children. • CBT resulted in decreased PTSD and depression in adolescents who had lost parents. • CBT also led to significant reductions in depression, anxiety, stress, and total DASS-21 scores in another study. • Ballroom dance training reduced anxiety in middle school children significantly. • Physical exercise improved general mental health. • Chinese qigong improved mental health significantly and had better effect in psychological crises than psychological counselling. • Interpersonal psychotherapy reduced PTSD and MDD significantly. • Herbal formula improved mental health overall significantly compared to placebo. • A web-based intervention (Chinese my trauma recovery) reduced PTSD symptoms significantly in adults. • General health education and brief structured intervention decreased alcohol use compared with control.	Social support was assessed in an RCT assessing narrative exposure therapy; it did not appear to improve significantly. A resilience intervention had a significant positive effect on interpersonal skills. Outward bound training significantly improved functional levels in medical personnel.	Psychological distress in the acute phase after an event can often fade without treatment, but some symptoms persist and intensify. Short term mental health and psychosocial interventions may prevent chronic symptoms and prevent onset of delayed psychosocial impairment.	Most of the studies had notable risk of bias, with weaknesses in the areas of randomisation, blinding, and lack of adherence to intention-to-treat analysis. Other limitations included limited sample sizes, the use of unvalidated outcome measures, and inappropriate data analyses.	According to the original review authors, eight studies were classified as having low risk of bias, seven with some risk of bias, and 10 as having high risk of bias; Moderate confidence

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						• A web-based intervention and narrative exposure therapy reduced PTSD significantly. • Debriefing and cohesion training for rescuers decreased PTSD symptoms significantly and improved symptoms of re-experiencing, avoidance and hyper-arousal. • A resilience intervention had a significantly positive effect on mental health. • Mental health education + a peer-to-peer app decreased anxiety significantly in children. • Aerobics and mindfulness led to reduced anxiety in adolescents and reduced depression. • ACT and aerobic exercise improved psychological distress and psychological flexibility significantly in an intervention group. • A self-affirmation writing exercise decreased anxiety. • Group psychotherapy + pulmonary rehabilitation significantly reduced anxiety symptoms and sleep disorders in COVID-19 inpatients. • Outward bound training significantly decreased general mental symptoms, depression and anxiety in an intervention group.				
Lipinski, K., Liu, L. L., & Wong, P. W. (**2016**). The effectiveness of psychosocial interventions implemented after the 2004 Indian Ocean Tsunami: A systematic review. Int J Soc Psychiatry, 62(3), 271-280.	Systematic review; Improving psychological wellbeing after the 2004 Indian Ocean Tsunami; 5/10; Non-RCTs (5)	Adults and children who had survived the Indian Ocean Tsunami; N = 682 I = 365 C = 317; India (3), Sri Lanka (2)	Interventions included: Group-based psychosocial care (1), school-based mixed psycho-educational, cognitive behavioural skills, art therapy and narrative therapy (1), narrative exposure therapy and meditation-relaxation training (1), brief intervention and traumatic incident revisitation (1), home visit befriending (1).	Comparison groups were no intervention, waitlist control, or other interventions (not specified)	Difficulties after stressful life events (IES), PTSD severity (UCLA PTSD index, DSM-IV - child version), mental-health (GHQ-12), depression (BDI-21)	All five studies reported reduction in PTSD symptoms. A school-based intervention produced statistically significant results between the treatment and wait-list control group on PTSD severity outcomes (Distinct time × group × baseline interaction; $F = 65.24$; $p < .001$). A befriending intervention helped lower scores on the BDI (post-test mean score: intervention = 13.11, control = 21.88 ($p = .000$)) and PTSD assessment (post-test mean score: intervention = 6.16, control = 10.51 ($p = .000$)) compared to control group. A 3-month bi-weekly group-based psychosocial care intervention statistically significantly reduced Indian women's scores on the Impact of Event scale ($p < .001$). Effect size not reported.	Not reported.	No clear hypothesised pathway described. The interventions which worked in reducing PTSD symptoms showed cultural competency - lay practitioners had outside training in the field in which they were administering care prior to the Tsunami.	A narrow range of publications were identified in the literature, sample sizes were small, and there were large variations in interventions and scales in the review. Improvements were seen in PTSD symptoms, but studies varied in quality and interventions. Some interventions were adopted less rigorously, so improvements could also be due to natural recovery.	According to the original review authors, two studies were rated good quality, two fair quality, and one poor quality; Low confidence

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						Decreases in PTSD symptoms were observed after meditation-relaxation (MED-RELAX) and narrative exposure therapy for children (KidsNET) interventions. Effect sizes for the KidsNET Group were 1.76 (CI 0.9–2.5) at post-test, and 1.96 (CI 1.1–2.8) at 6-month follow-up. Effect sizes for MED-RELAX were 1.83 (CI 0.9–2.6) at post-test, and 2.20 (CI 1.2–3.0) at 6-month follow-up. Another intervention involved either four 'breath water and sound' (BWS) sessions, or 4 BWS sessions + 3 – 5 traumatic incident reduction (TIR) sessions. Compared to control participants, BWS and BWS + TIR participants experienced reduced PTSD symptoms. Effect of treatment versus control at 6-week follow-up: F2.178 = 279.616; $p < .001$). Mean decreases in PTSD scores: BWS = 42.5 ± 10.0; BWS + TIR = 39.2 ± 17.2; and Controls = 4.6 ± 13.2.				
Lopes AP, Macedo TF, Coutinho ES, Figueira I, Ventura PR. Systematic review of the efficacy of cognitive-behavior therapy related treatments for victims of natural disasters: a worldwide problem. PLoS One. **2014**;9(10):e109013.	Systematic review; Responding to trauma/distress associated with natural disasters; 6/11; RCTs (3), non-RCTs (3)	Individuals with a diagnosis of PTSD after a natural disaster (all were earthquakes); N = 399 I = 209 C = 190; Armenia (2), China (1), Iran (1), Turkey (2)	Interventions involved components of CBT, including: behavioural treatments, exposure therapy (in vivo; quake platforms; narration of trauma), brief trauma/grief focused therapy, and problem solving.	Waiting lists.	Post-traumatic stress disorder symptoms (CAPS, IES-R, CPTSD-RI, Mississippi PTSD Scale, TSSC, CRIES, CPTSD-SS).	All studies reported a significant reduction of PTSD symptoms after treatment, suggesting efficacy of CBT (particularly exposure therapy) following earthquakes. The magnitude of change or clinical significance was not reported.	Not reported.	Not reported.	The existing studies involved a small number of people with PTSD, indicating the need for more research in the area, particularly with stronger methodologies, including more long-term follow-ups, and randomized controlled trials. No study was found focusing solely on an elderly population, even though this is the group that is most vulnerable to post-disaster psychiatric morbidity.	According to assessments by the original authors, most included studies had a low risk of bias; Low confidence
Natha F, Daiches A. The effectiveness of EMDR in reducing psychological distress in survivors of natural disasters: A review. Journal of EMDR Practice and Research. **2014**;8(3):157-70.	Systematic review; Reducing impact of natural disasters on individuals; 5/8; RCTs (4), part-controlled study (1)	Survivors of natural disasters; N = 172 (152 at follow-up); Iran (1), Mexico (1), Turkey (1), USA (2).	Eye movement desensitisation and reprocessing (EMDR) therapy interventions were assessed, including: computerised EMDR (1), standard EMDR (3), and EMDR-PRECI (protocol for recent critical incidents) (1).	Waitlist / delayed-treatment control groups.	PTSD symptoms (SUD, CRI, PSS-SR0, depression (BDI, CDI), anxiety (BAI, RCMAS), impact of events (IES-5).	Analysis of between-group differences and within-group differences indicated that EMDR was effective in reducing psychological distress, across all measures. Although most studies focused on PTSD symptoms, the findings are not restricted to this presentation alone. Statistical and clinical significance was shown in reducing anxiety, depression, fear, grief, and phobia (effect sizes not reported).	Not reported.	EMDR is a structured treatment intervention based on the adaptive information processing model, emphasizing the brain's memory storage and information processing system. The model hypothesizes that the basis of current psychological distress are the emotions and physical sensations related to the unprocessed traumatic event and their inappropriate storage within the memory system. EMDR involves requesting the client to recall specific memories of the traumatic event while following the therapist-directed hand movements. It is thought that the	The waitlist design of the 4 RCTs do not adequately control for demand characteristics, potentially implying that any intervention is better than no intervention. This issue is only mitigated within the studies that stated previous psychotherapy as ineffective (as the symptoms were persistent). There were issues with attrition in some studies, and some studies did report on potential confounders (e.g., education levels or social/family support). Only one study reported on pre-existing mental health issues.	The quality of the studies was rated using an adapted Revised Gold Standard (RGS) scale. One study was rated as moderate quality and four as high quality; Low confidence

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								bilateral stimulation and accessing the unprocessed trauma activates the brain's processing system and facilitates the assimilation of the traumatic memory into the larger memory network. Thus, the traumatic memory is no longer isolated, allowing adaptive processing to occur as a result of the new associations made within the brain.		
O'Sullivan C, Bosqui T, Shannon C. Psychological interventions for children and young people affected by armed conflict or political violence: A systematic literature review. Intervention: Journal of Mental Health and Psychosocial Support in Conflict Affected Areas. **2016**;14(2):142-64.	Systematic literature review; Reducing psychosocial or mental health effects of armed conflict; 15/17; RCTs (11), cluster-RCTs (4)	Youths living in countries with protracted armed conflict or political violence; N = 4,165 youths + 87 mother-child dyads; Bosnia (2), Burundi (1), Democratic Republic of Congo (3), Indonesia (1), Israel (1), Lebanon (1), Nepal (1), Palestine (1), Sri Lanka (1), Uganda (2).	Interventions ranged by setting and activities. Some were set in classrooms and others were family-based. Interventions involved psychosocial structured activities, relaxation techniques, teaching recovery techniques, psychoeducation for mothers, mobilisation of support and self-efficacy, group interpersonal psychotherapy, creative play, narrative exposure therapy, academic catch-up, mind body-skills, trauma and grief component therapy, or group trauma-focused cognitive behavioural therapy.	Comparison conditions included wait lists (12) and unspecified active controls (5).	Anxiety (GAS-C, SCARED-5, PENN State Worry), psychosocial functioning (parental ratings, SDQ), PTSD (CPSS, CRIES-8, HTQ, UCLA-PTSD-RI), depression (DSRS, AYPA, CAPS), psychological distress (SDQ). Maternal mental health (Birleson's Depression Inventory).	Compared to controls, classroom-based interventions had no effect on PTSD symptoms, anxiety, depression or general psychological functioning for clinical and non-clinical samples of youth. Compared to controls, two studies of Group Trauma-Focused-CBT led to statistically significant decreases in PTSD symptoms [decrease of 24.36 (95% CI -28.63, -1.29, P<0.0001)], anxiety [decrease of 28.88 (95% CI -28.39, -19.37, P<0.00001)], and conduct problems [mean decrease of 6.89 (95% CI -9.10, -4.69, P<0.00001) for clinical youth samples. Heterogeneity was not significant. When looking at clinical youth samples, compared to waitlist controls, a mind-body skills programme (Cohen's d = 1.13), narrative exposure therapy (d = 0.76) academic catch-up groups (d = 0.66), and trauma and grief component therapy (d = 1.66) had greater effects on PTSD symptoms. Group interpersonal therapy (d = 0.52) was also more effective than creative play (d = 0.2) in reducing depression within clinical youth samples.	Not reported.	Not reported.	The limited effectiveness of interventions for non-clinical cohorts may be a result of the use of clinical measures for non-clinical populations. The use of such measures may result in floor-effect results, with the resultant missed opportunity to examine changes which may occur at a sub-clinical level. A particular area of concern is the lack of evidence supporting interventions delivered to youths who do not meet clinically significant thresholds. Across both nonclinical and clinical interventions there is a lack of longitudinal data, therefore, the long-term impact of these interventions remains unquantified. Few studies were identified that utilised locally validated outcome measures. Further research into interventions for younger youths is needed.	Average study quality was rated as high, meeting 83.4% of the criteria (range: 70-93%); Critically low confidence
Pfefferbaum B, Nitiéma P, Newman E. A Meta-analysis of Intervention Effects on Depression and/or Anxiety in Youth Exposed to Political Violence or Natural Disasters. Child and Youth Care Forum. **2019**;48(4):449-77.	Meta-analysis; Psychosocial support following man-made and natural disasters; 23/24; RCTs and cluster-RCTs (n unclear)	Individuals 18 years of age of younger who had been exposed to manmade mass trauma or a natural disaster; N = 4143; China (2), Gaza (1), Indonesia (1), Israel (5), Lebanon (1), Nepal (1),	All interventions were psychosocial interventions. 17 studies focused on interventions after man-made mass trauma and 6 studies after natural disasters. 18 interventions were group psychosocial interventions and 5 were individual psychosocial treatments. 10	Waitlists / non-treatment.	Depression, anxiety (measured with unspecified psychometric instruments).	The summary intervention effect was not significant for either depression [g = 0.14, 95%CI -0.01, 0.28, I2 = 53%] or anxiety [g = 0.39, 95%CI -0.07, 0.85, I2 = 75%]. There were statistically significant effects for depression with interventions delivered following a natural disaster (g = 0.40; p = 0.0192) or in a high-income country (g = 0.30; p = 0.0253), and with non-trauma-focused interventions (g = 0.29; p = 0.0155) and those delivered in more than eight	Not reported.	For the most part, investigators have not dismantled interventions to examine the effectiveness of specific components or to identify the essential components needed for improvement. The findings of the current study suggest the importance of doing so in addressing depression and anxiety in youth exposed to mass trauma and support the hypothesis that non-trauma-focused interventions may be needed and more effective than trauma-focused interventions	The failure to find significant effects for depression or anxiety with either group or individual applications may reflect the small number of trials in the current review and indicates a need for additional research in this area.	The risk of bias of the included studies was mixed. Most studies were low risk on majority of assessment items or did not provide enough information to determine level of risk; Critically low confidence

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
		Palestine (1), Rwanda (1), Sri Lanka (2), Burundi (1), Taiwan (1), Uganda (4), USA (2).	interventions were trauma-focused and 13 were not. 12 interventions had less than or equal to 8 sessions, while 11 had more than 8 sessions.			sessions (g = 0.23; p = 0.0416). The effect for anxiety symptoms was significant only with non-trauma-focused interventions (g = 0.83; p = 0.0428).		for depression and anxiety. The finding that interventions delivered in more than eight sessions were effective for depression underscores the importance of children's enduring involvement in therapeutic activity.		
Purgato M, Gastaldon C, Papola D, van Ommeren M, Barbui C, Tol WA. Psychological therapies for the treatment of mental disorders in low- and middle-income countries affected by humanitarian crises. Cochrane Database of Systematic Reviews. **2018a**;2018(7).	Systematic review; Supporting people after humanitarian crises; 30/36; RCTs (30)	Populations in low- and middle-oncome countries in humanitarian settings, that is, in contexts affected by armed conflicts or by disasters associated with natural, technological, or industrial hazards. Participants were of any age, gender, ethnicity, or religion; N = 2815 I = 1698 C = 1117 (Unclear for 2 studies); China (5), Democratic Republic of the Congo (3), Iran (1) Iraq (5), Kosovo (1), Mozambique (1), Pakistan (2), Rwanda (3), Sri Lanka (1), Syria (2) Thailand (2), Turkey (2), Uganda (2).	Interventions took place following natural disasters (n = 8) and man-made disasters such as genocide, armed conflict, and war (n = 22). Psychological therapies were categorised mainly as cognitive-behavioural therapy (CBT) (including narrative exposure therapy (NET), common elements treatment approach (CETA), and brief behavioural activation treatment (BA)); eye movement desensitisation and reprocessing (EMDR); interpersonal psychotherapy (IPT); thought field therapy (TFT); and trauma or general supportive counselling. Although interventions were described under these categories, several psychotherapeutic elements were common to a range of therapies (e.g., psychoeducation, coping skills).	Comparison conditions were wait lists in most studies or no treatment or treatment as usual.	PTSD (IES-R, HTQ, CAPS, FAQ, PSS-I, CRIES-13, MPSS, SIFP, PDS, UCLA-PTSD-RI, PCL-5), anxiety (HSCL-25, HADS-A), major depressive disorder (BDI, BDI-II HSCL-25, SCID-I/NP, CES-D, SCID, HADS-D, PHQ-9, SCL-D), psychiatric problems/psychological distress (SCL90-R, TSI, SRQ, AYPA, SLIPSS-A, GHQ-12), conduct problems.	In adults, psychological therapies may substantially reduce endpoint PTSD symptoms compared to control conditions (standardised mean difference (SMD) -1.07, 95% confidence interval (CI) -1.34 to -0.79; 1272 participants; 16 studies; low-quality evidence). Psychological therapies may also substantially reduce endpoint depression symptoms compared to control conditions (SMD -0.86, 95% CI -1.06 to -0.67; 1254 participants; 14 studies; low-quality evidence). Psychological therapies may moderately reduce anxiety at endpoint (SMD -0.74, 95% CI -0.98 to -0.49; 694 participants; five studies; low-quality evidence). Effects were smaller at four and six-month follow-up points. In children and adolescents, there was very low-quality evidence for lower endpoint PTSD symptoms scores in psychotherapy conditions (CBT) compared to control conditions, although the confidence interval is wide (SMD -1.56, 95% CI -3.13 to 0.01; 130 participants; three studies). No RCTs provided data on major depression or anxiety in children.	Not reported.	CBT is often used as an umbrella term that encompasses a wide range of therapeutic approaches, techniques, and systems that share some common elements. These different treatments are based on their own various theoretical models describing putative treatment mechanisms.	No studies looked at the effectiveness or acceptability of psychological therapies for depressive and anxiety symptoms beyond six months. More research evidence is needed, particularly for children and adolescents over longer periods of follow-up. Ideally, trials should be randomised, should use culturally appropriate and validated instruments to evaluate outcomes, and should assess correlates of reductions in treatment effects over time.	The quality of evidence was rated as low and very low by original review authors; High confidence
Purgato M, Gross AL, Betancourt T, Bolton P, Bonetto C, Gastaldon C, et al. Focused psychosocial interventions for children in low-resource humanitarian settings: a systematic review and individual participant data meta-analysis. Lancet	Systematic review and individual participant data meta-analysis; Supporting children after humanitarian crises; 11/11; RCTs (11)	Children (up to 18 years of age) exposed to traumatic events in humanitarian settings in low- and middle-income countries; N = 3143; Burundi (1), Democratic	All interventions were group-based focused psychosocial support interventions. Focused psychosocial support interventions have generally been developed pragmatically to meet conditions in humanitarian settings – e.g., settings with overwhelming needs and few resources.	Waiting lists.	PTSD symptoms (Child PTSD Symptom Scale, IES-8, HTQ, UCLA-PTSD-RI), depressive symptoms (MINICA-9, DSRS, AYPA, APAI, HSCL, OMPA), anxiety symptoms	There was a beneficial effect of focused psychosocial support interventions on PTSD symptoms that maintained at follow-up. No difference in depressive and anxiety symptoms was found between treatment and control groups at the end of the intervention and at follow-up. The meta--analysis of RCTs on PTSD symptoms showed a small, beneficial effect of focused psychosocial support interventions versus waiting list at 0–4	Not reported.	Not reported.	Due to the brevity of the RCTs, the authors are unable to draw conclusions regarding maintenance of symptom reduction in the long term after trial completion. The finding that older children benefitted more from intervention deserves further research. These interventions might hypothetically be more easily implemented with cognitively more developed older youth.	The included studies were evaluated to be of good quality by original review authors; High confidence

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Glob Health. **2018b**;6(4):e390-e400.		Republic of the Congo (1), Gaza Strip (1), Indonesia (1), Kosovo (1), Nepal (1), Rwanda (1), Sierra Leone (1), Sri Lanka (1), Uganda (2).	These interventions might be characterised by their implementation by lay workers or by targeting people with psychological distress or other psychosocial problems broadly, as opposed to people identified with specific mental disorders. Four were classroom-based interventions, one was family-focused, one was a youth readiness intervention, one involved creative play, one was a mind-body skills program, one was a sports intervention, one involved teaching recovery techniques, and one involved a writing intervention.		(APAI scale, HSCL, OMPA, SCARED-5), psychological distress, conduct problems.	weeks after intervention (SMD –0·33, 95% CI –0·52 to –0·14; eight RCTs with 2355 participants). This beneficial effect was reduced but still significant at follow-up at least 6 weeks after intervention completion (–0·21, –0·42 to –0·01; six RCTs with 1808 participants). The meta--analyses that focused on depressive and anxiety symptoms highlighted no difference between intervention and control both at the end of intervention and at follow-up. There was a substantial level of heterogeneity between studies (I^2 between 70% and 80%). Exploratory analyses showed a stronger improvement in PTSD symptoms in children aged 15–18 years (–0·43, –0·63 to –0·23), in non-displaced children (–0·40, –0·52 to –0·27), and in children living in smaller households (<6 members; –0·27, –0·42 to –0·11).			Developing focused psychosocial support interventions according to basic demographic characteristics of the target population (e.g., age, displacement status, and household size) could possibly be useful in optimising scarce resources and maximising benefits.	
NEIGHBOURHOOD DOMAIN (8 reviews)										
Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. J Epidemiol Community Health. **2019**;73(5):379-87.	Systematic review and meta-analysis of randomised controlled trials; Access to permanent housing; 4/4; RCTs (8)	Adults, aged 16 years and older, who meet at least one of the European Typology for Homelessness and Housing Exclusion (ETHOS) criteria: roofless, houseless, living in insecure housing, living in inadequate housing; N = 3474 I = 1824 C = 1650; Canada (1), USA (3)	The intervention Housing First was defined as 'rapid provision of permanent, non-abstinence-contingent housing'.	Treatment as usual, including: (a) entered programmes following Treatment First models, (b) allowed to use any services other than those offered by Housing First programme, (c) customary housing services with case managemen t, and (d) hospital discharge planning service with no continued relationship, transport to	Mental health—including self-reported mental health and clinical assessment of mental ill health; Substance use—including self-reported occasions of substance use and self-reported problematic substance use.	For mental health and substance use, no clear differences were seen when compared with TAU. Two studies provided data eligible for meta-analysis of self-rated mental health. A very small, non-significant improvement was seen in intervention groups compared with treatment as usual (SMD=0.07; 95%CI −0.19 to 0.33; p=0.60, I^2=82%.	Housing First intervention participants spent more days housed (SMD=1.24; 95%CI 0.86 to 1.62) and were more likely to be housed at 18–24 months (risk ratio=2.46; 95%CI 1.58 to 3.84).	The authors argued that Housing First could impact on health outcomes through housing stability as a mediator.	A lack of clear difference seen across the RCTs may be due to heterogeneity of sample participants, differences in provision of attached services, differences in application of consumer choice and the relatively short-term observation period.	The overall risk of bias was assessed as high for each outcome reported across all four studies; High confidence

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				shelter, and access to existing services.						
Benston EA. Housing Programs for Homeless Individuals With Mental Illness: Effects on Housing and Mental Health Outcomes. Psychiatr Serv. **2015**;66(8):806-16.	Systematic review; Reducing homelessness; 7/14; RCTs (6), Quasi-experimental (1)	Homeless individuals with mental illness; N = 1666; USA (7)	The review included "permanent housing programs". Interventions not detailed for each included study.	Detail not reported.	Psychiatric symptoms, substance use - unclear how these were measured.	One study reported that the experimental housing condition outperformed a comparison or control condition by reducing psychiatric symptoms. One study reported that the experimental housing condition was associated with a reduction in substance use. One study found no difference in substance use between persons in experimental and control conditions, because substance use declined in both conditions. Four studies found that the preferred housing condition did not yield any advantage in clinical outcomes over the comparison or control condition.	A majority of participants placed in experimental housing programs with case management support remained in housing for at least one year or experienced more days housed than homeless relative to a comparison group.	Not reported.	Many supportive housing studies do not employ randomization because of ethical concerns about assigning vulnerable individuals to control groups that withhold services. Services such as "case management" are applied broadly, leading to problems defining and conceptualizing variables. Most of the reviewed studies did not analyse the effect of housing on mental health outcomes. The chronic yet fluctuating nature of mental illness makes clinical outcomes difficult to interpret.	Limitations were found in each of the studies, such as attrition, selection and response bias, imprecise definitions and implementation of housing programs, and a lack of appropriate controls; Critically low confidence
Groton, D. (**2013**). Are housing first programs effective? a research note. Journal of Sociology and Social Welfare, 40(1), 51-63.	Systematic review; Improving access to housing; 4/5; RCT (1), non-RCT (1), unspecified design with control group (2)	Chronically homeless individuals or homeless individuals with a mental health diagnosis; N = 1109; USA (4)	All studies included a Housing First approach - providing housing to the intervention group.	Comparison groups included: waiting list, treatment as usual (public shelter / continuum of care), or transitional care prior to permanent housing placement.	Substance use, alcohol dependence, mental health / psychiatric symptoms (Alcohol Use Quantity Form, Addiction Severity Index, Short Inventory of Problems, Alcohol Dependence Checklist, 7-item Therapeutic Alliance Scale, Medical Outcomes Study Short Form-12, Brief Symptom Inventory, case manager interviews, administrative reports, follow-back calendars, Colorado Symptom Inventory).	There was no significant difference in mental health or substance abuse outcomes in all studies comparing Housing First to other conditions. Only one study reported that participation in Housing First led to a statistically significant decrease in alcohol-related measures, compared to individuals using public shelters (wait list). For example, there was a significant time effect and significant differences between groups for typical quantity of alcohol consumed. The growth model for typical quantity of alcohol consumed, for example, had a Wald X2 of 25.51 and significance of $p < .001$. In lay terms, both control and intervention groups experienced a 7% decrease in typical quantity consumed every 3 months, but the intervention group decreased by 3% per each month of treatment as well. Experience of symptoms related to alcohol dependence was also significant (Wald $X2 = 25.88$, $p < .001$), both groups experienced a 4% decrease in dependency-related symptoms. However, those in the intervention had an additional monthly 2% reduction.	In one study, Housing First groups stayed in permanent housing for statistically significant more days (Cohen's $d = 0.4$). For another study, the intervention group was consistently significantly more housed than the control group (New York Housing study).	Not a clearly hypothesised causal pathway - housing first shows promise in helping people maintain housing - the results did not show a significant improvement in psychiatric symptoms other than reducing alcohol use in one study.	Low retention rates, failure to collect data consistently across experimental conditions, and vulnerability to recall bias all weaken the current studies' ability to fairly assess Housing First programs.	Quality of evidence was not formally assessed. Limitations listed by the authors for the studies included: low generalisability of findings to other populations, use of primarily self-reported data or scales unlikely to be sensitive, lack of randomisation leading to baseline differences, and short follow up period; Critically low confidence
Krahn J, Caine V, Chaw-Kant J, Singh AE. Housing interventions for	Systematic review; Improved housing;	Homeless or at risk of being homeless pregnant/	A housing intervention is defined as an organised program that provided homeless	Comparison groups included: Traditional	Maternal mental health (BDI-II, SCL-90-R, ASI, BSI-SF-	The HPTC program was effective at improving maternal mental health outcomes (BDI, SCL-90-R, ASI; Hedge's g effect size = 0.24, $p<.001$. No significant	Participants in the Family Critical Time Intervention program took fewer days on	Preventing pregnant or parenting women with addictions from accessing housing because they are not complying with treatments	While the result of the review provides evidence for the effectiveness of housing programs in improving mothers	Authors utilised the STROBE (strengthening the reporting of

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homeless, pregnant/parenting women with addictions: a systematic review. Journal of Social Distress and the Homeless. **2018**;27(1):75-88.	5/8; RCTs (4), quasi-experimental (1)	parenting women who had a substance use disorder or diagnosable mental illness; N = 678 I = 331 C = 347; USA (5)	pregnant/parenting women who use substances with transitional or permanent housing. Three types of housing interventions were explored in the relevant studies. One study looked at the Homelessness Prevention Therapeutic Community (HPTC) for addicted mothers and their children program. The program aims to change participants values and lifestyles, address parenting, prepare for employment and build a supportive community, rather than just focusing on reducing substance use. Two studies evaluated the effectiveness of Family Critical Time Intervention program. Through this intervention, participants received support from a community case manager over 9 months. The case managers help link them to appropriate support and services in the community, address family functioning, provide emotional and practical support during the transition between homelessness and housing. Two studies evaluated the effectiveness of the Ecologically Based Treatment intervention. Mothers in this program receive an independent apartment of their choosing. They also receive 3 months of rental and utility monetary support and 6	Therapeutic Community (TC) using mutual self-help and peers to facilitate change, treatment as usual, temporary shelter using rapid re-housing and reach out coordinated services.	36), child internalising and externalising behaviours (CBCL, Youth Self-report, Teacher Report Form, CDI)	intervention effect was found for the impact of HPTC on participants substance use, in comparison to control group. No significant treatment effects were found for Family Critical Time Intervention program, compared to comparison groups, when assessing maternal mental health and substance use. Any improvements from baseline were associated with passage of time and housing, as opposed to the intervention itself. When measuring children's mental health, assignment to the Family Critical Time Intervention rather than TAU led to improvements in internalizing (mean effect size: 0.4) and externalizing (mean effect size 0.2) behaviours for children aged 1.5–5 years. Temporary shelter (comparison condition of 2 studies) was as equally effective at reducing mother's mental health problems as an Ecologically Based Treatment program, where mothers got to choose their own housing (effect sizes for depression were greater than 0.7 in both conditions). With regards to children's internalising and externalising behaviours, children in the EBTP intervention group demonstrated significant reductions in internalising (ES = 0.61) and externalising (ES = 0.62) behaviours compared to comparison group children.	average to move into stable housing than families in the comparison group (91.24 days (SD=82.3) and 199.15 days (SD=125.4) respectively). Mothers in both experimental and control group reported increased independent living days at follow-ups.	or have poor mental health could prevent them from reaping the benefits associated with access to housing. Case management is a key component across all programs included in the review. Having a case manager was associated with significant improvement in mental health, housing stability, and reduction in substance use. Families can transition from homelessness to housed community living better if they are provided linkages to other support services in the community, in junction with having access to affordable and stable housing. However, the authors also suggested that it was unclear in the present review which case management approach is beneficial for participants mental health outcomes. Further research is warranted.	and children's mental health, the lack of standardised outcome measures, varying study design, quality and differences in population characteristics across studies make it difficult to determine whether one program model consistently meets the needs of this population and can produce the best outcomes. Small number of studies in the review and heterogeneity in outcomes and their measures across the studies makes it difficult to compare which housing program were most efficacious for homeless, pregnant/parenting women using substances. Future research should also look at housing programs and their effectiveness in other settings/countries to improve the generalisability of findings.	observational studies in epidemiology) checklist to rate the quality of the evidence. Four papers were rated as high quality and one as medium quality; Low confidence

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			months of case management and substance abuse therapy from a therapist. This includes helping mothers to get access to food/resources, obtain government entitlements for cash assistance, childcare, support with any potential crisis or urgent needs that may arise.							
Moore THM, Kesten JM, López-López JA, Ijaz S, McAleenan A, Richards A, et al. The effects of changes to the built environment on the mental health and well-being of adults: Systematic review. Health Place. **2018**;53:237-57.	Systematic review; Improved urban infrastructure; 10/14; CBA studies (9), cluster-RCT (1)	Adults or older adults in urban environments and high-income countries; Could not determine; The Netherlands (1), Spain (1), UK (6), USA (2)	Three types of interventions assessing the effects of changes to the built environment were included: changes to transport infrastructure (n = 2), urban regeneration (n = 6), and improving green infrastructure (n = 2).	No intervention.	Poor mental health (GHQ-12, MHI-5, stress question, WEMWS).	There was no strong evidence of an effect of urban regeneration interventions on mental health outcomes. There was no effect of improving green infrastructure on mental health outcomes. Intervention effect of one transport infrastructure intervention could not be determined. There were no differences in mental health outcomes in the second transport infrastructure study (comparing people living in streets with different levels of traffic noise following introduction of a bypass). 6 urban regeneration interventions looked at mental health outcomes. There was no strong evidence of an effect of urban regeneration interventions on mental health outcomes. 'Neighbourhoods Law' and 'District Approach' dichotomised their mental health scales grading people as having good or poor mental health. The proportion of participants with poor mental health in 'Neighbourhoods Law' was similar in the intervention group from baseline (0.180) to follow up (0.176), whereas it increased in the control group (0.138 at baseline to 0.173 at follow up). The proportion of people classified as having a mental disorder living in intervened districts of the 'Neighbourhoods Law' study was reduced at five years, with weak evidence suggesting a small beneficial effect for the intervention SDID − 0.11 (95% CI − 0.22 to 0.01), but this study is at 'critical' risk of bias. When pooled with data from the 'District Approach' (3 years) the overall effect was reduced to SDID − 0.03 (95% CI − 0.08 to 0.02).	One urban regeneration intervention measured four aspects of social ties with the community, and found no effect on problems with social relations, extent to which people feel part of the community, extent that people are friendly in an area or the extent that people feel part of the local community. One green infrastructure study found positive effect of improving green infrastructure on social isolation/inclusion outcomes; the authors reported increased 'supportive acts of neighbouring' (SDID − 0.68, 95% CI − 1.11 to − 0.25) as measured in one of the four domains from the Multidimensional Measure of Neighbouring scale but also increased 'neighbour annoyance' (SDID − 0.73, − 1.16 to − 0.30). The authors also reported no	Further consideration of the causal processes triggered by changes to the environment which could affect these specific outcomes is needed. A greater understanding of these processes may help to understand why the authors found limited effects and help enhance the effects of similar interventions in the future.	According to the authors: It is important to note that mental health and well-being were not the primary outcome of most of the included interventions. Examining effects of modifications to the environment on mental health and well-being is complex and limited by methodological challenges associated with quasi-experimental evaluation. For instance, it is often challenging to define exposure to population level interventions and to identify an unexposed group. There is currently very little robust public health evidence from intervention studies that changes to the built environment can improve mental health. The authors argue that some study designs being used seem ill-suited to assess changes to the built environment, and that we will likely require need to go beyond the traditional comparative effectiveness research in this area. For example, natural experiments either with a suitable control or with good quality baseline and follow-up data can be used to assess changes to the built environment.	One relevant study could not be quality appraised. One study was rated low risk of bias, three were rated moderate risk of bias, two serious risk of bias, and three critical risk of bias; Low confidence

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						Pooled data from 'NDC' and 'Wythenshawe Regeneration' showed no effect on symptoms of mental health SDID − 0.01 (95% CI − 0.05 to 0.04). In the one study where the majority of the intervention was focused on changes to the private, or home environment ('GoWell'), weak evidence of a small beneficial effect of the intervention was identified (SDID −0.13, 95% CI − 0.26 to − 0.01). Results from the 'Well London' RCT, suggested no differences in mental health between intervened and non-intervened areas (SDID − 0.01, 95% CI − 0.15 to 0.12). The 'Well London' RCT reported no evidence of a reduction in people feeling anxious or depressed, SDID − 0.01 (95% CI − 0.06 to 0.04).	effects on 'social ties' (SDID − 0.21, − 0.63 to 0.19) and 'neighbourhood attachment' (0.12, − 0.28 to 0.53). Using a Likert scale, one other green infrastructure study showed no effect of improving green infrastructure on whether people felt a neighbourhood to be friendly or sociable. Two urban regeneration studies assessed fear of crime; one reported no difference between intervened and control areas on whether people felt safe either in the day or at night, while the other found intervention areas reported a larger decrease in fear of crime between 2002 and 2006 (adjusted difference in means =− 0.67 p = 0.028) and people in the control groups reported feeling safer walking alone after dark compared with the intervention group (adjusted difference in means =− 0.14 p = 0.02). Two green infrastructure interventions assessed fear of crime; one found no effect of the intervention compared to control on a single item fear-of-crime measure, while in the other study fewer people felt safe in woodland in the intervention			

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							compared to the control site, based on a single, fear of crime measure. However, the numbers of people who visited woodlands in the intervention community increased 25%, compared to the comparison site.			
O'Donnell R, Hatzikiriakidis K, Savaglio M, Vicary D, Fleming J, Skouteris H. The extent to which non-conditional housing programs improve housing and well-being outcomes: a systematic review. Housing, Care and Support. **2022**;25(1):46-60.	Systematic review; Access to stable housing; 12/31; Parallel-groups RCT design (10), cluster-RCT (2)	Study participants included any homeless population group (e.g., adults, families, no limit to mental health diagnosis) who resided in any type of non-conditional supported housing (e.g., scattered site, lead tenancy, congregate housing); N = 7992 I = 3269 C = 4303 (Not reported for two studies); Canada (6), France (1), USA (5)	Interventions were non-conditional supported housing arrangements that did not require pre-requisites for engagement. Housing First was the most common intervention used. Participants were assisted with finding and moving into housing, received rent subsidies and case management, or provided with immediate access to housing.	Treatment as usual, which included either (a) access to usual support services in the community (other than Housing First), (b) case management services, or (c) housing support conditional on clinical service engagement.	Mental health symptom severity (CSI, MCSI), self-rated mental health (SF-12, ACTGSF-21), substance use (GAIN-SS, RAPS, ASI, TLFB, MINI), psychological distress (K-6), child behaviour (SDQ).	Findings related to mental health and substance use outcomes were mixed. Five studies measuring general substance use severity did not find any significant differences between the intervention and control group at follow-up. Two studies reported that alcohol severity use was significantly lower for those in supported housing programs, compared to controls. Another study reported that drug use severity was significantly lower for veterans in a housing program compared to those in a control group. Only four studies observed significant improvements in general mental health symptom severity among participants in non-conditional housing support programs, compared to participants in the control group at follow-up. Families engaged in the Family Options Study (e.g., received priority access to long-term rent subsidies) experienced significant improvements in their child's behaviour.	Housing stability of participants in intervention groups at follow-up was greater in comparison to those in control groups. Adults who received the Housing First model of support (e.g., immediate access to housing alongside case management support) were adequately housed for a significantly longer period of time, compared to those who did not receive such support.	Non-conditional supported housing models are underpinned by the belief that support needs (e.g., for mental health, substance use) cannot begin to be properly addressed without the basis of stable, long-term housing.	The programs that were clearly more holistic in their approach, aiming to address each tenant's unique needs to enhance various aspects of their health and well-being, yielded better outcomes. Therefore, the current findings confirm that effective holistic treatment and wraparound psychosocial support to address health-related factors associated with homelessness is required, for all types of non-conditional supported housing arrangements. Future research may benefit from evaluating the outcomes of individuals who accept the offer for additional support, compared to those who decline the offer and only receive housing support. Services received by those in TAU groups may have contributed to a lack of significant differences observed between the groups.	Overall, the authors reported a moderate risk of bias in the included studies; Critically low confidence
Onapa H, Sharpley CF, Bitsika V, McMillan ME, MacLure K, Smith L, et al. The physical and mental health effects of housing homeless people: A systematic review. Health Soc Care Community. **2022**;30(2):448-68.	Systematic review; Improving access to housing; 13/24; Non-RCTs (3), RCTs (8)	Adults (18 years and older) who do not have suitable accommodation alternatives and their current living arrangement "is in a dwelling that is inadequate; has no tenure, or if their initial tenure is short and not extendable; or does not allow them to have control of, and access to space for social relations' as defined by the Australian Bureau	Any housing intervention intended to provide the homeless person with access to any form of housing that was adequate and secure, categorised into four types: (i) permanent supportive housing, (ii) transitional housing, (iii) social housing and (iv) community housing.	There were no restrictions for study comparators – treatment as usual and any housing intervention or homeless service intervention was included.	Anxiety, depression (PHQ-9), psychiatric symptoms (CSI), suicidal ideation and attempts, substance use (DAFBC, GAIN-SS, ASI).	Overall, there were no significant differences on mental health outcomes between housing intervention groups. Depression was measured in two relevant studies. In one study, group status was related to a linear decrease in PHQ- 9 scores ($p < .01$), with the intervention group (permanent supportive housing with a case manager) reporting greater reductions in PHQ- 9 scores over time relative to the comparison group (PSH with no case manager). In another study, higher depressive and anxiety symptoms at the start of the study increased the risk of poor outcomes regardless of type of housing intervention (permanent supportive housing or community residence). In one study, there were no significant differences between housing	Participants in HF were more likely to remain stably housed than those in TAU. In one study, continuum of care intervention was associated with significantly faster decreases in homeless status and increases in stably housed than HF.	Access to safe, secure, and affordable housing is widely accepted as a key solution to address the problem of homelessness and some of the health disparities that exist in homeless populations. Housing, combined with support services to help homeless people remain housed (known as Housing First [HF]), has been identified as the foundation for meeting the needs of homeless people with mental illness. However, understanding of how housing has a positive impact on the physical and mental health of homeless people remains unclear and underdeveloped.	According to the authors: A key issue identified in the reviewed literature was the use of different methods to implement the same housing model. For example, Housing First and support services offered across different sites and nations (primarily the United States and Canada) are not always clearly defined or fully reported. This discrepancy makes it difficult to draw solid conclusions about the effectiveness of the model in the reviewed literature and is an important issue that has been acknowledged elsewhere. One possible explanation for this is that some studies made it	According to the authors, most studies were judged to be moderate and high risk of bias; Moderate confidence

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		of Statistics (ABS) (2012). Most participants had mental health or substance use problems; N = 10798; Canada (9), USA (4)				first and TAU groups on suicidal ideation and attempts. Two studies measuring psychiatric symptoms found no significant differences between groups (housing first vs TAU; housing first vs continuum of care models). Nine relevant studies measured substance use. These studies reported no significant differences in substance use outcomes between intervention (HF) and comparison groups (TAU, COC) at long-term follow-up.			difficult to assess the impact of housing because the control group was given different services that may not be available to people in other places. Another important issue identified in the reviewed literature is the difficulty of controlling for confounding variables, which can lead to two common conceptual issues in housing and health research: moderation and mediation. Heterogeneity of the participant groups and the relatively short-term follow-up periods were also an issue.	
Thomson H, Thomas S, Sellstrom E, Petticrew M. Housing improvements for health and associated socio-economic outcomes. Cochrane Database Syst Rev. **2013**(2):Cd008657.	Systematic review; Improved physical fabric of housing; 10/39; CBA studies (9), RCT (1)	Individuals were mostly social housing tenants or private householders in socioeconomically deprived areas and in receipt of welfare benefits; N = 8512 I = 4294 C = 4218; Germany (1), New Zealand (1), Northern Ireland (1), UK (7)	Six studies assessed rehousing or retrofitting of homes with or without neighbourhood renewal. Four studies assessed warmth and energy efficiency improvements in homes.	Unclear, but it appears some were waitlist controls.	Anxiety, depression, mental health/emotional role (SF-36, GHQ-12), mental/stress conditions. Several measurement tools were not reported.	Overall, few statistically significant changes in mental health outcomes were reported post-intervention. Of the studies assessing rehousing or retrofitting with or without neighbourhood renewal, only one reported a statistically significant reduced level of self-reported anxiety or depression among the intervention group compared with the control group following the housing improvement (OR 0.361, 95% CI 0.152 to 0.856). Of the studies assessing warmth and energy efficiency improvements, only one reported statistically significant increased improvement in 'role emotional' relative to the control group (+10.9%, P < 0.001); however, the full SF-36 Mental Component Score (MCS) was not reported.	A wide range of measures of housing condition were reported across the studies, including measures of damp, cold, mould, air quality, fuel use and fuel expenditure. Most studies reported improvements in these housing condition measures for individuals in the intervention groups over those in control groups. Changes in wider neighbourhood measures (e.g., number of neighbourhood problems, or fear or crime) were mixed.	Interventions to upgrade the housing fabric typically involve substantial changes to housing and may affect, intentionally or not, exposure to a range of potential hazards. For example, energy efficiency measures may result in improved warmth, elimination or containment of mould or damp, and improved air quality as well as reduced fuel costs. It is hypothesised that reduction in exposure to housing conditions associated with poor health will result in health improvement, although the timescale for the impact on health is unclear and it may take years to emerge. Improved housing conditions may be regarded as an intervention which can tackle the complex dynamic between poverty and poor health.	A number of studies had high levels of contamination, in which the control groups received some degree of housing improvement which may have underestimated the effects of the interventions. Authors conclude that stress associated with redevelopment process has adverse health impacts (e.g., moving process induces stress). The extent of health improvement reported will depend on the extent of improvement in actual housing conditions experienced by householders. Health improvement is most likely if the housing improvements are targeted at those in most need, that is those living in poor housing and with existing poor health. The health impacts of programmes which deliver improvements across areas and do not target according to levels of individual need were less clear, but reported impacts at an area level may conceal health improvements for those with the greatest potential to benefit.	Original authors rated the studies as poor quality with unclear risk of bias; High confidence
SOCIOCULTURAL DOMAIN (31 reviews)										
Blewitt C, Fuller-Tyszkiewicz M, Nolan A, Bergmeier H, Vicary D, Huang T, et al. Social and Emotional Learning Associated With	Systematic review and meta-analysis; Social and emotional learning;	Children aged 2 to 6 years in centre-based early childhood education and care settings;	Interventions were universal curriculum-based social and emotional learning programs delivered in centre-based early childhood education	Unclear.	Problem behaviours and emotions including aggression, introversion/withdrawal/anxie	Individuals participating in social and emotional learning programs experienced small reductions in problem behaviours and emotions compared to individuals in control conditions.	Compared with control participants, children in intervention conditions showed significant improvement in a	The authors discussed how children who can understand and regulate their emotions are able to show empathy, navigate social friendships, and develop prosocial relationships. Further research suggests that emotional	Authors discussed the challenges in engaging parents in the SEL intervention programs. School-based intervention research has found that when parents are not involved in the program, effects may remain specific to the	The authors found variability in study quality. Twelve studies (16.0%) were rated as high quality; 33 studies (44.0%) moderate quality;

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Universal Curriculum-Based Interventions in Early Childhood Education and Care Centers: A Systematic Review and Meta-analysis. JAMA Network Open. **2018**;1(8):e185727.	58/79; Experimental or quasi-experimental (n unclear)	N = 18,292 (for whole review); Africa (1), Australia (4), Europe (13), North America (40).	centre settings. Interventions drew on overlapping theories of child development and shared a common goal to increase children's social and emotional skills through explicit and active instruction, modelling, opportunity for practice, and reinforcement, typically using classroom routines and activities (e.g., circle time, small-group sessions, and play) and developmentally appropriate teaching methods (e.g., storytelling, singing, role play, and puppetry).		ty, problem behaviours, conflict, externalising symptoms, internalising symptoms, emotional reactivity/emotional control problems, anxiety, depression, behaviour inhibition, and attention problems, were measured using a wide range of validated tools.	170 effects, across 58 studies, were meta-analysed. The weighted mean effect size in this category was small (Cohen d [SE], 0.19 [0.04]; 95% CI, 0.11-0.28; P < .001), and the test of heterogeneity showed significant variability across effects (ICC = 0.75). The meta regression indicated specialist- or researcher-led programs (B = −0.23; SE, 0.10; P = .02) resulted in stronger effect sizes. Parent assessment of child behaviour suggested less improvement (B = −0.23; SE, 0.06; P < .001), whereas greater improvement based on teacher report was identified (B = 0.10; SE, 0.05; P = .06); however, this did not reach significance. When significant moderators were analysed together, parent informant (B = −0.23; SE, 0.06; P < .001) and intervention leader (B = −0.22; SE, 0.10; P = .03) remained significant.	range of the social and emotional learning outcomes, including social competence (Cohen d [SE], 0.30; [0.06]; 95% CI, 0.18-0.42; P < .001), emotional competence (Cohen d [SE], 0.54 [0.16]; 95% CI, 0.22-0.86; P < .001), behavioural self-regulation (Cohen d [SE], 0.28 [0.09]; 95% CI, 0.11-0.46; P < .001), and early learning skills (Cohen d [SE], 0.18 [0.08]; 95% CI, 0.02-0.33; P = .03). Several variables appeared to moderate program outcomes, including intervention leader, type of assessment, informant, child age, and study quality.	competence in early childhood contributes to social competence concurrently and in later childhood, and emotional knowledge has been shown to be associated with social behaviour and academic competence in later childhood. Therefore, encouraging children's emotional skills through SEL intervention in the preschool years may have ongoing health and well-being benefits.	classroom. Furthermore, it is known that more intensive models that combine parent and teacher training lead to stronger outcomes that last over time. Continued efforts to understand the barriers to parental involvement and design home-based modules that complement work within the classroom appears warranted.	and 30 studies (40.0%) poor quality; Low confidence
Blewitt, C., O'Connor, A., Morris, H., May, T. Mousa, A., Bergmeier, H., Nolan, A., Jackson, K., Barrett, H, & Skouteris, H. (**2021**). A systematic review of targeted social and emotional learning interventions in early childhood education and care settings. Early Child Development and Care.	Systematic review; Social and emotional learning in young children; 12/17; RCTs (6), non-RCTs (6)	Children aged 0 – 6 years who were showing some emotional, social, and/or behavioural issues. In the original papers, participants had been identified through any form of screening process to be experiencing social, emotional, or behavioural difficulty. This meant that some participants were experiencing internalizing behaviours such as withdrawal or anxiety, externalizing behaviours including aggression,	Tier 2 social and emotional learning (SEL) interventions that are targeted at children who have begun to show emotional, social, and/or behavioural issues. All the interventions had to be a classroom-based intervention addressing at least one of the following: self-awareness (recognizing emotions, thoughts, strengths and limitations, self-confidence, self-efficacy), self-management (effectively regulating emotions, thoughts and behaviours, including impulse control), social awareness understanding and empathizing with others), relationship	Majority of studies used a no intervention regular control group. Two studies included a 'nothing' control group as well as an active control group or another within-classroom group control.	A mix of validated scales reported by teachers and/or parents, and validated observational methods, were used.	Overall, study findings were mixed. There was some evidence of significantly less externalising behaviours in intervention versus control children, but limited evidence for differences in internalising behaviours. Five studies reported no significant differences between intervention and control participants on emotional problems. Five studies reported mixed effects; for example, positive intervention effect for externalising outcomes, but no differences in internalising problems, or different outcomes depending on teacher versus parent reported outcomes. Three studies reported significant differences between groups in emotional problems (effect sizes were generally small – medium).	Across the whole review, 13 of the 14 studies that explored children's social competence reported a significant post-intervention improvement on at least one outcome measure. SEL interventions did not appear to improve emotional competence in three studies. Four studies incorporated an assessment of children's behavioural regulation, with mixed results. The findings suggest Tier 2 SEL programmes may offer a promising early intervention approach, particularly with	SEL programmes aim to improve trajectories by fostering children's social-emotional skills, attitudes, and behaviours. The Collaborative for Academic, Social and Emotional Learning (CASEL) describe self-awareness, social awareness, self-management, relationship skills, and responsible decision-making as competencies that can be encouraged and nurtured through explicit lessons, child-centred teaching practices, integration within broader curricula and centre-wide strategies.	Studies had poor follow-up after interventions, making it difficult to infer the impacts of the program as children need to practice the behaviours. There was variety and variability in studies. Studies varied in their delivery methods and applications, and it was difficult to interpret whether certain activities were more or less beneficial. Few studies described engagement with caregivers. Home-based components within SEL interventions may strengthen outcomes. Describing the socio-ecological factors is important for these types of interventions. A limited range of childhood problems were considered - programmes mostly focused on children with problematic externalizing or aggressive behaviours. Notwithstanding the potential impact of disruptive behaviour on classroom management, there appears be a dearth of	Studies ranged from weak to strong quality. The four studies awarded a weak rating were downgraded due to limited information on the age of participants. Studies were also constrained by non-randomized design and poor description of control conditions. Most group studies did not include blind assessors; Critically low confidence

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		disruption, or antisocial behaviour; N =1892 I = 864 C = 1029; Australia (1), Belgium (1), Canada (1), USA (9)	skills (forming and maintaining prosocial relationships, communication, listening, cooperation, managing conflict), and responsible decision making (identifying and effectively solving social and behavioural problems, evaluating consequences of actions). Most programmes were delivered to preschool populations from low to mid socioeconomic background, with diverse ethnic representation. The number of sessions ranged from 1 to 18. Duration of session(s) ranged from 10mins to 60mins. Frequency varied from one off, to weekly, to multiple sessions per week. There was a mixture of teacher led and interventionist (not regular teacher).				regards to aspects of children's social skill development. However, the content and methods of SEL programmes, outcomes examined, and methodological quality differed considerably across studies, and caution is therefore required when considering the results.		approaches targeting internalizing behaviours. There were issues relating to the samples - children in need of Tier 2 supports were predominately identified by their classroom teacher. Teacher and parent-rated measures of child functioning in non-clinical samples of young children show a low correlation.	
Boncu A, Costea I, Minulescu M. A meta-analytic study investigating the efficiency of socio-emotional learning programs on the development of children and adolescents. Romanian Journal of Psychology. **2017**;19(2).	Meta-analytic study; Increasing socio-emotional skills; 33/33 Experimental or quasi-experimental studies with control groups (n unknown).	Participants were enrolled in the educational system, from preschool to the end of the high school; Not reported; Not reported	School-based social and emotional learning interventions were assessed.	Every study had a comparison group, but no details are provided.	Externalising problems (various behavioural problems - made by student self-report, teachers, parents, independent scholars, or using school documents), Internalising problems (depression, anxiety, stress, or social withdrawal, data that can be collected from students,	Externalizing problems were reduced by SEL programs, results reporting a small to medium effect size ($g = .37$, $p < .01$, 95% CI = [0.176; 0.568]) with a high indicator of heterogeneity, $Q = 658.81$, $p < .01$, $I^2 = 96.81$. Internalising problems were also reduced by SEL programs, but the effect size was very small ($g = .17$, $p < .01$, 95% CI = [0.068; 0.280], $Q = 62.89$, $p < .01$, $I^2 = 72.96$). Moderator analyses suggest that students aged 7 - 12 years reaped most benefits from the SEL programs.	In term of social and emotional skills, results revealed a statistically significant size effect ($g = .36$, $p < .01$, 95% CI = [0.252; 0.470]) with evidence of heterogeneity, $Q = 86.82$, $p < .01$, $I^2 = 74.662$.	SEL is based on five components: self-awareness, self-management, social-awareness, relationships skills, and responsible decision making. The five competencies mentioned, are aiming to offer to youth a foundation for reducing conduct problems and emotional distress, and also to increase academic performance and positive behaviours. Another key point in mastering the SEL competencies is the shift of the youth ability from an external control of their emotions and reactions to an internal one.	Quality of the evidence was not assessed by the original review authors. Involving new moderators, such as the type of program and the type of activities delivered to youth, could improve our understanding of the results.	Quality of the evidence was not assessed by the original review authors; Critically low confidence

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
					teachers, or parents).					
Cantone E, Piras AP, Vellante M, Preti A, Daníelsdóttir S, D'Aloja E, et al. Interventions on bullying and cyberbullying in schools: A systematic review. Clinical practice and epidemiology in mental health: CP & EMH. **2015**;11(Suppl 1 M4):58.	Systematic review; Reducing bullying and cyberbullying in schools; 9/17; RCTs (9)	School students; I = 10,149 + 7 schools C = 4,932 + 7 schools; Australia (2), Finland (1), the Netherlands (1), Switzerland (1), USA (4).	School-based interventions to reduce bullying and cyberbullying. Interventions were either focused (on an individual level) or took a universal approach, being either whole-school, multi-level systemic, or mixed intervention programs.	Every study had a comparison group, but details are not provided.	Depression (Short Depression Inventory for Children, CES-DC, BDI, 13-item mood and feelings questionnaire short-form), Behaviour / externalising problems (BASC, other non-specified scales, classroom observation, SBQ), anxiety (SCARED, Fear of Negative Evaluation, Social Avoidance and Distress, Social Anxiety scale for children revised), substance use.	It was difficult to extract findings pertaining to mental health outcomes. Generally speaking, students in bullying interventions experienced declines in behaviour / externalising problems at school, fewer substance use behaviours, and reduced anxiety, compared to control students. One study reported no significant intervention effect on depression.	The majority of studies did not show positive effects in the long term; the interventions focused on the whole school were more effective in reducing bullying than interventions delivered through classroom curricula or social skills training alone.	None reported.	Quality of the evidence was not assessed by the original review authors. No information is available on the duration of the effects 12 to 24 months after the treatment, and many studies did not report follow-up information.	Quality of the evidence was not assessed by the original review authors; Critically low confidence
Casanova G, Zaccaria D, Rolandi E, Guaita A. The effect of information and communication technology and social networking site use on older people's well-being in relation to loneliness: Review of experimental studies. Journal of Medical Internet Research. **2021**;23(3).	Systematic review; Reducing loneliness; 7/11; Quasi-experiment (1), pilot studies (with control groups) (2), experimental studies with randomised sampling (4).	People over 60 years old from residential homes, communities or day centres, or living at home; N total = 639 at baseline and 568 at follow-up; Not reported.	All experimental studies used training classes on computers (PC) or social networking sites (SNS) as the main part of the intervention. Most interventions included the provision of extra incentives to support internet and communication technology (ICT) use (e.g., tutoring and exercise sections).	Comparison conditions varied, including: passive / waitlist control group alone (4), active control group (1), passive and active control group (1), and 1 study had 2 passive control groups and an intervention implemented in 2 different	Depression / mental health (CES-D, DACL, SF-36, SCL-90, GHQ-12), cognitive functioning (RAVLT, ReyCFT, DSST, DFRTT, TMT, COWAT, Miyake EFsT, MMSE, COAST, SDMT, WAIS, ACER).	Compared to control participants, one study reported decreased depression among intervention participants, and another reported improved cognitive functioning. Effect sizes or clinical/practical significance were not reported. The remaining studies reported no significant differences.	Only one study reported positive intervention effects on loneliness. All other studies reported no significant effect on loneliness.	ICT may have positive effects on the individual sense of self-worth, strength of personal identity, and self-esteem.	Quality of the evidence was not assessed by the original review authors. Overall, studies had small sample sizes which limited the generalisability of the results. In some cases, bias was introduced by the randomisation procedure relying on availability of participants/willingness of people to participate. In almost all of the studies, participants must have been early users of ICTs, and in some of them the availability of a PC was a fundamental participation criterion. This may introduce selection bias. Finally, in almost all cases the ICT use is self-reported by participants and may correspond to a different level of actual knowledge and ability in using the PC.	Quality of the evidence was not assessed by the original review authors; Critically low confidence

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
				places of living.						
Cheney G, Schlosser A, Nash P, Glover L. Targeted group-based interventions in schools to promote emotional well-being: A systematic review. Clinical Child Psychology and Psychiatry. **2014**;19(3):412-38.	Systematic review; Social and emotional learning; 12/16; Pre-post intervention with non-randomised control group (12).	Participants were vulnerable school students - with or at risk of social, emotional, behavioural (SEB) problems - aged 4 - 18 years in the UK; N = 2623; United Kingdom (12).	Interventions were group-based and delivered in educational settings, with vulnerable pupils. Interventions identified were (1) Nurture Group, (2) The Oasis, (3) SEAL interventions - social and emotional aspects of learning, including New Beginnings, Going for Goals, Getting on Falling Out, and Good to be Me, (8) FRIENDS, (9) Social skills training, (10) Pyramid Club. These interventions aimed to improve behaviours, develop relationships, and teach social and emotional skills.	Control groups were either matched children with no social, emotional, or behavioural problems, or children waiting to receive an intervention.	Emotional and behavioural functioning (BP), social, emotional, and behavioural difficulties (SDQ), anxiety (SCAS), depression (CDI).	The intervention with the strongest support was the Nurture Group. Most variants were found to be effective on at least one measure of outcome (magnitude of effects not reported), irrespective of the proportion of the school day spent within the group. The evidence for the remaining interventions was sparse. The SEAL interventions Getting on Falling out (GoFO) and Good to be Me (GtbM) did not appear to be well supported. Statistical significance for the remaining two SEAL interventions was reduced, or no longer achieved, at follow up. The FRIENDS, social skills, and Pyramid Club interventions were supported by the literature, but outcomes for each were only reported in one relevant paper.	Not reported.	Teachers are well placed to recognise children whose difficulties impact upon their well-being, but may not reach the diagnostic threshold. School-based programmes can reduce or alleviate many barriers to clinic-based treatment, such as timing, location, stigmatisation, transportation and cost, by offering convenient and less threatening alternatives. Group therapy is often utilised with children because they are particularly responsive to socialisation and benefit from peer-led learning. It may be more acceptable than individual therapy for children since it provides a less threatening context, similar to their everyday school lives, where various behavioural and emotional difficulties may be addressed.	Results from follow-up studies are less clear and limited by a high level of sample attrition. The findings reported in relation to social and emotional aspects of learning, cognitive, behavioural and social skills-based interventions were limited as each intervention is only evaluated by one paper. The review highlighted a need to implement well-designed, longitudinal studies with larger samples in order to evaluate which interventions are effective in UK schools.	For the whole review, the overall range in rated quality was 44% to 78%. Ten studies had a quality rating of 60% or over, suggesting the majority of studies were of moderate to good quality; Critically low confidence
Choi M, Kong S, Jung D. Computer and internet interventions for loneliness and depression in older adults: A meta-analysis. Healthcare Informatics Research. **2012**;18(3):191-8.	Meta-analysis; Improving education and social support; 4/6; RCTs (3), quasi-experiment (1).	Older adults living in either communities or facilities; N = 255 I = 139 C = 116; Israel (1), USA (3).	Interventions were all training programs, teaching participants about computer and Internet use;	Each study had to have a comparison group, but they are not described.	Depression (GDS, CES-D, DACL).	The computer and internet training interventions did not statistically significantly reduce depression among older adults. The scores on the instruments measuring depression (e.g., Centre for Epidemiologic Studies Depression Scale [CES-D] and Geriatric Depression Scale [GDS]) were low at baseline, which indicated that study participants seemed to have low levels of depression. Thus, there was little room for improvement after the intervention. The overall mean weighted effect size for depression in five studies was 0.500 (95% CI, -0.141 to 1.142) based on 344 older adults, which was not statistically significant.	The overall mean weighted effect size for loneliness in five studies was 0.546 with a 95% CI of 0.033-1.059 (Z = 2.085, p = 0.037) based on data from 353 older adults. Thus, computer and Internet training interventions had effect in decreasing loneliness in older adults.	Computer and Internet interventions were effective in decreasing loneliness among older adults in the current study. In other words, a possible reason for these results is that computer and Internet usage are now serving as social supports among older adults, thereby ultimately decreasing their loneliness. Specifically, the results suggested that computer and Internet usage helps older adults to communicate with family and friends as well as obtain news and other useful information.	Two studies had small sample sizes, which might have limited the generalizability of their results statistically. The scores on the instruments measuring depression (e.g., Centre for Epidemiologic Studies Depression Scale [CES-D] and Geriatric Depression Scale [GDS]) were low at baseline, which indicated that study participants seemed to have low levels of depression.	Studies were rated as mostly unclear or high risk of bias; Critically low confidence
Coll-Planas L, Nyqvist F, Puig T, Urrútia G, Solà I, Monteserín R. Social capital interventions targeting older people and their impact on health: A systematic review. Journal of Epidemiology and	Systematic review; Improving social capital; 17/36; RCTs (17)	Participants over the age of 60 (or alternatively studies with a mean age over 64); N = 2895 (for depression and anxiety outcome data);	Interventions that promoted social capital or one of its components. Programmes were mainly based on social support (e.g., support groups, peer support), social activities, befriending schemes and/or engaging participants in activities.	Unclear - control conditions that do not promote social capital.	Depression and anxiety - measured with subjective measures.	Overall, social capital interventions were generally ineffective in reducing depression and/or anxiety.	Social capital interventions were generally ineffective in reducing loneliness.	The authors discussed how social capital-based interventions might improve health outcomes and use of health-related resources by promoting physiological (less damage), psychological (less stress, more self-esteem), behavioural (better lifestyle and self-management), and instrumental (better health care access) changes.	The majority of studies were judged to be at high or unclear risk of bias. In addition to the lack of reporting of relevant details on methods and the limited scope for blinding, attrition was a high source of bias and intention-to-treat analysis was underused.	Of the studies measuring depression and anxiety, 5 were classified as low risk of bias, 3 were unclear, and 9 were high risk of bias; Moderate confidence

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Community Health. **2017**;71(7):663-72.		For the whole review: America (17), Asia and Oceania (5), Europe (14).	From the social capital perspective, the cognitive dimension and the new and bonding relationships were the most frequently promoted.							
Cordier, R., Speyer, R., Mahoney, N., Arnesen, A., Heidi Mjelve, L., & Nyborg, G. (**2021**). Effects of interventions for social anxiety and shyness in school-aged children: A systematic review and meta-analysis. PLoS ONE, 16 (7 July).	Systematic review and meta-analysis; Provision of social support and capital; 19/25; RCTs (2), pseudo-RCTs (3), comparative studies with concurrent controls (14).	Participants in all studies were school-aged children between 6 to 12 years of age, participating in an intervention for social anxiety and shyness; N = 1462; Australia (3), Canada (2), China (2), Hong-Kong (1), Nigeria (1), UK/Ireland (3), Unknown (2), USA (5).	Interventions varied and aimed to provide social support / capital to shy school children. Interventions included: Social effectiveness training for children (2), problem solving and conversational skills training (2), social skills training (4), facilitation of play skills (3), coping techniques / relaxation techniques (1), psychoeducation / cognitive restructuring (2), cognitive bias modification training (1), self-expression training (1), counselling/ conditioning approach (1), teacher/parental training/education program (3), emotional recognition training program (1).	Four control condition types were included: (1) waitlist control groups where participants served as an untreated comparison group who eventually went on to receive the intervention, (2) control groups that received no intervention (3) alternative treatment controls, (4) medication control groups.	Social anxiety (preschool age psychiatric assessment, BIQ, CBCL, PAS, total social anxiety and phobia scales, K-GAS severity, ADIS-C severity, SPAI-C, STAI-C) internalising symptoms (CBCL), depression (depression anxiety stress scale, PANAS), behavioural inhibition (BIQ).	The results indicated a significant reduction reported for anxiety, social phobia, and internalising behaviours (withdrawal, avoidance and isolation). Shyness interventions for school-age children demonstrated a large, significant effect when compared to comparison groups ($z(18) = 5.03$, Hedge's $g = 0.82$, $p < .001$, 95% CI = 0.5–1.14). Of the 18 studies included in the between-groups analysis, 33.3% (n = 6) produced a large effect size, 5.5% (n = 1) produced a moderate effect size, 38.8% (n = 7) produced a small effect size, and 22.2% (n = 4) produced a negligible effect size. The between study heterogeneity was significant $Q(17) = 113.84$, $p < 0.001$) and 85.1% of true variability (I2) could be explained by individual study characteristics. Interventions delivered in school produced a moderate, significant effect size ($z(7) = 2.93$, Hedge's $g = .76$, $p < .01$, 95% CI = 0.25–1.27). Interventions focusing on both children and their parents demonstrated a large but non-significant effect size when compared to control groups ($z(3) = 1.54$, Hedge's $g = 1.01$, $p = .123$, 95% CI = -0.28–2.3). Those focusing on children alone demonstrated a large, significant effect size ($z(12) = 3.95$, Hedge's $g = .93$, $p < .001$, 95% CI = 0.46–1.39). Interventions that focused on the parents alone produced a small but significant effect size ($z(3) = 3.62$, Hedge's $g = 0.49$, $p < .001$, 95% CI = 0.22–0.75). Interventions that used group sessions ($z(13) = 4.31$, Hedge's $g = .92$, $p < .001$, 95% CI = 0.49–1.33) or a combination of individual and group sessions produced large effect sizes when compared to control groups ($z(3) = 1.98$, Hedge's $g = .88$, $p < .05$, 95% CI = 0.1–1.75). Interventions using only individual	Significant improvement was found for play skills and aspects of social functioning, social competence, social skills, social interaction, social adjustment, interpersonal skills, peer victimisation, perceived social support from peers, and pro-social behaviour. Social skills training interventions resulted in intervention group engaging more significantly in peer interactions than control group participants.	Shyness has been theorised to be behavioural inhibition to the unfamiliar (wariness in unfamiliar situations) or social withdrawal including solitary behaviour or symptoms of social anxiety disorder. These are considered risk factors for further social anxiety. To reduce academic and concomitant psychosocial difficulties in school for shy children, effective, feasible interventions are required that are age appropriate, and consider cognitive and social development, social context and parental involvement. Shyness can predict poor social skills and higher anxiety so promotion of protective factors and introduction of intervention can help change shyness as a child matures into adulthood.	There was variation in how shyness was defined / conceptualised across the studies - some studies required diagnosis of social phobia for inclusion into intervention, while others relied on parent or teacher report of shy behaviours. This limits the generalisability of results between studies. Participating children had a range of diagnoses that may have confounded results. The review only focused on 6–12-year-old children, so no conclusions about effectivity of interventions for younger children / adolescents could be made. Longevity of intervention effects could not be determined. The review was unable to ascertain which individual intervention components contributed most to effectiveness of interventions.	Average methodological quality rating across all studies was 83.4%, indicating strong quality. Twelve were rated strong quality and seven were rated good quality; Low confidence

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						sessions produced a small and non-significant effect when compared to control groups.				
Durlak JA, Roger P. Weissberg, Allison B. Dymnicki, Rebecca D. Taylor, Kriston B. Schellinger. The Impact of Enhancing Students' Social and Emotional Learning: A Meta-Analysis of School-Based Universal Interventions. **2011**.	Meta-analysis; Social and emotional learning; 61/213; Almost half (47%) of the studies employed randomised designs.	Students between the ages of 5 and 18 years without any identified adjustment or learning problems. More than half the programs (56%) were delivered to elementary school students, just under a third (31%) involved middle school students, and the remainder included high school students; N = 270,034 for whole review; For whole review: USA (186), outside of the US (27).	Interventions were school-based social and emotional learning programs. 53% of the interventions were delivered in the classroom by a teacher, usually took the form of a specific curriculum, and a set of instructional strategies (e.g., behaviour rehearsal, cooperative learning) that sought to develop specific social and emotional skills. 21% of interventions were delivered in class by non-school personnel, such as university researchers or outside consultants. 26% of programs were multicomponent programs, which typically had two components and were often supplemented by teacher-administered classroom interventions with a parent component or a schoolwide initiative - e.g., parents working with child to complete skill-related homework or attending parent discussion groups. About 77% of the programs lasted for less than a year, 11% lasted 1–2 years, and 12% lasted more than 2 years. The mean number of sessions was 40.8 and the median number of sessions was 24.	Not described, but inclusion criteria stated that the study must have included a comparison group.	Conduct problems (measures of different types of behaviour problems, such as disruptive class behaviour, noncompliance , aggression, bullying, delinquent acts, CBCL or independent observations), emotional distress (internalized mental health issues, such as depression, anxiety, stress, or social withdrawal, which could be provided by students, teachers, or parents on measures such as the Children's Manifest Anxiety Scale).	Compared to controls, SEL participants demonstrated significantly improved social and emotional skills, attitudes, behaviour, and academic performance that reflected an 11-percentile-point gain in achievement. Compared to controls, SEL participants demonstrated fewer conduct problems (mean effect size (hedge's g) = 0.22, CI 0.16 to 0.29, p<.05, n=112) and had lower levels of emotional distress (mean effect size g = 0.24, CI 0.14 to 0.35, p<.05, n=49). Programs delivered by non-school personnel did not produce a significant difference in emotional distress between SEL and control groups. There were significantly reduced conduct problems in SEL vs control groups only when SEL programs delivered by non-school personnel were considered. There were no significant differences between multicomponent programs and other program types in reducing conduct problems and emotional distress. Programs following all four recommended training procedures for SEL interventions (i.e., coded as SAFE) produced significant effects for all six outcomes, whereas programs not coded as SAFE achieved significant effects in only three areas (i.e., attitudes, conduct problems, and academic performance).	SEL skills improved (mean effect size = 0.57, CI 0.48 to 0.67, n=68). Student attitudes improved (mean effect size = 0.23, CI 0.16 to 0.30, n=106). Positive social behaviour improved (mean effect size = 0.24, CI 0.16 to 0.32, n=86). Attitudes improved (mean effect size = 0.27, CI 0.15 to 0.39, n=35).	The SEL approach integrates competence promotion and youth development frameworks for reducing risk factors and fostering protective mechanisms for positive adjustment. In addition to person-centred explanations of behaviour change, researchers have highlighted how interpersonal, instructional, and environmental supports produce better school performance through the following means: (a) peer and adult norms that convey high expectations and support for academic success, (b) caring teacher–student relationships that foster commitment and bonding to school, (c) engaging teaching approaches such as proactive classroom management and cooperative learning, and (d) safe and orderly environments that encourage and reinforce positive classroom behaviour. Two variables moderated positive student outcomes: SAFE practices and implementation problems, suggesting that beneficial programs must be both well designed and well conducted.	Quality of the evidence was not assessed by the original review authors. A limited number of studies considering follow-up timepoints. It was not possible to explore potential moderators because only 57% of the studies monitored implementation and subdividing the studies created extremely small cell sizes that would not support reliable results. Although all reviewed studies aggregated the development of social and emotional skills in one way or another, only 32% assessed skills as an outcome. This is essential to confirm that the program was successful at achieving one of its core proximal objectives. There was no standardized approach in measuring social and emotional skills. Only a few studies tested and found a temporal relation between skill enhancement and other positive outcomes.	Quality of the evidence was not assessed by the original review authors; Critically low confidence
Fenwick-Smith, A., Dahlberg, E. E., & Thompson, S. C. (**2018**). Systematic review of resilience-	Systematic review; Social and emotional	Primary school aged children aged 5-12 years; N = 6028	A range of universal primary school-based interventions were assessed, including: relationship education,	Some control groups consisted of no	Psychological and emotional symptoms, and emotion and behaviour self-	Overall, universal primary school-based interventions resulted in improved mental health outcomes for children. Six studies reported positive outcomes with improvements in internalising	Seven of the eight relevant studies reported positive outcomes with improvements in	Potential risks for poor self-esteem and mental health can be overcome by protective factors like coping skills, healthy social relationships, and help seeking	Results were not reported by gender despite gender differences in prevalence of mental health problems and type of resilience protective factors	A mixed methods appraisal tool was used to assess the quality of included studies. Three were

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enhancing, universal, primary school-based mental health promotion programs. BMC Psychology, 6(1).	learning in children; 8/11; RCTs (6), non-RCT (2)	I = 3650 C = 2378; Canada (1), Ireland (2), Japan (1), Lithuania/ Denmark (1), Netherlands (1), Norway (1), USA (1).	mindfulness, stress-management, coping skills education, emotional well-being, mental health promotion, cognitive behavioural program.	intervention, while others included an active intervention for comparison.	regulation. Measures not specified.	behaviours (effect size unclear). Effective programs included involvement of teachers, and teachers' ability to adapt the program/delivery for students.	student resilience + protective factors including coping skills and self-efficacy.	behaviours and meaningful activities in interactions.	that are used. Ethical implications of providing a beneficial program to one group of children and not the control group were raised. There was also a lack of complete/ stringent randomization described in studies that included a control group.	scored at 100%, two at 75%, two at 50%, and one at 25%; Low confidence
Flores, E. C., Fuhr, D. C., Bayer, A. M., Lescano, A. G., Thorogood, N., & Simms, V. (**2018**). Mental health impact of social capital interventions: a systematic review. Soc Psychiatry Psychiatr Epidemiol, 53(2), 107-119.	Systematic review; Improving social capital, including social relationships and participation in community networks; 6/7; RCTs (2), quasi-RCTs (2), cluster-RCT (1), non-randomised pilot with control groups (1).	A range of study populations were included in the review, including: • Women who were survivors of sexual violence (1) • Socially isolated and affective disturbed adults (1) • Deprived urban communities (aged >16 years) (1) • Older adults who relocated within last 2 years (1) • Aboriginal and islander adults with MH condition/ chronic risk factor (1) • Post-conflict survivors (aged >16 years) (1) N = 5047; Australia (2), Congo (1), Japan (1), Rwanda (1), UK (1),	A range of interventions aiming to improve social capital, including social relationships and participation in community networks, were included. Interventions included: Community engagement and educative programs, cognitive processing therapy, sociotherapy, and neighbourhood projects.	Comparison conditions included individual support services (1), treatment as usual (3), and waiting list (2).	Depression (DASS-21, GDS), anxiety (mini-SPIN, DASS-21), PTSD symptoms (Hopkins symptom checklist-25, 16-item Harvard trauma questionnaire), mental health (GHQ-12, Warwick Edinburgh mental wellbeing scale, self-report of common mental disorders, psychological distress (SRQ-20).	The effect of social capital interventions on the mental health outcomes of interest were not entirely clear, and the magnitude of effects were not clearly articulated. One study (Haslam) looking at a community engagement and educative program (G4H), reported that average depression score reduced from "moderate" to "mild" ($p < 0.05$), and average anxiety and stress scores from "severe" to "moderate" (both $p < 0.001$), from the start of the intervention to a 2-month follow-up. The authors reported sustained improvement from the start on measures of depression, anxiety, and stress at 6-month follow-up. Another study, looking at the Well London program, did not report any significant findings pertaining to relevant mental health outcomes. A study looking at a community-based singing activity intervention conducted and coordinated through local aboriginal groups, reported a reduction from 54.8% at baseline vs. 38.3% at follow-up in the proportion of adults in the intervention group classified as depressed ($p < 0.02$). A study looking at a sociotherapy intervention reported a significant effect of the intervention on linear change in mental health (-0.38, $p<.05$). The mental health outcomes of two remaining intervention studies were unclear.	Findings were mixed and inconclusive regarding intervention effects on social capital outcomes.	Social relationships, group memberships and social identities provide beneficial impact by protecting population mental health while having impact on psychological well-being through strengthening trust between communities and local authorities.	There were issues with the included studies around blinding and group allocation (due to ethical reasons). The studies were not comparable in terms of samples used, interventions implemented, and in outcome measurements used, which prevented pooled effect size calculation.	All studies were reported to be high to moderate quality; Moderate confidence
Franck, L., Molyneux, N., & Parkinson, L. (**2016**). Systematic review of	Systematic review;	Individuals were between 77 - 86 years of age, receiving aged	One intervention involved reminiscence therapy. One intervention involved	One comparison group was on a waitlist.	Depression (CES-), psychological wellbeing (SCL-	Reminiscence therapy significantly reduced depression in residential aged care facility setting. There was a significant difference for depression on	There was a significant difference between control participants and the	Possible facilitators of improvement following reminiscence therapy include the group processes of sharing,	Across all studies, participants were not representative of the entire recruitment population, and samples were small. No	According to the original review authors, 1 study was rated as high quality

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interventions addressing social isolation and depression in aged care clients. Qual Life Res, 25(6), 1395-1407.	Improving social inclusion and integration; 2/6; RCTs (2)	care services (community or residential, and were usually disadvantaged groups with high depression + social isolation; N = 166 at baseline and 127 at follow-up; Taiwan (1), USA (1)	playing a Nintendo Wii game for 1h per week in the company of an undergraduate research assistant.	One comparison group watched 1h of TV with or without a research assistant.	90-R), mood (PANAS).	post-test and follow up (z=-7.09, p<0.0001; z = -7.82, p<0.0001) and psychological well-being (z=-10.25, p<0.0001; z= -10.63, p<0.0001). There was no significant difference in mood between Wii intervention participants and those in a control group.	reminiscence therapy participants for loneliness at follow-up (z = -27.26, p<0.0001, z = -22.75, p<0.0001), with Ethe intervention group showing improvement from moderate-to-mild loneliness. The Nintendo Wii intervention participants had lower levels of loneliness than controls at post-test (F(2.30) = 6.24, P<0.005).	interacting, feedback, and praise, which encourage cohesion, friendship, personal understanding of each other, a sense of belonging to a group, and acceptance by a group. Facilitators of reminiscence therapy were also highly trained in this evidence-based therapy.	study attempted to conceal assignment to intervention or to blind either subjects or those measuring intervention outcomes.	and one as moderate quality; Low confidence
Ghiga I, Pitchforth E, Lepetit L, Miani C, Ali GC, Meads C. The effectiveness of community-based social innovations for healthy ageing in middle- and high-income countries: a systematic review. Journal of Health Services Research and Policy. **2020**;25(3):202-10.	Systematic review and meta-analysis; Improving social supports and networks for older adults; 9/44; RCTs (3), cross-sectional survey with historical control (1), case series with historical controls (1), controlled cohort (3), cross-sectional survey with concurrent control (1).	People aged 50 years and over; N = 1598; Israel (1), the Netherlands (1), Norway (1), Scotland (1), USA (5).	Interventions were community-based social innovations for healthy ageing in middle and high-income countries. Community-based social innovation interventions are those that seek to empower older people to improve their self-abilities and motivate them to take care of themselves and their peers. Community responsibility and engagement are key components of these interventions. Interventions should be run by one or more people from the community themselves, who could be paid, or volunteers, for at least 12 months.	Usual environment, waiting list, or other community-based social innovations interventions.	Depression (CES-D, HSCL-20, WHO-BREF QOL Questionnaire).	Community-based social innovation interventions were found to reduce depression at follow up (SMD = −0.70 (95% CI −1.34 to −0.06) Most studies reported that the interventions had positive impacts on participants. Meta-analysis was conducted on 11 studies measuring depression. However, the interventions and outcome results were too heterogeneous to warrant further inference from these exploratory meta-analyses. Heterogeneity: Tau^2 = 0.48; Chi^2= 49.25, df=4(P<0.00001), I^2= 92%; test for overall effect z=2.16 (P=0.03).	There was no difference between participants who received community-based social innovation interventions and those in the control/comparator group with regards to social support outcomes.	The interventions and outcomes reported in the included studies were too different for the summary results to be generalisable. However, the authors suggested that community-based social innovations have the potential to lead to cost-effective scalable solutions and help to fill gaps within healthcare systems for older people. These interventions should be used together with health and social care services rather than an alternative to these services.	Interventions and outcomes included were too heterogenous for the results to be generalisable. It is unclear whether the lack of difference between the intervention and control groups for social support outcomes were due to the small numbers of studies included. The term community-based social innovation is used sparingly in the literature, so authors had to use their subjective judgements to decide whether programmes constituted as community-based social innovations.	Of the relevant included studies, 3 studies were rated as medium quality, 2 studies were rated as high quality and 3 studies were rated as low quality. Most studies gave insufficient details to allow authors to assess all aspects of quality; Low confidence
Goldberg, J.M., Sklad, M., Elfrink, T.R., Schreurs, K.M.G., Bohlmeijer, E.T., & Clarke, A.M. (**2019**). Effectiveness of interventions adopting a whole school approach to enhancing social and emotional development: A	Systematic review and meta-analysis; Improving social and emotional skills of children; 10/50; RCTs (6), quasi-experiments (4).	Children and young people aged 4–18 years attending primary or secondary school; N = 38,566; Australia (3), Canada (1), Finland (1), Hong	The school interventions needed to include a whole school approach as defined by WHO (1998). This included a coordinated set of activities across curriculum teaching, school ethos, and environment, and family and community partnerships. The	All studies included a control / comparison group, but these were not described.	Internalising symptoms were assessed, which included outcomes related to reducing psychopathology, such as depression and anxiety, and also feelings of	Schools / children who experienced the whole-school social and emotional learning interventions had significantly lower internalising problems/symptoms than control groups. These were small but significant differences (d= 0.109, adjusted to d= 0.060).	Across the whole review, post-intervention outcomes demonstrated significant but small improvements in participants' social and emotional adjustment (d=0.220) and behavioural adjustment (d=	A growing body of research suggests that social and emotional skills are malleable and can be effectively taught using a variety of approaches and formats including classroom-based programming and whole school approaches. Research indicates that interventions yield most successful outcomes when they are integrated into daily practice and school culture, seek to engage all	There is a need for significant infrastructure and capacity to support system-wide implementation of whole school interventions; however, this is often missing, which might have influenced the ability of the interventions to achieve the desired changed. There is limited support, especially outside of the USA for the implementation of these findings. Few studies	The original review authors rated four studies as moderate quality and six as strong quality; Low confidence

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meta-analysis. European Journal of Psychology Education, 34, 755–782.		Kong (1), UK (1), USA (3)	interventions had to be aimed at children and young people aged 4–18 years attending primary or secondary school, adopt a competency enhancement focus, or aim at reducing problem behaviours through the application of social and emotional skills.		wellbeing. The specific measures used were not reported.		0.134). Regarding the intervention characteristics, the inclusion of a community component as part of a whole school intervention was shown to have a significant impact on participants' social and emotional adjustment (Q = 5.092, df = 1, p = 0.024). Results indicated that whole school interventions which contained a community component showed significantly higher effect sizes than interventions without a community component (d = 0.447 vs d = 0.152).	staff, reinforce skills outside of the classroom (such as hallways and playgrounds), support parental engagement, and coordinate work with outside agencies. Reviewers of the evidence to date conclude that taking a whole school approach is more likely than individual classroom-based interventions to result in enduring positive change, because of its multi-component focus.	considered internalising symptoms as an outcome. As a result, the power to detect significant effect sizes was reduced.	
Guzman-Holst, C., Zaneva, M., Chessell, C., Creswell, C., & **Bowes**, L. (**2022**). Research Review: Do antibullying interventions reduce internalizing symptoms? A systematic review, meta-analysis, and meta-regression exploring intervention components, moderators, and mechanisms. Journal of Child Psychology and Psychiatry and Allied Disciplines.	Systematic review and meta-analysis; Anti-bullying in schools; 26/27; RCTs (3), cluster-RCTs (13), non-RCTs (10)	Children and adolescents aged between 4-19 years. Participants mean aged was 10.5 years; N =49480; Australia (7), Canada (3), China (1), England (4), Finland (1), Italy (2), Netherlands (2), Pakistan (1), USA (5)	Anti-bullying interventions were assessed. Forty-eight percent of studies targeted grades1–6, and 52% of studies targeted grades 7–12. Fifty-nine percent of studies had interventions delivered by school staff or teachers and all were based in schools. Seventy percent of studies included whole-school interventions, 26% targeted interventions, and 3.7% included both whole-school and targeted components. Interventions varied and included: adventure-based learning; changing school environment; youth-led aggression prevention program; socio-ecological approach with parent	No intervention	Depression (CES-DC, MFQ, SDI-C, CDI, SMFQ, MDD scale, CDI-2, BASC-PR), anxiety (SCAS, SCARED, PROMIS, RCMAI), internalising symptoms (ESBS, BASC-C, YSR, CBC), emotional problems (SDQ), social anxiety (FNE; SADS, SASC-R, SPQ).	Antibullying interventions had a very small effect in reducing overall internalizing symptoms (ES, 0.06; 95% CI, 0.0284 to 0.1005), anxiety (ES, 0.08; 95% CI, 0.011 to 0.158), and depression (ES, 0.06; 95% CI, 0.014 to 0.107) at postintervention. Two heterogeneity measures indicated that there was low heterogeneity in the data (Q = 21.47, df = 21, p = .4304; I2 = 2.2%, 95% CI: 0% to 47.4%). The reduction in internalizing symptoms did not vary significantly across geographic location, grade level, program duration, and intensity. The intervention component 'working with peers' was associated with a significant reduction, and 'using CBT techniques' was associated with a significant increase in internalizing outcomes. Whole-school approaches were significantly more effective than usual school practice and had a larger effect size than targeted interventions, which were not significantly more effective than usual practice.	Not reported.	Interventions that achieve greater reductions in bullying victimization should theoretically lead to greater reductions in internalizing symptoms. Interventions including a 'work with peers' component were associated with larger effects on internalizing symptoms than those that did not use this – they may increase student's perception and sense of safety at school. It is possible that antibullying interventions may be acting in many other ways to reduce internalizing, such as by promoting a positive school climate, encouraging bystanders to take action, fostering prosocial skills, through peer support or other types of social support, or possibly a combination of elements that work towards improving student's mental health.	Quality and risk of bias varied widely in the included studies; some studies had no randomization, inadequate data handling, missing data, or attrition was not described. Included interventions had the primary aim of reducing bullying, but general conflict resolution/ aggression prevention interventions were excluded. There was a focus on internalizing symptoms, not externalising symptoms.	According to the original review authors, 10 studies were rated low bias, 6 as medium bias, and 10 as having high risk of bias; High confidence

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			component; curriculum based using 4 step conflict resolution model; ecological model targeting school culture; problem solving/coping/cognitive restructuring; social-emotional learning; curriculum-based changes; CBT-based interventions; antibullying program; art therapy; general counselling.							
Kuosmanen T, Clarke AM, Barry MM. Promoting adolescents' mental health and wellbeing: evidence synthesis. Journal of Public Mental Health. **2019**;18(1):73-83.	Systematic review; Social and emotional learning and anti-bullying in schools; 14/66; RCTs and quasi-experiments (n not reported)	Young people aged 8 – 19 years; Not reported; Finland (1), Netherlands (2), Portugal (2), USA (9)	A range of school-based social and emotional learning (SEL) interventions were included in the review. Programs had a primary focus on either social and emotional skills or substance misuse/problem behaviours. Relevant SEL interventions were delivered by teachers, with one program being delivered by an educational psychologist. SEL interventions teach participants skills in the areas of self-management, self-awareness, social-awareness, relationship skills, and responsible decision making. Included interventions included: Positive Attitude (2), Skills for Life (2), Positive Action (4), Lion's Quest (1), Life Skills Training (4). One study evaluated the effectiveness of KiVA anti-bullying intervention.	Not described.	Negative mental health outcomes and substance use/misuse (unclear what tools/scales were used). However, authors stated that they selected studies using pre-defined criteria which were adapted from the Blue Prints for Healthy Youth Development standards.	SEL programs appear to be effective in improving mental health outcomes for adolescents in European countries. Preventative interventions looking at reducing emotional and behavioural problems reported positive outcomes for substance misuse, with preventative effects lasting to young adulthood. SEL interventions appear to be effective for youth from a wide range of demographic backgrounds, including those with and without emotional problems. The magnitude of changes/effect sizes were not reported.	Children and adolescents in the Positive Attitude program reported greater social awareness and self-control. Those who received the Lion's Quest intervention also reported greater social functioning and academic achievement. The only anti-bullying intervention included in the review also reported significant positive effects on bullying and victimisation of adolescents aged 9 to 13 years old.	The author hypothesised that teacher-delivered programmes are most cost-effective and sustainable. However, adequate training for teachers and school staff, supportive organisational structures and practices is essential to ensure successful delivery.	Detailed quality assessment of the retrieved studies was not conducted. Differences in programme effectiveness when delivered across countries could be due to the various implementation structures across programs. Varying levels of implementations, along with cultural and contextual differences could explain the differences in programme impact. Systematic high-quality implementation structures, which include aspects such as training, explicit guidelines for staff, establish clear goals in line with program components, and ensure complete and accurate implementation, are needed.	Detailed quality assessment of the retrieved studies was not conducted, however studies with the most robust evidence base of effectiveness were selected using pre-defined criteria (adapted from the program selection criteria used by Blue Prints for Healthy Youth Development); Critically low confidence
Lee, R. S., Brown, H. K., Salih, S., & Benoit, A. C. (**2022**). Systematic review of Indigenous involvement and	Systematic review; Improving psychosocial support and education offered	Indigenous adult populations in colonial states like Canada, USA, Australia and New Zealand;	A range of different interventions with Indigenous populations were assessed, including psychoeducational, psychosocial, cultural,	No intervention / wait list.	Depression (Hamilton depression scale-24, PHQ-9, CESD, PCL-C, BDI, youth risk	Among six RCTs evaluating depressive symptoms, two measured statistically significant reduced symptoms immediately post-intervention (-6.4 (2.5), p = 0.015; 8.9 (5.4), p<0.05), and one at 6 months after baseline in both	Improvements were also reported on a range of strength-based mental health outcomes, including hope, self-esteem,	Interventions that promote cultural healing and continuity, connection to land, inclusion of community strengths and leadership are known to be protective and promotive	Indigenous mental health is encompassed through the term social and emotional wellbeing (SEWB) in Australia; the review search did not include these terms, so relevant studies from	Original review authors rated 6 studies as moderate quality and 5 as weak;

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content in mental health interventions and their effectiveness for Indigenous populations. Australian and New Zealand Journal of Psychiatry, 56(10), 1230-1251.	to Indigenous populations of colonial states; 11/21; RCTs (8), pre-post studies with comparison groups (3)	N = 1128 I = 542 C = 556 CG (30 unknown); Australia (4), New Zealand (1), USA (6).	and community interventions. The interventions included Indigenous involvement in the content/delivery of the interventions in at least one of the following stages: (a) recruiting, (b) data collection, analysis and sharing, (c) facilitating and administering activities, (d) research training, and (e) decision-making.		and resiliency surveillance survey), anxiety (HADS), hopelessness (Beck hopelessness scale), stress (perceived stress scale), mental health (SF-36), psychological distress (K10), severity of mental illness (HoNOS), PTSD (symptom scale self-report version, PCL-C), stress (stressful life events, brief coping scale).	arms (Intervention: b = 0.42 (0.25, 0.58, p<0.001; Control: b = 0.29 (0.14, 0.43), p<0.001). One trial measured statistically significant lower depression scores at 20 weeks after baseline (-2.60 (-3.75, -1.45). Of the above studies, it was difficult to determine whether statistically significant changes were within or between groups. Depression scores were not reduced in one RCT, and one trial did not report their scores. Psychological distress was assessed in two studies. One showed statistically significant lower mean distress score post intervention (8.9 (5.4), $p \leqslant 0.05$), while the other did not report results. PTSD symptoms were assessed in three studies. A statistically significant reduction in mean PTSD scores immediately and 3-months post intervention was reported in one study (Pre: 27.1 (10.8); Post: 14.7 (8.4); 3-month post: 19.0 (9.7); d = 1.03, p < 0.001), while there were no reported reductions in the other interventions. One RCT measured a statistically significant reduction in perceived stress scores in the intervention arm (-5.7 (1.9), p = 0.006). Among three pre–post studies with comparison groups, two studies using the same intervention measured fewer stressful events in the intervention group, but statistical significance was only measured in one of the studies. In the third study, stress and coping scores were statistically significantly improved in the intervention group. There was no intervention effect on anxiety scores in one RCT.	resilience, and motivational state.	elements of mental health for Indigenous people.	Australia may have been missed. The findings do not indicate differences between communities within Indigenous populations of same country. Not only were actual involvement of Indigenous peoples and organizations and their roles often unclear, wording to describe involvement also varied greatly. With the current evidence, it is not possible to comment on intervention effects by level of Indigenous involvement, as reporting is currently poor and the interventions in the current review were compared to no intervention or wait list groups (rather than interventions with no Indigenous involvement).	High confidence
Luo, L., Reichow, B., Snyder, P., Harrington, J., & Polignano, J. (**2022**). Systematic review and metaanalysis of classroom-wide social-emotional interventions for preschool children. Topics in Early	Systematic review and meta-analysis; Improving social and emotional skills of preschool children; 24/39;	Preschool aged children with or without disabilities. The average child age at the beginning of the study had to be between 36 and 60 months; N = 7580	Classroom-wide social-emotional interventions for preschool children. Interventions used: small group activities only (1), large/whole group activities only (2), group and individual activities (1), whole group activity (e.g., circle time) with small	Comparison groups not described. Inclusion criteria specified the need for a no intervention or a business-as-	Challenging behaviours (PKBS, BPI, ESP, C-TRF, SESBI, TCRS, SSRSM SDQ, T-POT, revised-ECOS, BIQ, RSB, SCDE)	Classroom-wide social–emotional interventions had a statistically significant and noteworthy effect on the reduction of challenging behaviour of preschool children (g = −0.31, 95% CI [−0.43, −0.19]; z = −5.03, p < .001; k = 28). For challenging behaviour, an effect size of −0.31 (95% CI = [−0.43, −0.19]) translates into an improvement index of −12.17 percentile points, 95% CI = [−16.64%, −7.53%], suggesting that	Classroom-wide social–emotional interventions had statistically significant and noteworthy effects on the social competence of preschool children (g = 0.42, 95% CI = [0.28, 0.56]; z = 5.77,	In the context of multitiered systems of support, implementing universal social–emotional practices in early childhood classrooms represents a promising approach to improving all young children's social–emotional competence and promoting their positive behaviour. Specific pathways to change were not discussed.	Regarding moderator analyses, the findings should be interpreted with caution given the number of univariate moderator analyses conducted and the possibility of inflation of Type I error rates. Most included studies lacked detailed descriptions of child participants (e.g., special education status, English language learner status),	Across the whole review, most studies did not adequately describe the method by which participants were assigned (i.e., sequence generation). No study included in the review was free of blinding of

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Childhood Special Education.	Quasi-experimental (7), experimental (17)	I = 3991 C = 2994 (Unclear for 2 studies) Australia (1), Norway (1), Romania (2), Spain (1), UK (2), USA (17)	group activity and embedded instruction into daily routines (4), a family component (15), unclear (15). Interventions were delivered by: teachers and researchers (2), teachers and facilitators (1), clinicians only (1), researchers only (1), n=17 teachers only (17), not reported (2). Dose of interventions was variable: total length of intervention varied from 5 weeks to 40 weeks, number of teaching episodes or intervention sessions delivered to children per week ranged from one session per week to a session everyday (i.e., five times per week). The duration of each teaching episode or session ranged from 5 to 180 mins per session.	usual comparison group.		the intervention would have led to a 12.17% decrease in percentile rank (i.e., reduction in challenging behaviour) for an average child in the treatment group and that 62.17% of the children in the treatment group scored below the control group mean. As indicated by the Q-statistic and I^2 value, there was considerable heterogeneity between studies, Q (27) = 131.40, p < .001, I 2 = 79.45%. Interventions with a family component had a statistically significant larger effect size than those without a family component for challenging behaviour, Q (1) = 7.92, p = .005. Moderator analyses indicated that effect sizes were larger for studies in which intervention was delivered by non-classroom teachers (e.g., researchers, curriculum facilitators, team) than those delivered by classroom teachers for challenging behaviour, Q (1) = 6.40, p = .011).	p < .001; k = 34). This translates to an improvement index of 16.28 percentile points, 95% CI = [11.03%, 21.23%]. There was large heterogeneity between studies, Q (33) = 291.37, p < .001, I2 = 88.67%. Classroom-wide social–emotional interventions had a statistically significant and noteworthy effect on preschool children's emotional competence (g = 0.33, 95% CI = [0.10, 0.56]; z = 2.85, p = .004; k = 14). This translates into an improvement index of 12.93 percentile points, 95% CI = [3.98%, 21.23%]. There was large heterogeneity between studies, Q (13) = 60.38, p < .001, I 2 = 78.47%.		so it is difficult to identify the population of participants to which results may be generalized. Strategies or methods used for random allocation were rarely reported - this synthesis included studies with both random and non-random group assignments.	participants and personnel. Greater than 50% of studies had high risk of detection bias due to outcome assessors who were not blind to children's condition assignment. Finally, a majority of the studies also had a high risk of bias for procedural fidelity; Moderate confidence
Murano, D., Sawyer, J. E., & Lipnevich, A. A. (**2020**). A meta-analytic review of preschool social and emotional learning interventions. Review of Educational Research. 90(2), 227–263.	Systematic review and meta-analysis; Improving social and emotional skills of preschool children; 25/48; RCTs (randomised at classroom/child level) (11), RCTs (randomised at site/school level) (13), quasi experimental design (1)	Preschool children, including those who were deemed at risk (such as students demonstrating high levels of externalising behaviours); N = 16232; Not reported.	Interventions were preschool social and emotional learning (SEL) programs. The school-based interventions were either targeted (4) or universal (21). Most were delivered by teachers (16), while others were delivered by researchers (1), teachers and parents at home (7), unclear (1).	Description provided: 'often a wait-control group in most studies'.	Problem behaviour, including externalising and internalising problems. Specific measures not reported, but informants varied, including: researchers, teachers, parents, and children.	Universal SEL interventions positively reduced problem behaviours in pre-schoolers. Pre-schoolers who received universal SEL vs control had fewer problem behaviours. The effect sizes were interpreted as meaningful in the context of educational interventions (n = 24, g = .32, CI = [.29, .45]). In terms of participant risk status, studies with high percentages of low SES and minority students had gains approximately equal to studies without majority low-SES or minority student samples. In targeted SEL interventions, where only students identified as being at-risk received intervention services, the overall effect size suggested that SEL interventions reduced problem behaviours in pre-schoolers who received the intervention versus controls (n = 14, g = .50, CI = [.37, .64]).	Compared with children in control conditions, children who received a universal SEL intervention showed improvements in overall social and emotional skills (n = 37, g = .34, 95% confidence interval [CI] = [.27, .41]). Compared with children in control conditions, often a wait-control group in most studies, children who received a targeted SEL intervention showed improvements in	Given the uniqueness of the preschool years, in which students spend less time in school and more time at home compared with their school-aged counterparts, it is logical that interventions combining both parent and teacher intervention components have been successful in helping pre-schoolers develop social and emotional skills. This notion is also theoretically supported by ecological systems theory, as both the home and school interact within the pre-schoolers' most immediate mesosystem.	Across the whole review, only 58% of primary studies explicitly discussed fidelity of implementation. In the future, intervention studies should always measure and report fidelity of implementation, considering how critical it is for programs to operate successfully. Studies that reported implementation issues did show smaller effect sizes, which confirms the importance of fidelity of implementation. There was a small number of studies in several of the subgroup analyses, particularly in the targeted intervention analyses. As a result, these effect size estimates may be less precise due to the lack of power and should be interpreted	Quality of the evidence was not clearly assessed. The authors state that the included studies were relatively high quality due to stringent inclusion and exclusion criteria; Low confidence

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						These effect sizes were larger than the effect sizes for universal interventions, potentially suggesting that students identified at-risk had more to gain from early intervention than their non-at-risk peers. (Meta-analytic results pertain to all interventions in review, including school-, home- and community-based interventions).	social and emotional skill development (n = 13, g = .44, 95% CI = [.35, .53]). All effect sizes were significantly different from zero (all p's <.05).		cautiously. There are effect sizes reported in this meta-analysis that remain uncorrected for cluster-randomized designs, in which results are reported at the student level, rather than the unit of randomization (in many cases, either the district, school, or classroom). As a result, the variances of the effect sizes are likely underestimated. In addition to effect size estimates being biased, the authors report that they also may have had an increased Type I error rate for all subgroup analyses completed with uncorrected effect sizes. Several measures reported unacceptable reliability estimates, with estimates as low as α = .47 for several parent rating scales.	
Nagy E, Moore S. Social interventions: An effective approach to reduce adult depression? J Affect Disord. **2017**;218:131-52.	Systematic review; Improving social capital and education; 14/24; RCTs (7), cluster-RCTs (2), randomised intervention / field experiment (2), non-randomised intervention with control (2), longitudinal study with intervention and non-intervention group (1).	The target population of interest was adults from the general population. Studies looking exclusively at older adults (i.e., 65 or older), children, or adolescents (i.e., under 18) were excluded; N = 4468 at baseline; Australia (1), Canada (1), Finland (1), Japan (2), Netherlands (1), South Africa (1), Sweden (1), UK (4), USA (2).	Social interventions whose primary aim was to reduce depressive symptoms were included. Social interventions included interpersonal-level interventions that actively engaged individuals with their broader social networks by fostering social support or social capital within groups or communities. The intervention had to include an interactive component to facilitate bonding and/or interaction with others. Interventions combined components of peer support, skill building, group-based activities, psychoeducation, psychotherapy, exercise, and links to community resources.	Unclear. All relevant studies included a comparison group. Some compared social interventions to other psychosocial treatments, medication use, or inactive conditions.	Depression (BDI, CES-D, HRSD, MDI-10, PSE-10, HAD, SCID, SCL-20, BJSQ).	Study findings were mixed. Four studies reported no statistically significant change in depression/symptoms with no intervention effect. Three studies reported clinical improvement in depression/symptoms among participants, but no statistically significant intervention effect. Seven studies reported statistically and clinically significant improvements in depression/symptoms, attributable to social intervention effect. The social interventions varied across these seven studies, including Internet training/group support programs, social support and education programs for mothers and their children, group walks in nature, befriending intervention, workplace social support and skills program, individual exercise and team sport interventions, and group-based interpersonal therapy program. Griffiths: One study compared an internet training program (ITP) with an internet support group (ISG), and a combination of both (ITP + ISG). The ITP and the ITP + ISG resulted in reduced depression caseness. Endpoint OR predicting depression caseness: ITP endpoint OR=0.19, p<0.05; ISG endpoint OR = 0.27, p>0.05 NS, ITP+ISG endpoint, OR=0.12, p<0.05.	Not reported.	The interpersonal level of the social ecological model may be especially pertinent to intervene upon when addressing depression, since symptoms have been shown to spread throughout social networks. Interventions aimed at reducing depression through interpersonal initiatives would be advantageous for reducing depression in general adult populations since they have the capacity to reach broader groups than individual-level interventions, and thus have the potential to impact populations through community-based initiatives. Mechanisms theoretically proposed to link the social environment with mental health have included the social psychological processes of social influence, social comparison, social control, role-based meaning, self-esteem, sense of control, belonging and companionship, and perceived availability of support.	A number of studies reported that the interventions were likely inadequately powered to detect changes in symptoms due to small sample sizes. Overall, the social interventions identified through this review were highly varied in terms of (a) strategies used to engage individuals socially, (b) duration and intensity, and (c) delivery settings and formats. Findings suggest that there is not one type of social intervention that could work to reduce adult depression, but instead, there is the potential for social interventions to use different strategies to foster interpersonal interaction and improve mental wellbeing among adults. Further research is needed to identify the mechanisms that link the social components of social interventions with reductions in depressive symptoms. Future interventions should consider follow-ups that are longer term, to examine how long and to what extent, intervention effects are sustained.	The studies were predominantly rated as low or unclear risk of bias; Critically low confidence

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						Lipman: At first follow-up assessment, mothers in a 10-week social support and education group showed significant improvements in mood (24.1 to 17.0; β = –6.55) compared with the mothers in a control group. At the third follow-up assessment, the mood score of mothers in the intervention group were 17.8, however these results were not statistically significant. Improvements in mood from baseline to first follow-up: b = –6.55 [standard error (SE) 2.27]; p<0.01; standardized effect = 0.55. In a study of group walks in nature, controlling for other significant predictors, group walks in nature were significantly associated with lower depression. At Time 2, the mean depression score was 6.53 (SD=5.70) in the nature group walkers compared to 9.78 (SD=7.96) in the non-group walkers; t-test= t(1514) = 8.47*** Effect size r=0.21. In a Befriending Intervention study, overall 'remission' (including partial remission to 'borderline case' level) occurred in 65% (28,143) of the befriended group and 39% (17,143) of the controls (x2=4.66, d.f.=l, P<O.OS). All reached the minimum duration criterion of two months' remission. Depressive symptoms decreased significantly in a group-based social and work-related skills intervention group compared to a comparison group at post-intervention and seven months follow-up. Looking at time 1–7 month follow up: Coeff=0.04**, SE = 0.02, d=–0.17 (intervention was 0 and experimental was 1 when entered into model). Depressive symptoms decreased significantly in the intervention group compared to the comparison group (1.279 vs. 1.326 at time 3). One study compared a team sport/psychosocial intervention with an individual exercise intervention and a control group. Results indicated a significant decrease for individual exercise (t(60) = –3.79, p<0.01) and				

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						team sport/psychosocial intervention (t(60) = −4.95, p<0.01) conditions on depression scores over time. Percentage change in BDI-II scores from pre- to post-intervention: control condition=1% increase; IE condition=52% decrease; team sport/psychosocial condition=45% decrease over the 10week intervention period. Significant group difference scores were found at the 8-week follow-up between control and team sport/psychosocial intervention conditions (mean BDI scores of 10.94 vs. 4.32). A group-based interpersonal therapy intervention led to a significant reduction in depressive symptoms as measured by the BDI in the intervention participants compared to the controls over a 12 and 24-week period. Magnitude of reduction not reported.				
Noone C, McSharry J, Smalle M, Burns A, Dwan K, Devane D, et al. Video calls for reducing social isolation and loneliness in older people: A rapid review. Cochrane Database of Systematic Reviews. **2020**;5:1-40.	Rapid review; Social support for older people; 3/3; Cluster quasi-randomised trials (3)	Older adults over the age of 65 years (in nursing homes); N = 201; Taiwan (3)	Interventions involved the use of video calls (laptops of smartphones) once per week for at least five minutes to facilitate communication between nursing home residents and members of their family.	Usual care (not specified).	Depression (GDS).	The evidence suggests that video calls may result in little to no difference in symptoms of depression compared to usual care at three months' follow-up (MD 0.41, 95% CI −0.90 to 1.72; 3 studies; 201 participants) or six months' follow−up (MD −0.83, 95% CI −2.43 to 0.76; 2 studies; 152 participants). The evidence suggests that video calls may have a small effect on symptoms of depression at 12-month follow-up, though this finding is imprecise (MD −2.04, 95% CI −3.98 to −0.10; 1 study, 90 participants).	The evidence was very uncertain and suggests that video calls may result in little to no difference in loneliness compared to usual care at three months (MD −0.44, 95% CI −3.28 to 2.41; 3 studies, 201 participants), at six months (MD −0.34, 95% CI −3.41 to 2.72; 2 studies, 152 participants) and at 12 months (MD −2.40, 95% CI −7.20 to 2.40; 1 study, 90 participants).	Video calls to reduce loneliness or social isolation may work by widening the participant's social circle or by increasing frequency of contact with existing acquaintances.	There is a need for more high-quality studies of the effectiveness of these interventions. More diverse stakeholder groups and settings are needed in future studies, given the current homogeneity of populations with a strong focus on nursing home residents observed.	The studies were judged as high risk of bias overall; High confidence
Pollok J, van Agteren J, Chong A, Carson-Chahhoud K, Smith B. Evaluation of existing experimental evidence for treatment of depression in indigenous populations: A systematic review. Australian Journal of	Systematic review; Indigenous culture / knowledge; 3/4; RCTs (3)	Indigenous populations from any setting were eligible for inclusion, such as in-patient, out-patient or primary care settings. Pregnant young Apache American Indian adolescents, rural American Indian	All interventions were culturally adapted CBT programs which were either delivered by trained Indigenous people, created in consultation with Indigenous leaders and organisations, and incorporating specific Indigenous cultural values.	Comparison groups included an education program (1) or treatment as usual (2) which included offering local or school services.	Depressive symptoms (CES-D, EPDS, DISC, CDI), anxiety (MASC).	The evidence provided in this review is currently not sufficient to conclude that culturally adapted behavioural interventions targeting depression in Indigenous people are effective. In two studies, depressive symptoms significantly improved for American Indian participants in both conditions, with no statistically significant between-group differences. One study of these studies also found no significant reductions in anxiety symptoms post-intervention or at 3-month follow-up. In	Not reported.	Culturally adapted CBT programs were designed with the support and consultations of Indigenous people, and the overall score for participant satisfaction was rated as high; consequently improving treatment uptake and adherence.	Very few studies have been published in this area and there is a need for more high-quality research. Looking only at diagnosed depression, rather than the more holistic account of social and emotional wellbeing (which more adeptly captures Indigenous conceptualisations of mental health), narrowed the number of studies included in the review. There are debates about applying Western	The studies were rated to be at unclear or high risk of bias for the majority of bias types; Moderate confidence

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
Psychology. **2018**;70(4):305-17.		reservation school students, and Maori and Pacific high school students were included; N = 119; New Zealand (1), USA (2)				one study of Maori and Pacific adolescents, participants in the intervention group reported lower levels of depression as measured by the CDI across four times of measurement with baseline mean score M = 26.75 (SD = 6.22), follow-up score M = 10.67 (SD = 6.12) and M = 11.92 (SD = 7.04) at one year follow-up. Results from immediate post-test ($p = .045$) and one-year follow-up ($p < .001$) confirmed the effect observed in the intervention group as statistically significant. At 1 year, the improved scores for depression in the control group regressed to preintervention level (M = 25.33, SD = 4.72) as documented by the follow-up post-hoc t tests.			psychometric tools to Indigenous populations.	
Ronzi, S., Orton, L., Pope, D., Valtorta, N. K., & Bruce, N. G. (**2018**). What is the impact on health and wellbeing of interventions that foster respect and social inclusion in community-residing older adults? A systematic review of quantitative and qualitative studies. Syst Rev, 7(1), 26.	Systematic review; Improving social inclusion and integration; 14/40; RCTs (11), non-RCTs (3)	Primarily healthy older people between 60 - 95 years old. Two studies included older people with dementia, and three included older people with Parkinson's Disease; N = 2655 I = 1536 C = 1119; Japan (2), Netherlands (1), Spain (1), UK (4), USA (6).	Social integration and inclusion interventions varied, including: mentoring (1), intergenerational activities (3), dancing (2), music/singing (2), information and communication technology (ICT) activities (3) multiactivity program (2), art and culture activities (1).	Comparison conditions included no intervention, usual practice, or other interventions around respect / social inclusion.	Mental health (SF-12, SCL, WEMWBS), depression (GDS-10, CES-D, GDS-S-J, YDS, HADS), dementia (QOL – Alzheimer's disease), stress (PSS).	There was a lack of evidence for mentoring, dancing, and ICT interventions. Intergenerational, music/singing, art and culture, and multi-activity interventions showed overall positive effect on mental health outcomes. Two studies with intergenerational interventions found significant effect on depression scores. In one study, a reduction of 26.3% was obtained in the post-treatment evaluation (MD = 3.53, $p < 0.001$) and a reduction of 18.5% at 2-year follow-up (MD = 0.94, $p < 0.001$). Another study showed significant reduction in depression scores in older people with Parkinson's disease (MD = 0.26, $p = 0.001$) and older people without Parkinson's disease (MD = 0.52, $p = 0.001$). The two music and singing intervention studies found a positive effect on mental health. One study found a significant reduction of 36.6% in depression scores at 3-month follow-up (MD = − 1.52, $p < 0.01$) and of 12.5% at 6-month follow-up (MD = − 0.53, $p = .014$). The same study also noted a reduction of 31.1% in anxiety scores at 3 month follow up (MD = − 1.78, $p < 0.01$). One study found an improvement of 14.3% in mental health scores (vitality subscale: MD = 10.4, $p = 0.03$) at 8-week follow-up.	Not reported.	Other reviews have been conducted and report that interventions which promote social participation have been associated with an overall positive impact on cognitive outcomes. Interaction with children or art sessions can improve social, mental or physical health of older people. These interventions lead to improvements in health outcomes through mediating factors like improved self-esteem. In intergenerational initiatives, regular interaction with young people leads to older people feeling valued, included and appreciated thereby leading to enhanced subjective health.	Included studies concerned higher/ upper middle-income countries only. The authors were not able to quantitatively synthesise findings or assess publication bias.	Studies were rating as having low bias (5), low-medium bias (2), medium bias (6), and medium-high bias (1); High confidence
Schindler HS, Kholoptseva J, Oh SS, Yoshikawa H, Duncan GJ, Magnuson KA, et al. Maximizing the	Meta-analysis; Increasing social and emotional skills;	Children from birth to five years old; Not reported;	Early childhood centre-based education (ECE), focusing on interventions around social and emotional	Comparison groups were either controls which	Externalising problems, conceptualized as aggressive, disruptive,	The sample represented 143 effect sizes nested in 55 contrasts and 31 studies. Of the 55 contrasts, 39 were treatment versus control comparisons. The remaining 16 were treatment versus	Not reported.	Not reported.	The limitations of using meta-analytic data precluded the ability to identify the features that were most effective. Future research should continue	Formal quality appraisal or risk of bias was not conducted. Inclusion criteria were quite

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potential of early childhood education to prevent externalizing behavior problems: A meta-analysis. Journal of School Psychology. **2015**;53(3):243-63.	31/31; Experimental and quasi-experimental (n unclear)	USA (31)	learning (SEL). Level 1 programs were those without a clear focus on social and emotional development, Level 2 programs were those with a clear but broad focus on social and emotional development, and Level 3 programs more intensively targeted children's social and emotional development. Studies in which the intervention was designed for children with diagnosed behavioural, emotional, or medical disorders or learning disabilities were excluded.	received no service (39 contrasts), or alternative treatment groups (16 contrasts, e.g., received a different Level SEL intervention).	impulsive, or hyperactive behaviour. The most common instruments were subscales of the Child Behaviour Checklist, observations / counts of behaviour problems (e.g., in laboratory-based tasks), the Social Skills Rating System, the Preschool and Kindergarten Behaviour Scale, and the Eyberg Child Behaviour. Inventory.	alternative treatment contrasts. Each successive level of programs did a better job than the prior level at reducing externalizing behaviour problems. Level 1 programs, or those without a clear focus on social and emotional development, had no significant effects on externalizing behaviour problems relative to control groups (ES =.13 SD, p<.10). On the other hand, level 2 programs, or those with a clear but broad focus on social and emotional development, were significantly associated with modest decreases in externalizing behaviour problems relative to control groups (ES=−.10 SD, p<.05). Hence, level 2 programs were significantly better at reducing externalizing behaviour problems than level 1 programs (ES=−.23 SD, p<.01). Level 3 programs, or those that more intensively targeted children's social and emotional development, were associated with additional significant reductions in externalizing behaviour problems relative to level 2 programs (ES=−.26 SD, p <.05). The most promising effects came from level 3 child social skills training programs, which reduced externalizing behaviour problems half of a standard deviation more than level 2 programs (ES =−.50 SD, p<.05).			replicating the analyses with more contemporary national ECE studies, explore the circumstances under which child social skills trainings are more or less effective at preventing externalizing behaviour problems, and examine how much implementation support and dosage is needed to achieve the greatest benefits at scale.	strict, meaning higher quality study designs were included; Critically low confidence
Siette J, Cassidy M, Priebe S. Effectiveness of befriending interventions: a systematic review and meta-analysis. BMJ open. **2017**;7(4):e014304.	Systematic review and meta-analysis; Building and sustaining social relationships in the community; 9/14; RCTs (7), quasi-experiments (2)	Individuals of all ages, residing in the community and allocated to a befriending intervention, irrespective of ethnicity, gender, nationality or health status; N = 1931; Australia (1), Canada (1), UK (6), USA (1).	Befriending was defined as an intervention that introduces the patient to one or more individuals whose main aim is to provide the patient with additional social support through the development of an affirming, emotion-focused relationship over time. The relationship should be established by and monitored via an agency. The social support should be primarily non-directive and emotional in nature, with the core focus of building a 'friendship'. Additionally, the	Usual care or no treatment.	Depression (HADS, PSE-10, CES-D, BDI, PHQ-9).	Nine comparisons of befriending and usual care or no treatment included a measure of depression as their primary outcome and provided suitable data for meta-analysis. Befriending had no effect on depressive scores (p=0.12), with a standardised mean difference (SMD) of −0.18 (95% CI 0.05 to −0.41, I2=71%).	Five comparisons included a measure of loneliness and demonstrated a SMD of −0.03 (95% CI 0.12 to −0.18, I2=0%).	As our current evidence does not allow for conclusions about more specific effects, future research should specify a model for the hypothesised effect of befriending, select patients accordingly and use an appropriate outcome measure.	One limitation relates to data on participation rates. Not all of the studies reported participation rates, and it was not always possible to derive an average of the rate of participation. There was also a lack of data on participant engagement with befriending across time. It might be that participants initially engage very well with befriending schemes but after time drop out, when in fact greater experience with the intervention is needed for participants to find it helpful. Such findings will have an impact on determining the optimal length of time for befriending which, given the paucity of relevant data in the included studies, could not be established in this review.	Studies were rated as high quality (5), medium quality (3), and low quality (2); Low confidence

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			befriending sessions were delivered by volunteers and offered as a free service.							
Singla DR, Waqas A, Hamdani SU, Suleman N, Zafar SW, Zill EH, et al. Implementation and effectiveness of adolescent life skills programs in low- and middle-income countries: A critical review and meta-analysis. Behav Res Ther. **2020**;130:103402.	Critical review and meta-analysis; Social, emotional, and life skills training in schools; 19/45; RCTs (13), cluster-RCTs (6)	Adolescents, aged 10 to 19 years, in low- and middle-income countries (LMICs) as defined by The World Bank; N = 62825; Burundi (1), Chile (1), China (4), Democratic Republic of the Congo (1), India (3), Indonesia (1), Mauritius (1), Nepal (1), Sierra Leone (1), South Africa (2), Sri Lanka (1), Turkey (1), Uganda (1).	Adolescent life skills programs in schools. Programs most commonly included communication skills, problem-solving, assessing relations, stress management, emotional regulation, identifying/eliciting affect, and self-awareness. Most programs were targeted, typically focusing on a subgroup of high-risk individuals meeting a particular threshold of mental health symptoms. Among those who reported a theoretical orientation, the most commonly endorsed was cognitive and/or behavioural, followed by social-cognitive learning theory, psychosocial and motivational interviewing and interpersonal or mindfulness.	Unclear.	Depression, anxiety, mental health, substance use, PTSD symptoms / trauma, aggression, cognitive functioning, impulsivity, attention, behaviour. Measures / scales used not reported.	Mental health findings are reported for all studies in the review (could not separate out the school-based interventions only). Adolescents in interventions experienced significant reductions in anxiety symptoms, depressive symptoms, PTSD symptoms, and aggression, with small to medium effect sizes. These interventions reported a significant reduction in individual outcomes pertaining to mental health symptoms including anxiety (SMD=0.48, 95% CI=0.18 to 0.77, p = 0.002; I2=0%), depressive symptoms (SMD=0.24, 95% CI= 0.05 to 0.44, p = 0.016; I2=86.31%), PTSD symptoms (SMD=0.60, 95% CI=0.32 to 0.88, p = 0.00; I2=87.36%), and aggression (SMD=1.63, 95% CI=0.65 to 2.60, p = 0.00; I2=82.68%).	Meta-analysis with random effects model demonstrated a significant improvement in life skills (SMD=0.48, 95% CI=0.27 to 0.69, I2=88.22%).	Trial effectiveness of life skills programs reflects three key relationships: the adolescent's relationship with themself (i.e., stress management skills), their relations with others, notably peers (interpersonal skills) and parental-child relations (namely parent-child communication skills).	Most programs targeted both boys and girls simultaneously; however, it was not clear whether curricula were gender sensitive, which may be important to target relevant risk factors of maternal and child health (e.g., intimate partner violence and involvement of father in parental care). Gender-sensitive criteria may be especially impactful in LMICs where patriarchal norms may be prevalent and there is a unique opportunity to prepare both boys and girls to modify their attitudes early on during this preconception phase. The role of adolescents in program development was lacking.	For the whole review, there was overall low risk of bias in 27 (60%) of the studies, compared to 18 (40%) studies reporting a high risk of bias; Moderate confidence
Ştefan CA, Dănilă I, Cristescu D. Classroom-Wide School Interventions for Preschoolers' Social-Emotional Learning: A Systematic Review of Evidence-Based Programs. Educational Psychology Review. **2022**.	Systematic review; Social-emotional learning; 23/23; Experimental (17), quasi-experimental (6) studies.	Children aged 3 - 6 years, either normal developing, at risk (e.g., low SES), or exhibiting some degree of risk for emotional and behavioural problems (EBP); N = 9964; Canada (3), Sweden (1), Turkey (3), UK (1), USA (15).	Four social-emotional classroom-based learning programs were included: "I Can Problem Solve" (6), "Pathways to Alternative Thinking Strategies (PATHS)" (7), "Second Step" (5) and "Tools of the Mind" (5). The program was delivered as a universal intervention in 10 studies, and as a selective/targeted intervention (e.g., high risk, low SES pre-schoolers) in 13 studies.	Unclear – wait list or control group.	Cognitive functioning/ADHD (inhibition, impulsivity, attention) emotional and behavioural problems (PBQ, McCarthy scales, PIPS, SDQ, ASBI), aggression/anger (PSBS, DECB, ACES anger bias, Paths kit, PTRS, TOCA-R), internalising and externalising	Overall, participation in these 4 social-emotional programs led to reduced emotional and behavioural problems and increased executive functioning skills. For the ICPS program, reductions in EBPs were observed (g = − 0.12 to − 0.83) among intervention participants, but no improvements in EF were observed. Outcomes for EBPs varied depending on teacher ratings vs ratings from independent observers. One study testing for mediators of intervention effects, indicated that better developed social competence after ICPS implementation was associated with fewer EBPs. Children in the PATHS intervention group exhibited lower EBP (g = − 0.05 to − 5.23) when rated by their teachers, but not their parents, and improved EF skills (g = 0.15 to 0.64)	All four programs resulted in better social-emotional skills/competence for participating children. The ICPS participation was associated with improvement in children's social competence (g = 0.050 to 1.52). Children in the PATHS intervention group exhibited gains in social–emotional competencies (g = 0.08 to 3.43). Tools of the Mind reported effect sizes of g =	Gains in cognitive skills such as executive functions, language, or theory of mind play an important role in the processing of social information and increased self-control, thereby helping children to be more proficient in understanding emotions, intentions, or socially acceptable behaviours.	Most studies were conducted in the USA; the relative scarcity of data from cultural adaptations of well-established programs indicates that more research is needed to ascertain how SEL classroom-based curriculum can be transferred to other cultures with different educational systems and expectations for young children's development. Findings from previous meta-analyses suggest that combining classroom interventions with parent trainings leads to more consistent reductions in challenging behaviours, probably because children's skills and behaviours are systematically reinforced both at school and at	Studies were rated as unclear and high risk of bias on most items by original study authors. The biggest issue was an inability to blind teachers (who also rated outcomes) or participants; Critically low confidence

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					problems (PKBS).	when assessed by both objective tasks and teacher ratings. Children who were eligible for free meals and who exhibited higher baseline emotional difficulties exhibited fewer EBP post-intervention, and girls exhibited fewer anxiety/somatic complaints compared to boys as a result of PATHS participation. Second Step participation was associated with reduced EBP (g = − 0.38) and increased EF skills (g = 0.07 to 0.39). Second Step participation was predictive of teacher-rated lower internalizing/externalizing problems (g = − 0.38). All studies which reported findings on EF relied on direct child assessment. Tools of the Mind reported effect sizes of g = − 0.21 to − 0.47 for EBP and g = 0.05 to 0.43 for EF (by both lab tasks and observer ratings). Children from high poverty schools exhibited better outcomes post-intervention.	0.26 for children's social competencies. Second Step participation was associated with improved social–emotional skills (g = 0.07 to 0.62).		home. Consequently, future research could investigate if parental involvement in the context of universal classroom-wide interventions strengthens reported outcomes for EBP.	
Taylor, R.D., Oberle, E., Durlak, J.A. and Weissberg, R.P. (**2017**), "Promoting positive youth development through school-based social and emotional learning interventions: a meta-analysis of follow-up effects", Child Development, Vol. 88 No. 4, pp. 1156–1171.	Systematic review and meta-analysis; Increasing students' social and emotional learning; 38 studies measure internalising problems, 30 studies measure conduct problems, out of 82 studies (degree of overlap unclear); Randomised studies (52), non-randomised designs (30).	School samples ranging from kindergarten to grade 12 Students represented ethnically, socioeconomically, and regionally diverse samples; N = 97406 (for whole review); For the whole review, USA (44) and outside USA (38).	For the whole review, the programs were most often classroom-based interventions. The majority of these sought to promote competencies through a series of structured group lessons lasting between 30 and 45 mins. A few incorporated the development of competencies as part of regular academic instruction, and a minority also expanded the classroom intervention with additional components such as efforts to enhance classroom or school climate, various school-wide initiatives, or parent involvement. Thirty-two interventions were delivered in the classroom by school personnel, 27 were delivered in the classroom by a non-school personnel, and 23 were multicomponent. The	Not described. But control groups had to be present, as stated in the inclusion criteria.	Conduct problems (problem behaviours, such as violence, aggression, bullying, classroom disruption, or non-compliance. These measures of externalising behaviours could either be self-reported or observed by others). Emotional distress (primarily symptoms of internalising difficulties, such as depression, anxiety, and stress, which were typically based on student reports).	For the whole review, students in school-based SEL interventions continued to demonstrate significant positive benefits in seven outcomes collected, on average, from 56 weeks and up to 195 weeks (i.e., 3.75 years) following program participation. At first glance, the follow-up mean ES may seem quite modest. Analysis including 38 studies, found that at post-intervention, the intervention group faired significantly better in emotional distress (n = 38, ES = .12, 95% CI [.06, .19]). However, an analysis including n=30 studies found that post-intervention mean ESs were not significant for conduct problems (n = 30, ES = .07, 95% CI [.00, .14]); there were no significant differences between groups. The Q statistic was not significant for conduct problems (Q= 44.73, ns) or emotional distress (Q= 38.10, ns).	Follow-up outcomes (collected 6 months to 18 years postintervention) demonstrate SEL's enhancement of positive youth development. Benefits were similar regardless of students' race, socioeconomic background, or school location. Post-intervention social-emotional skill development was the strongest predictor of well-being at follow-up. For the 82 studies, measures of social and emotional assets at post-intervention showed significant positive impacts of the intervention, with participants having stronger SEL skills (n = 36, ES = .17, 95% CI [.11, .24]) and improved attitudes (n = 25, ES = .17, 95% CI [.09,	Positive youth development (PYD) focuses on enhancing young people's strengths, establishing engaging and supportive contexts, and providing opportunities for bidirectional, constructive youth–context interactions. SEL interventions promote asset development by enhancing five interrelated cognitive, affective, and behavioural competencies considered to be important for success in school and life: self-awareness (e.g., recognizing emotions, strengths and limitations, and values), self-management (e.g., regulating emotions and behaviours), social awareness (e.g., taking the perspective of and empathizing with others from diverse backgrounds and cultures), relationship skills (e.g., establishing and maintaining healthy relationships), and responsible decision making (e.g., making constructive choices across varied situations). The effective promotion of these social and emotional assets (i.e., enhanced skills and improved attitudes) is then expected to lead to better short- and long-term developmental outcomes that	Almost three quarters of the studies (i.e., 72.2%) relied on self-report measures to evaluate student outcomes. Although it is important to include young people's perspectives regarding their skills, attitudes, and behaviours, future research should also incorporate additional measures from the perspectives of others (e.g., teachers, parents, observers) and public record data (e.g., graduation rates, employment, income). Although the authors found consistent positive effects for SEL interventions with students from diverse racial and socioeconomic demographics, these analyses were limited by the lack of data in many studies. More than 40% (34 of 82) of the studies did not report any specific percentages of student ethnicity, and only a third (26 of 82) reported the percentage of students in poverty.	The original review authors did not assess the quality of evidence; Critically low confidence

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			mean number of sessions was 20, median number of sessions was 15.		Most outcomes were child-reported, and the remaining were parent-, teacher-, observant, or school records methods.		.24]) compared with controls. Program participants also faired significantly better than controls at post on academic performance (n = 8, ES = .22, 95% CI [.07, .36]), and drug use (n = 21, ES = .12, 95% CI [.04, .19]). However, postintervention mean ESs were not significant for positive social behaviours (n = 28, ES = .06, 95% CI [-.01, .13]). The Q statistic was not significant for six of the seven outcome categories, which indicates a homogenous group of outcomes within each category, for attitudes (Q= 22.53, ns), positive social behaviour (Q= 14.42, ns), academic performance (Q= 5.90. ns), and drug use (Q=24.35, ns). Only social and emotional skills had a significant test for heterogeneity at follow-up (Q=65.81, p<.05).	include more prosocial behaviour, enhanced academic performance, fewer conduct problems, lower levels of emotional distress, and reduced substance abuse.		
van de Sande MCE, Fekkes M, Kocken PL, Diekstra RFW, Reis R, Gravesteijn C. Do universal social and emotional learning programs for secondary school students enhance the competencies they address? A systematic review. Psychology in the Schools. **2019**;56(10):1545-67.	Systematic review; Social and emotional learning; 35/40; RCTs (22), quasi-experiment (13)	Participants who were adolescents aged between 11 and 19 years; N = 33582; Australia (5), Canada (1), Germany (3), Great Britain (1), Netherlands (2), New Zealand (2), Portugal (1), Spain (2), Sweden (2), Taiwan (1), USA (15).	Interventions were universal secondary school-based social and emotional learning (SEL) programs. SEL competencies being targeted were self-awareness, social awareness, self-management, relationship skills, and decision making. Interventions were delivered by teachers or researchers/masters students/school counsellor.	Comparison groups were exposed to care as usual or a waitlist control. No further details provided.	Depression, anxiety, aggression, substance use. Does not specify measures used.	The majority of the studies that measured outcomes for psychosocial health problems found decreases in those problems in students who participated in the evaluated SEL programs. The pooled effect analyses identified significant positive intervention effects for depression, anxiety, aggression, and substance use. Effect sizes were small to medium. The pooled effect analysis of 19 studies (19,408 participants) assessing depression found positive intervention effects (Cohen's d (SE) = 0.310 (0.54), 95%CI = 0.205 - 0.416, I2 = 99.991). Eight studies (5,808 participants) assessing anxiety found positive	SEL competency outcomes were significantly improved in students participating in SEL programs. This included measures of self-awareness (d = 0.424), social awareness (d = 0.579), self-management (d = 0.387), relationship skills (d = 0.242), and decision-making (d = 0.335). Effect sizes were small to medium.	Social and emotional learning (SEL) competencies are important for preventing or reducing psychosocial problems in adolescents. As adolescents become independent of their parents and make important choices regarding education and work, their social, emotional, and cognitive development is challenged. To cope with the developmental tasks and challenges that are associated with this life stage, young people need to develop advanced and complex cognitive, social, and emotional skills.	Future research should use various assessment methods, including behavioural observation/skill performance, self-report, and informant-report to gain insight into the performance of secondary students' SEL competencies. More insight is still needed to understand the relationship between the different SEL competencies and psychosocial health and between the SEL competencies themselves. Such insights could help to ensure that school programs focus on those targets that are vital to achieving the effects they intend	According to the original review authors, 22 studies were classified as having a strong study design and the remaining 13 were classified as having a moderate study design; Critically low confidence

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
						intervention effects (Cohen's d (SE) = 0.266 (0.041), 95%CI = 0.186 - 0.345, I2 = 99.971). Eleven studies (15,315 participants) assessing aggression found positive intervention effects (Cohen's d (SE) = 0.326 (0.049), 95%CI = 0.230 - 0.421, I2 = 99.980). Six studies (4,061 participants) assessing substance use found positive intervention effects (Cohen's d (SE) = 0.385 (0.124), 95%CI = 0.142 - 0.629, I2 = 99.653).			and to reduce students' exposure to programs and program targets that are ineffective.	
Yang W, Datu JAD, Lin X, Lau MM, Li H. Can Early Childhood Curriculum Enhance Social-Emotional Competence in Low-Income Children? A Meta-Analysis of the Educational Effects. Early Education and Development. **2019**;30(1):36-59.	Meta-analysis; Social and emotional learning; 27/29; RCTs (19), quasi-experiments (8)	Participants were 3 to 5 years of age, from low-income families, and were receiving some form of early childhood service at an early childhood institution (e.g., preschool, pre-K, kindergarten, pre-primary institution, early childhood program/centre); N = 19272 I = 5795 C= 13478; Australia (1), Germany (1), USA (25).	Educational programs or specific methods of an educational program that aimed to promote learning and development in young children. Curricula were classified into two types: specially designed curriculum approaches or models aimed at developing young children's social-emotional competence (SEC) (Type 1) and popular curriculum approaches or models developed for children in the early years but that lacked a specific affective purpose (Type 2). We termed Type 1 curricula SEL focused and Type 2 curricula non–SEL focused.	Children in comparison groups received local curriculum as usual.	Negative social-emotional outcomes including aggression, attention problems, behaviour problems, negative coping behaviour, negative feelings, and social problems. A wide range of validated psychometric measures were used.	The mean ESs demonstrated significant effects on most of the negative outcomes of SEC development, except behaviour problems (n = 21, mean ES = −0.070, Z = −1.477, p > .05). This finding implies that curriculum intervention can effectively reduce the negative outcomes of SEC in low-income children and promote children's social-emotional performance. Specifically, Early Childhood Curriculum had significant effects in reducing disadvantaged young children's aggression (n = 3, mean ES = −0.449, Z = −6.886, p < .01), attention problems (n = 3, mean ES = −0.463, Z = −7.104, p < .01), negative coping behaviour (n = 6, mean ES = −0.153, Z = −5.293, p < .01), negative feelings (n = 4, mean ES = −0.424, Z = −6.918, p < .01), and social problems (n = 5, mean ES = −0.271, Z = −6.141, p < .01). Type 1 curricula influenced negative social-emotional outcomes (n = 13, ES = −0.152, SE = 0.024, 95% CI [−0.198, −0.105], Z = −6.392, p < .01) more significantly than non-SEL-focused curricula. The results indicated that the Type 2 curricula had little or nonsignificant effects on low-income children's negative social-emotional outcomes (n = 14, ES = 0.022, SE = 0.031, 95% CI [−0.039, 0.083], Z = 0.700, p > .05). Type of curriculum, fidelity of curriculum implementation, and duration of intervention were found to affect the magnitude and direction of negative outcomes among children in the intervention and control groups. Studies with good intervention fidelity (ES = −0.133, SE = 0.027) and a shorter intervention duration (less than one school year; ES = −0.503, SE = 0.065) might have had significantly stronger effects in decreasing low-	Positive social-emotional outcomes reported, but not necessarily social and emotional skills/learning.	The results align with the theory of change (Bonell et al., 2015) for understanding the underlying mechanism of SEL-focused curricula in helping low-income children improve their SEC. Growing up in poverty can produce disparities in SEC that can affect children's learning experiences and developmental outcomes. SEC is a multifaceted concept encompassing knowledge and skills integrated across the cognitive, emotional, and behavioural domains of development. The key domains of SEC, such as social behaviour, adaptive behaviour, self-regulation, and interpersonal relationships, are associated with school adaptation and long-term adjustment. A lack of SEC can result in problem behaviour and peer rejection, and behavioural problems that occur in the early years can perpetuate through childhood and adolescence. In contrast, positive development of SEC will benefit young children in their peer relations, school readiness, and well-being. For example, SEC can improve children's school adjustment by reducing their chances of peer rejection. As a result, children with developed SEC are more likely to become a more integral part of the school community and have greater motivation to learn.	This study focused on children's developmental outcomes but not on intervention processes such as teacher–child interaction and the application of learning materials. As interactions with peers and adults are critical to the development of SEC in children, teaching and learning processes should also be evaluated when determining the effects of early childhood curriculum. Subsequent systematic reviews of the processes and mechanisms through which curricula affect the SEC of young children would be of great value. First, for a more robust research design, future studies on the efficacy of early childhood curriculum should provide more information on the qualifications of participating teachers as well as the initial skills and demographics of participating children. Second, more randomized comparative longitudinal studies are needed to examine the length and effectiveness of SEL in young children. Third, it may be necessary to monitor and unify the implementation of curricula in control groups to better carry out cross-study comparisons. Fourth, experimental studies of the influence of early childhood curriculum on children's SEC continue to focus mainly on schools in the United States. There is an urgent need for relevant research evidence from other cultural contexts to	According to the original review authors, four studies were classified as less than satisfactory quality and the remaining 23 were classified as satisfactory design quality; Critically low confidence

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
						income children's negative outcomes for SEC development.			explore the possibility of any cross-cultural variation.	
MULTIPLE DOMAINS (4 reviews)										
Barnett P, Steare T, Dedat Z, Pilling S, McCrone P, Knapp M, et al. Interventions to improve social circumstances of people with mental health conditions: a rapid evidence synthesis. BMC Psychiatry. **2022**;22(1):302.	Systematic review; Housing and homelessness; Money and basic needs; Work and education; Social isolation and connectedness; Family, intimate and caring relationships; Victimisation and exploitation; Offending; Rights, inclusion and citizenship; 54/103; RCTs (54)	Adults (18 years or older) with any mental health condition or personality disorder, established through clinical diagnosis, meeting threshold criteria on an established diagnostic screening tool or symptom severity measure (excluding: intellectual/learning disability, dementia or other organic mental disorder, neurodevelopmental disorder or acquired cognitive impairment, anti-social personality disorder, adjustment disorder, substance use disorder) or who use specialist mental health services; N = 11,101 (Not reported for one study); Australia (1), Canada (4), Denmark (2), France (1), Germany (1), Ireland (1), Italy (1), Japan (1), the Netherlands (9), Norway (1), UK (3), USA (29).	Studies tested a large variety of interventions. All were non-pharmacological interventions designed to improve social circumstances in the domains of Social isolation (13), housing (15), offending (2), employment (21), rights inclusion and citizenship (2), victimisation (1).	Routine care, no support or an active intervention.	Depression (BDI, PHQ-9, BSI, HAMD), cognitive functioning, paranoid thoughts, psychiatric symptoms (BPRS, PANSS, CAPE, Colorado symptom index, SF-36, global severity index, GAF, Symptom Checklist-90), PTSD symptoms (PCL-5), social anxiety symptoms (Liebowitz social anxiety scale).	14 studies reported benefits on mental health measures for the intervention group compared to the control group (social isolation: N = 2 CMD, N = 1 SMI; employment: N = 2 CMD, N = 1 SMI, N = 1 mixed; housing: N = 3 SMI; offending N = 2 SMI; rights, inclusion and citizenship: N = 2). No studies reported that mental health symptoms were significantly worse than the control group. 40 studies reported no differences between arms.	Evidence supports the use of Housing First (designed to reduce homelessness) and Individual Placement and Support (designed to improve employment) in people with mental health conditions. Some evidence supports the use of interventions focused on supporting socialisation or training socialisation skills to improve objective measures of social isolation among people with mental health conditions.	Mental health follows a socio-economic gradient, such that the risk of poor mental health increases with greater social adversity. Social circumstances can have a role in both the onset and the continuation of mental disorders and can also be a significant barrier to accessing effective treatment. Therefore, the alleviation of social adversity could have benefits on clinical outcomes.	Housing First programmes have demonstrated positive outcomes relating to gaining housing in those who are without stable housing at baseline, however it remains unclear how best to support those who are not homeless to retain the stability in their tenancies, and little focus has been on improvement in perceived housing quality, something which has been associated with an exacerbation of clinical symptoms. In other areas of interest, evidence remains weak (e.g., interventions to tackle loneliness among people with mental health conditions).	For all studies included in the review: the quality of RCTs varied. Areas of most concern were blinding of outcome assessment and of participants and personnel; Low confidence
Moledina A, Magwood O, Agbata E, Hung JH, Saad A, Thavorn K, et al. A	Systematic review and meta-analysis;	People with lived experience of homelessness in high income	Interventions varied considerably. Of the relevant studies (measuring mental	Control/comparison groups varied	Mental health: any measures assessing psychological	Most studies found no benefit of permanent supportive housing (PSH) on mental health, or improvements that were not significantly different from	The majority of studies found both significant short- and long-term benefits of	Housing interventions: Access to adequate housing is an end-all objective of most homeless individuals. The unconditional	More longitudinal research is needed to better examine non-housing outcomes. Furthermore, poor reporting, lack of blinding	The original authors judged there to be a moderate or high risk of bias in most

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
comprehensive review of prioritised interventions to improve the health and wellbeing of persons with lived experience of homelessness. Campbell Systematic Reviews. **2021**;17(2).	Reducing impact of homelessness on individuals; housing interventions; income assistance interventions; social supports; 33/128; RCTs (26), quasi-experimental trial (6), randomised longitudinal trial (1)	countries. This included those who have been, are currently, or are at risk of becoming homeless or vulnerably housed; N = 11,061 I = 6,073 C = 4,387; Canada (5), the Netherlands (2), UK (1), USA (25).	health outcomes and targeting a social determinant (e.g., housing, employment, education, poverty)), interventions included assertive community treatment (1), critical time interventions (3), income assistance (6), intensive case management (7), peer support (2), permanent supportive housing (10), and standard case management (4).	considerably . Many studies included an alternative intervention or the same intervention with or without one element. Many studies reported treatment or care as usual, which varied considerably across studies and was quite intensive in some cases.	status, including psychological distress, self-reported mental health status, or mental illness symptoms. Typical tools to measure mental health include the CSI and the self-reported mental status SF-12. Substance use: As measured by the number of days using alcohol or substance, the rate and frequency of using alcohol or sub- stances, number of days of abstinence from alcohol or substances, or physical and mental consequences of using alcohol or substances. Typical tools to measure substance use outcomes include the GAIN-SS.	control/comparison groups. The effects of PSH on substance abuse were mixed, though most studies found no difference in substance use with PSH compared to the usual care. Mental health impacts of income assistance interventions were mixed - rental subsidies for a homeless population with AIDS and homeless families with one child demonstrated benefits on their mental-health status based on their self-reported depression scores and psychological distress levels, but the effect did not appear significant among homeless veterans with psychiatric or addiction disorders who received housing vouchers. Programmes in financial empowerment and compensated work-therapy did not show significant benefits on mental health status. Generally, standard case management (SCM) interventions had mild effects on mental health by reducing the odds of depression, with very slight improvements in both psychological well-being and psychiatric symptoms; however, the overall mental health status remained largely unaffected. Similarly, SCM interventions had negligible or no effect on participants' substance-use outcomes, with some studies reporting even better improvements in the non-intervention groups. Four trials examined substance use outcomes following the receipt of peer-support programmes. Findings from these trials suggested preliminary benefits pertaining to days of substance use but that these benefits seemed to have been trivial in magnitude and to have attenuated with time. Findings on mental health were mixed and polarised as one randomised controlled trial found that pairing homeless African Americans with ethnically matched peer-support workers decreased their psychological distress and improved their overall mental health status. Another study, however, reported that providing peer-support	permanent supportive housing on housing stability, as compared to usual care. There were a minimal number of studies that examined the effects on income and employment. The effect of income assistance interventions appeared most significant on measures of housing stability, specifically in the format of rental subsidies. The effect of income-assistance interventions on employment and income improvement was reported as insignificant or uncertain. Housing stability outcomes for standard case management were mixed. Although the effectiveness of SCM interventions on housing outcomes varied, the SCM interventions had better outcomes among the programme graduates of the interventions, which underscores the fidelity to this type of intervention. Regardless of the nature and complexity of the peer-support programmes that were delivered to individuals with lived experience of	provision of stable housing that is permanent in tenure, supportive in nature, and scattered across the rental market has been associated with a positive impact on the long-term residential stability of homeless individuals. As well, synchronising the provision of permanent housing with supportive services is found to improve social functioning and quality of life. Income assistance interventions: Financial hardships halt all efforts to end the cycle of homelessness. Evidence suggests that increasing income is an effective strategy to improve both access to health services and health status. This correlation may, very well, be the result of reduced financial stressors and increased ability to afford fundamental life necessities, such as housing, food, and medications. Moreover, it was found that providing information on income assistance resources has the potential to improve the physical and psychosocial health of disadvantaged populations. Standard case management: Regardless of the heterogeneity and complexity of case-management models, literature suggests that case management is associated with improved residential stability and substance-use outcomes Patients who are provided with the services of a case manager are more likely to feel supported and guided in their quest to access and maintain fundamental health and social services. Peer support: The peer-support model employs workers with shared life experiences to provide social support, advocacy, education, and role modelling to homeless individuals. Among homeless populations, these elements have been found to improve quality of	and allocation bias reduced the certainty and precision of results. There are other ongoing gaps that warrant more investigation, including peer support programmes, community substance use interventions, and programmes targeted towards special populations. Further examination of implementation barriers of housing programmes is also needed. The absence of evidence on substance use interventions for people living with homelessness represents an important research and policy gap.	categories in each of the studies reviewed; High confidence

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						services to homeless women was associated with harms pertaining to their depression and anxiety symptoms. The findings on Intensive Case Management (ICM) interventions on mental health were mixed. In ICM groups modest reductions in psychiatric symptoms as well as psychological symptoms (deviant behaviour) were reported, youth self-reports of depression problems, and total behavioural problems but not of antisocial behaviour. In contrast, other studies reported no notable between-group differences in youth's self-reports on depression, antisocial behaviour on the Problem Behaviour Scale (PBS) or total behavioural problems. On substance use, ICM intervention had a small effect on substance and drug-use outcomes. There were largely no effects of Assertive Community Treatment interventions on mental health and substance use outcomes, compared to comparison groups. The impact of Critical Time Interventions (CTI) compared to TAU on mental health were mixed. Two studies found no significant difference in psychological distress, though in one study CTI had an added differential effect on psychological distress for participants experiencing less social support, suggesting that CTI may have more benefit in less-supported individuals. One study found that CTI appeared to significantly improve the symptoms of PTSD during follow up. Another trial demonstrated that CTI may also have a benefit for negative symptoms of schizophrenia. The findings of CTI benefits on particularly vulnerable subgroups—that is, participants with less social support, PTSD or schizophrenia—is important and requires further study. Within children, findings were mixed across studies for internalising problems, externalising problems, and depression. Findings pertaining to substance use were mixed.	homelessness, the findings suggest that these interventions cannot stand alone as an approach to decreasing housing instability. Four trials examined housing stability and found no added benefits to peer-support programmes, even when coupled with housing assistance. Intensive Case Management had a moderately significant positive effect on the housing stability of homeless persons, with evidence of immediate significant reductions in the number of days homeless as well as increased likelihood of being housed, by a magnitude of 5.8, with better accommodation or less time spent on the streets. However, no between-group differences were found in long-term reductions in homelessness in a variety of homeless populations. Overall, Assertive Community Treatment interventions had a moderately positive effect on housing stability in homeless persons with mental illness. No evidence was found on the effects of ACT on employment outcomes in the selected trials.	life and reduce problematic substance use.		

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
							Critical Time Interventions significantly improved housing stability and reduced days spent homeless.			
Sweet MA, Appelbaum MI. Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children. Child development. **2004**;75(5):1435-56.	Meta-analytic review; Supporting parents to help their children, with a focus on maternal education, employment, and social support, and reducing child maltreatment and increasing child socioemotional outcomes; 42/60; Quasi-experimental and random assignment designs (number unclear).	A small percentage of programs universally enrolled families. The majority of programs targeted families at some type of environmental risk (75%). Some programs targeted single, specific populations, such as low-income families (55%), families with a low-birth-weight child (15%), families at risk for child abuse or neglect (13.6%), teenage mothers (10.2%), depressed mothers (5.1%), and families dependent on public assistance (3.4%). Populations of developmentally delayed, physically challenged, or chronically ill children were excluded; Not reported; USA	Home visiting programs were investigated. Almost 75% of programs began and ended sometime between birth and 3 years of age. Programs offered the following services directed toward parents: parenting education (98.3%), parent social support (58.3%), parent counselling (41.7%), parent leadership and advocacy training (15%), and adult basic education (1.7%). Programs also provided information on child development (91.7%), fostered parent –child together activities (58.3%), supplied material goods to families (28.3%), provided home-based early childhood education (20%), and provided centre-based early childhood education (15%). In addition, 38.3% of programs reported providing case management services, and 33.3% provided child health or developmental screening of some sort. Programs provided both referrals to social and health services (68.3% for parent, 50% for child) and direct provision of health care (23.3% to parent, 31.7% to child).	Studies had control groups which could be no treatment or another intervention, but these are not described.	Child cognitive outcomes, parenting stress. Measurement tools used unknown.	Children in home visiting programs fared better than did control group children on cognitive outcomes (N = 41 programs, k = 82 effect sizes, weighted mean standardised effect size = .184, SE = .038, Z = 4.79, p<.001). Child cognitive outcomes varied by the following program variables: effect sizes were significantly higher in single site interventions than multisite interventions; effect sizes were significantly higher in quasi-experimental studies than randomised studies; effect sizes were significantly higher when program delivery was by professionals than by non-professionals; effect sizes were significantly higher when programs involved a greater number of home visits and contact hours; effect sizes were significantly higher for children in families that were targeted than in those from universally enrolled families; effect sizes were significantly higher when the primary goal of the program was around health care; effect sizes were smaller when the primary goal of the program was around maternal self-sufficiency or maternal self-help. The practical significance of these findings was reported as unknown by the study authors.	Children in home visiting programs fared better than did control group children on potential child abuse outcomes (N = 13 programs, k = 16 effect sizes, weighted mean standardised effect size = .239, SE = .072, Z = 3.34, p<.001). Mothers in home visiting programs fared better than did mothers in control groups on education outcomes (N = 5 programs, k = 27 effect sizes, weighted mean standardised effect size = .134, SE = .044, Z = 3.03, p<.01). Effect sizes pertaining to child abuse outcomes were significantly better when home visiting programs were single site (over multisite), delivered by paraprofessionals (over professionals or non-professionals), shorter in duration/length, targeted families with environmental risk and low income, and listed child abuse prevention as the primary program goal. Effect sizes pertaining to maternal education outcomes were significantly better	Home visiting programs operate under the belief that parents mediate changes for their children. Most home visiting programs have trained practitioners not to interact directly with children but to encourage and train parents to help their children. Direct help might include coaching parents to help their children with homework, and indirect help might include providing parents with emotional support and job training. Current programs are more likely to involve both parents, although traditionally such services have worked with mothers more than fathers.	Statistical significance does not necessarily indicate practical significance. Whether or not the magnitude of observed effect sizes is meaningful or important remains to be determined. Each analysis was performed independently of all others. It is likely, though, that program design features, populations targeted, and primary goals were related, even possibly confounded, with one another to some extent. This muddies interpretation of univariate findings and may even have resulted in alpha levels more liberal than intended. The set of analyses cannot be clearly and incisively interpreted. They may, however, suggest some themes to be taken up by future research. Standardization would likely enable future meta-analytic efforts to make more definitive statements about what types of programs work best for which types of outcomes. More precise and detailed conceptualization and measurement of both program intervention implementation and service delivery implementation may allow for a clearer understanding of the utility of home visiting programs. This may mean designing programs more specifically with evaluation in mind.	Quality of evidence was not assessed by original authors; Critically low confidence

Citation	Study type; Social determinant being addressed; Relevant number of studies / total studies in review; Study designs (n)	Population(s); Sum of participants (N = total, I = intervention, C = comparison); Geographic areas covered (n studies)	Intervention(s)	Comparison (s)	Outcome(s) measured	Main finding(s) – mental health outcome(s)	Other finding(s) – social determinant(s)	Hypothesised pathway(s)	Issue(s) identified	Quality of evidence (according to original review authors); AMSTAR-2 confidence rating
							when measured in quasi-experimental studies than randomised studies and when programs targeted teenage mothers specifically.			
Yakubovich, A. R., Bartsch, A., Metheny, N., Gesink, D., & O'Campo, P. (**2022**). Housing interventions for women experiencing intimate partner violence: a systematic review. Lancet Public Health, 7(1), e23-e35.	Systematic review; Improving housing access for women experiencing intimate partner violence; 11/34; RCTs (6), Non-RCT/CBA studies (4), historical control study (1)	Women experiencing intimate partner violence; N = 676; Canada (1), the Netherlands (1), South Korea (1), USA (8).	Housing interventions included: Shelter plus model (4), Shelter (3), Critical time intervention (1), supportive housing (2), transitional housing (1). Standard shelter services included various programming, such as crisis intervention; safety planning; counselling; group support; IPV, family violence, and relationship education; legal advocacy; parenting support and education; children's programming; financial assistance; and vocational training. The plus component in evaluations of shelter-plus models was most often group-based support or individual psychotherapy or counselling. I	Control groups received: partly different intervention, completely different intervention, no intervention.	Psychological distress, depressive symptoms, anxiety, parenting stress, mental health related to domestic violence, PTSD symptoms, mood disturbance, automatic negative thoughts, irrational beliefs, hopelessness and alcohol/ drug/ substance abuse. Specific measures used not specified.	The majority of relevant studies reported significant intervention effects. Depressive symptoms, PTSD, psychological distress, anxiety, and substance use largely showed evidence of reductions following housing interventions, particularly in the form of shelters. While few studies reported null findings, no studies reported negative effects of intervention participation. The magnitude of reductions in these mental health outcomes were not reported.	Evidence on abuse-related or socio-structural outcomes like social support, IPV, employment, and money stress was equivocal and sparsely populated. Evidence was minimal but studies found reductions in housing and partner stress, increases in perceived safety and intent to leave partner after housing interventions.	Intent to leave partner, perceived safety, housing and partner related stress were seen to improve after IPV-housing interventions. These benefits might be seen as evidence of the start of a hypothesised causal pathway to long-term personal and situational changes which include freedom from violence, housing and economic security, empowerment, improved physical and mental health and higher quality of life.	The authors did not consider outcomes related to children, pets, partners, or others. Issues present within relevant studies were small sample sizes, difficulties in random sequence generation and allocation concealment, issues around baseline characteristics and protection against contamination. It is also difficult to determine which program components may be most effective given the significant heterogeneity and overlap.	Most studies received low risk of bias ratings from the original authors; High confidence

Supplementary File 6. AMSTAR-2 ratings for all included reviews (N = 101)

AMSTAR-2 Checklist items (critical items bolded):

1. Did the research questions and inclusion criteria for the review include the components of PICO?
2. **Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?**
3. Did the review authors explain their selection of the study designs for inclusion in the review?
4. **Did the review authors use a comprehensive literature search strategy?**
5. Did the review authors perform study selection in duplicate?
6. Did the review authors perform data extraction in duplicate?
7. **Did the review authors provide a list of excluded studies and justify the exclusions?**
8. Did the review authors describe the included studies in adequate detail?
9. **Did the review authors use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that were included in the review?**
10. Did the review authors report on the sources of funding for the studies included in the review?
11. **If meta-analysis was performed did the review authors use appropriate methods for statistical combination of results?**
12. If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?
13. **Did the review authors account for RoB in individual studies when interpreting/discussing the results of the review?**
14. Did the review authors provide a satisfactory explanation for, and discussion of, any heterogeneity observed in the results of the review?
15. **If they performed quantitative synthesis did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review?**
16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?

Final confidence in review scores:

CRITICALLY LOW
LOW
MODERATE
HIGH

First Author Name & Year	AMSTAR-2 Items																Overall confidence
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Al-Tamimi 2022	N	PY	Y	PY	N	N	PY	N	N	N	NA	NA	N	N	NA	N	CRITICALLY LOW
Alzaghoul 2022	Y	Y	Y	PY	Y	N	Y	Y	Y	N	NA	NA	Y	Y	NA	Y	MODERATE
Asgary 2013	N	N	N	PY	Y	NA	PY	NA	NA	NA	NA	NA	NA	NA	NA	Y	LOW
Audhoe 2010	Y	N	N	PY	Y	Y	PY	Y	Y	N	NA	NA	Y	Y	NA	N	LOW
Barnett 2022	Y	PY	N	PY	N	N	PY	Y	Y	N	NA	NA	N	Y	NA	Y	LOW
Baxter 2019	Y	Y	Y	PY	Y	Y	Y	PY	Y	N	Y	Y	Y	Y	Y	Y	HIGH
Benston 2015	N	N	N	PY	N	N	N	N	PY	N	NA	N	Y	Y	NA	N	CRITICALLY LOW
Blewitt 2018	Y	N	N	PY	Y	Y	Y	N	PY	N	Y	N	Y	Y	Y	Y	LOW
Blewitt 2021	Y	N	N	PY	Y	N	PY	Y	Y	N	NA	NA	N	N	NA	N	CRITICALLY LOW
Boncu 2017	Y	N	N	PY	N	N	PY	N	N	N	N	N	N	Y	Y	N	CRITICALLY LOW
Bond 2019	Y	Y	Y	PY	Y	N	PY	Y	N	N	Y	N	N	Y	N	Y	CRITICALLY LOW
Branco 2021	Y	N	Y	PY	N	Y	PY	Y	Y	N	NA	NA	Y	N	NA	Y	LOW
Brown F.L. 2017	Y	N	Y	PY	Y	Y	PY	PY	Y	N	NA	NA	N	Y	NA	Y	CRITICALLY LOW
Brown R.C. 2017	Y	N	Y	PY	N	N	PY	Y	N	N	Y	N	N	Y	Y	Y	CRITICALLY LOW
Cantone 2015	N	N	Y	N	N	N	PY	N	N	N	NA	NA	N	N	NA	Y	CRITICALLY LOW
Casanova 2021	Y	N	Y	PY	Y	Y	PY	PY	N	N	NA	NA	N	N	NA	Y	CRITICALLY LOW
Charzynska 2015	N	N	N	PY	N	N	N	N	N	N	NA	NA	N	N	NA	N	CRITICALLY LOW
Chen 2016	Y	N	Y	PY	Y	Y	PY	PY	Y	N	Y	N	Y	Y	Y	Y	LOW
Cheney 2014	Y	N	Y	PY	N	N	PY	PY	Y	N	NA	NA	N	Y	NA	Y	CRITICALLY LOW
Choi 2012	Y	N	N	PY	N	Y	PY	N	Y	N	Y	N	N	Y	NA	Y	CRITICALLY LOW
Coll-Planas 2017	Y	Y	N	PY	Y	N	Y	PY	Y	N	NA	NA	Y	Y	NA	Y	MODERATE
Coombe 2015	N	N	N	PY	N	N	N	PY	Y	N	NA	NA	N	Y	NA	Y	CRITICALLY LOW
Cordier 2021	Y	N	Y	PY	N	N	PY	Y	Y	N	Y	Y	Y	Y	Y	Y	LOW
Doherty 2021	Y	Y	Y	PY	Y	Y	PY	Y	Y	N	Y	Y	Y	Y	Y	Y	HIGH
Drew 2019	Y	N	Y	PY	Y	N	PY	PY	Y	N	Y	Y	Y	N	NA	Y	LOW
Durlak 2011	Y	N	N	PY	N	Y	PY	N	N	N	Y	N	N	Y	Y	N	CRITICALLY LOW
Efevbera 2018	Y	N	N	PY	Y	Y	PY	N	N	N	NA	NA	N	Y	NA	Y	CRITICALLY LOW
Emezue 2022	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	NA	Y	MODERATE

First Author Name & Year	AMSTAR-2 Items																Overall confidence
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Evans 2022	N	Y	Y	PY	N	N	PY	N	Y	N	NA	NA	Y	Y	NA	N	MODERATE
Fang 2022	Y	N	N	PY	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	CRITICALLY LOW
Fenwick-Smith 2018	Y	N	Y	PY	Y	N	Y	Y	PY	N	NA	NA	Y	Y	NA	Y	LOW
Flores 2018	Y	PY	Y	Y	Y	N	PY	Y	Y	N	NA	NA	Y	Y	NA	Y	MODERATE
Franck 2016	Y	N	Y	PY	Y	Y	PY	Y	Y	N	NA	NA	Y	Y	NA	N	LOW
Frederick 2019	Y	N	Y	N	N	N	PY	PY	N	N	Y	NA	N	Y	N	Y	CRITICALLY LOW
Fu 2015	Y	N	Y	PY	N	N	PY	PY	N	N	Y	N	N	Y	Y	N	CRITICALLY LOW
Gayed 2018	Y	N	N	PY	Y	Y	PY	PY	PY	N	Y	Y	Y	Y	Y	Y	LOW
Ghiga 2020	Y	PY	Y	PY	Y	Y	Y	Y	PY	N	Y	Y	Y	Y	N	Y	LOW
Gillespie 2022	Y	PY	Y	PY	Y	Y	PY	PY	PY	N	NA	NA	Y	NA	NA	Y	MODERATE
Goldberg 2019	Y	N	N	PY	N	Y	PY	N	Y	N	Y	Y	Y	Y	Y	Y	LOW
Goldstein 2020	Y	N	N	PY	Y	N	PY	PY	N	N	NA	NA	N	NA	NA	Y	CRITICALLY LOW
Groton 2013	Y	N	Y	PY	N	N	N	Y	N	N	NA	NA	N	N	NA	N	CRITICALLY LOW
Guzman-Holst 2022	Y	Y	Y	Y	Y	Y	PY	Y	Y	N	Y	Y	Y	Y	Y	Y	HIGH
Gwozdziewycz 2013	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	CRITICALLY LOW
Kiss 2020	Y	PY	N	PY	N	N	N	PY	N	N	NA	NA	N	NA	NA	Y	CRITICALLY LOW
Krahn 2018	N	N	N	PY	Y	Y	PY	Y	PY	N	NA	NA	Y	NA	NA	Y	LOW
Kuosmanen 2019	N	N	N	PY	N	N	N	N	N	N	NA	NA	N	NA	NA	Y	CRITICALLY LOW
Le Roux 2022	N	N	Y	PY	N	N	PY	Y	N	N	NA	NA	N	NA	NA	Y	CRITICALLY LOW
Lee 2022	Y	Y	Y	PY	Y	Y	PY	Y	Y	N	NA	NA	Y	Y	NA	Y	HIGH
Li 2022	Y	PY	Y	Y	Y	Y	PY	Y	Y	N	NA	NA	Y	N	NA	Y	MODERATE
Linde 2020	Y	Y	N	PY	Y	Y	PY	PY	Y	Y	Y	Y	Y	Y	Y	Y	MODERATE
Lipinski 2016	Y	N	Y	Y	N	Y	PY	Y	Y	N	NA	NA	Y	N	NA	Y	LOW
Little 2021	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	NA	Y	HIGH
Lopes 2014	Y	N	N	PY	N	N	Y	PY	PY	N	NA	NA	Y	Y	NA	Y	LOW
Lund 2011	Y	N	Y	Y	Y	Y	PY	PY	Y	N	NA	NA	Y	Y	NA	Y	LOW
Luo 2022	Y	Y	N	Y	Y	Y	PY	N	Y	N	Y	N	Y	Y	Y	Y	MODERATE
Marshall 2014	Y	N	N	N	N	N	N	PY	N	N	NA	NA	Y	N	NA	Y	CRITICALLY LOW

First Author Name & Year	AMSTAR-2 Items																Overall confidence
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
McGuire 2022	Y	Y	Y	PY	Y	Y	PY	PY	Y	Y	Y	Y	Y	Y	Y	Y	HIGH
Moledina 2021	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	Y	HIGH
Moore 2017	Y	Y	N	PY	Y	Y	Y	Y	Y	Y	NA	NA	Y	Y	NA	Y	HIGH
Moore 2018	Y	Y	N	PY	Y	Y	Y	PY	Y	N	N	NA	Y	Y	NA	Y	LOW
Murano 2020	Y	N	Y	PY	N	Y	Y	N	Y	N	Y	N	Y	Y	Y	N	LOW
Nagy 2017	Y	N	N	PY	Y	Y	PY	PY	Y	N	NA	NA	N	Y	NA	N	CRITICALLY LOW
Natha 2014	N	N	N	PY	N	N	PY	PY	Y	N	NA	NA	Y	Y	NA	N	LOW
Nieuwenhuijsen 2020	Y	Y	N	PY	Y	Y	Y	Y	Y	N	Y	PY	Y	Y	NA	Y	MODERATE
Noone 2020	Y	Y	Y	PY	Y	Y	Y	PY	Y	Y	Y	Y	Y	Y	NA	Y	HIGH
O'Donnell 2022	Y	N	Y	PY	Y	N	PY	Y	Y	N	NA	NA	N	Y	NA	Y	CRITICALLY LOW
O'Sullivan 2016	Y	N	N	PY	Y	N	N	PY	Y	N	Y	Y	N	Y	N	N	CRITICALLY LOW
Onapa 2022	Y	PY	Y	PY	Y	Y	Y	PY	Y	N	NA	NA	Y	N	NA	Y	MODERATE
Pachito 2018	Y	Y	Y	PY	Y	Y	Y	PY	Y	Y	Y	Y	Y	Y	NA	Y	HIGH
Pega 2022	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	Y	HIGH
Pfefferbaum 2019	Y	N	N	N	N	N	PY	PY	Y	N	Y	Y	N	Y	Y	Y	CRITICALLY LOW
Pollok 2018	Y	Y	N	PY	Y	Y	PY	PY	Y	N	NA	NA	Y	Y	NA	N	MODERATE
Puig-Barrachina 2020	N	N	N	N	Y	Y	N	PY	N	N	NA	NA	N	N	NA	Y	CRITICALLY LOW
Purgato 2018a	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	HIGH
Purgato 2018b	Y	Y	Y	PY	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	HIGH
Ridley 2020	Y	N	Y	N	N	N	N	PY	N	N	N	N	N	N	Y	Y	CRITICALLY LOW
Rivas 2015	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NA	Y	HIGH
Ronzi 2018	Y	Y	Y	PY	Y	Y	PY	Y	Y	N	NA	NA	Y	Y	NA	Y	HIGH
Ruotsalainen 2014	Y	Y	Y	PY	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	HIGH
Schindler 2015	Y	PY	Y	N	N	Y	N	PY	N	N	N	Y	N	N	Y	Y	CRITICALLY LOW
Siette 2017	Y	PY	Y	PY	Y	Y	Y	PY	Y	N	Y	N	Y	Y	N	Y	LOW
Singla 2020	Y	Y	Y	PY	N	Y	PY	N	Y	N	Y	Y	Y	Y	Y	Y	MODERATE
Spencer 2021	N	N	Y	N	N	N	PY	PY	N	N	N	N	N	N	Y	Y	CRITICALLY LOW
Stefan 2022	Y	N	N	PY	Y	N	PY	PY	Y	N	NA	NA	N	Y	NA	Y	CRITICALLY LOW

First Author Name & Year	AMSTAR-2 Items																Overall confidence
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Stephens-Lewis 2021	Y	Y	N	PY	Y	Y	PY	Y	Y	N	Y	Y	Y	Y	N	Y	LOW
Suijkerbuijk 2017	Y	Y	N	PY	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	HIGH
Suto 2022	Y	PY	Y	PY	Y	Y	Y	Y	Y	N	NA	NA	Y	Y	NA	Y	HIGH
Sweet 2004	Y	N	N	N	N	Y	N	N	N	N	Y	N	N	Y	Y	N	CRITICALLY LOW
Taylor 2017	N	N	N	PY	N	Y	N	N	N	N	Y	N	N	Y	Y	N	CRTITICALLY LOW
Thomson 2013	Y	Y	Y	Y	Y	Y	Y	PY	Y	N	NA	NA	Y	Y	NA	Y	HIGH
van de Sande 2019	Y	PY	N	PY	Y	Y	N	PY	Y	N	Y	Y	Y	Y	N	Y	CRITICALLY LOW
Van Parys 2014	Y	N	Y	PY	Y	Y	PY	Y	Y	N	NA	NA	Y	N	NA	Y	LOW
van Rijn 2016	Y	N	N	N	Y	N	PY	PY	Y	N	Y	N	N	N	Y	Y	CRITICALLY LOW
Waid 2022	Y	Y	N	PY	Y	N	PY	N	Y	N	NA	NA	Y	N	NA	Y	LOW
Walsh 2015	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	HIGH
Walton 2016	Y	N	N	N	N	N	N	PY	N	N	NA	NA	N	Y	NA	N	CRITICALLY LOW
Wollburg 2023	Y	Y	Y	PY	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	HIGH
Yakubovich 2022	Y	Y	Y	Y	Y	Y	PY	Y	Y	N	NA	NA	Y	Y	NA	Y	HIGH
Yang 2019	Y	N	N	PY	Y	Y	PY	PY	N	N	Y	Y	Y	Y	Y	Y	CRITICALLY LOW
Zaneva 2022	Y	Y	N	PY	Y	Y	Y	PY	Y	N	Y	Y	Y	Y	Y	Y	MODERATE
Zimmerman 2021	Y	Y	Y	Y	Y	Y	PY	Y	Y	N	Y	Y	Y	Y	Y	Y	HIGH

Notes. NA = Not Applicable; N = No; PY = Partial Yes; Y = Yes.