Appendix 2: Map of evidence and evidence based guidance for North Wales early intervention and prevention (Social Services & Wellbeing Act implementation)

Purpose: The purpose of the map is to assist with the population needs assessment required under the Social Services and Wellbeing (Wales) Act 2014. It is an update of the map of evidence and evidence based guidance, originally produced in 2016. The map will support the development of a framework of core functions that contribute toward preventing or delaying the need for managed care. Whilst the map has been produced in response to a request from the Betsi Cadwaladr University Health Board (BCUHB) Public Health Team, it may also be of interest to other local public health teams across Wales.

Method: This map (the sources) was developed using literature searches to identify high level sources such as published systematic reviews or evidence syntheses/statements/guidelines from recognised (for example, expert body) sources providing an evidence base for the identified interventions. Where there were no recent systematic reviews, primary studies have been included. Some voluntary sector publications and conference reports which are particularly relevant to the intervention and/or applicable to Wales have been included. It should be noted that these reports reflect the opinion of the authors and have not been subject to peer review. This map is an update of an initial search conducted in 2016.

Note on Interpretation/use of sources: Most sources will have considered the effectiveness of the identified intervention. However, each source should be consulted for details of the population and the specific outcomes that have been considered. Evidence maps are useful for providing structured access to evidence, particularly where there are a large number of robust secondary sources on a particular topic. The sources included in this map have not been selected on the basis of an evidence review following systematic review principles and an explicit methodology, set out *a priori* in a protocol, which is transparent, repeatable and which aims to minimise bias. This means that these sources

should not be considered to provide an objective, reliable synthesis of the totality of the available evidence base. No critical appraisal of the included sources has been conducted; systematic reviews or evidence reviews following systematic review principles would normally include critical appraisal of their primary sources but the reliability of any other sources remains unchecked. Primary, as well as secondary sources, have been included. Limitations, both within the studies and of the study designs themselves, have been noted where applicable.

Acknowledgement The map is an update of a map of evidence and evidence based guidance produced in 2016. Any additional interventions included in this evidence map (2021) have been identified in consultation with the North Wales PNA / MSR Steering group members. The role of the Steering Group, Alwen Salisbury, Siwan Jones and Professor Robert Atenstaedt from the BCUHB Public Health Team is acknowledged in the production of this map.

Intervention	Source	Brief summary of source
Advocacy	Petri, G. et al. (2020). *Redefining Self-Advocacy: A Practice Theory-Based Approach*. Journal of Policy and Practice in Intellectual Disabilities. Volume 17, Issue 3. DOI: 10.1111/jppi.12343. Available here	This study explores "practice theory" through the analysis of interviews with advocates and self-advocates within the autism and intellectual disability advocacy movements. This is a qualitative, empirical study based on interviews and focus groups with 43 participants in two countries (UK and Hungary). The data was collected in 2016–17. Content analysis was used to identify themes. Data indicate that everyday practices of self-advocates and advocates such as parent advocates and professional advocates largely overlap. There are five major types of practices that are done by nearly all advocates: "informing and being informed," "using media," "supporting each other," "speaking up," and "bureaucratic duties." Contrary to several previous studies on self-advocacy that emphasized "speaking up" as the main activity in advocacy, **this study found that most practices of advocates and self-advocates are "para-advocacy"**

Intervention	Source	Brief summary of source
		practices that may or may not lead directly to "speaking up." Practices of self-advocates are often embedded in other everyday activities people do. It should be noted that this is a qualitative study, a design which explores believes, experiences and attitudes and can be useful for generating hypotheses, rather than assessing the effectiveness of interventions.
	National Institute for Health and Care Excellence. (In development. Expected publication date: 26 July 2022). *Advocacy services for adults with health and social care needs*. **In development** [GID-NG10156]. London: NICE. **Expected publication date: 26 July 2022**	**Expected publication date: 26 July 2022**
Affordable / social housing	Chambers D et al. (2018). *Housing for vulnerable people. Systematic review of the evidence for 'housing vulnerable' adults and its relationship to wellbeing*. London. What Works Centre for Wellbeing. **Available here**	This systematic review aims to address a lack of review-level evidence around the impact of housing interventions on wellbeing of people who are vulnerable to discrimination or exclusion in relation to housing. Key findings: Housing First provides immediate access to housing without preconditions with support by either mobile teams or on-site services. Housing First has been

Intervention	Source	Brief summary of source
		evaluated in the UK, in a large Canadian randomised trial (AH/CS), in the USA and other settings. **Based on the authors' findings, there is strong evidence that Housing First can improve housing stability and measures of physical health in the short term.** Evidence was classed as moderate for positive effects on personal wellbeing, mental health and locality-related wellbeing ('where we live') and for absence of effect on personal finance and community wellbeing. Strength of evidence for other outcomes was rated as low or very low. Research identified a range of factors that can affect the effectiveness of Housing First, including fidelity to core components and whether the service is delivered in one place or service users are dispersed in separate apartments.
	Joseph Rowntree Foundation. (2021). *We can't allow renters to be locked out of our post-pandemic recovery.* York: JRF. Available here.	This briefing from the Joseph Rowntree Foundation discusses the continuing difficulties for renters and low-income households post-pandemic. Their research shows that 1.7 million renting households are worried about paying their rent, and almost 1 million renting households are worried about being evicted post-pandemic. Black, Asian and minority ethnic (BAME) renters, renters with children, lower-income renters, and renters who have lost income during the pandemic, are disproportionately struggling. Key recommendations of the report include:

Intervention	Source	Brief summary of source
		• **Immediately provide support for renters in arrears in England by increasing the funding for Discretionary Housing Payments, and amending how they are administered.** • Protect people from harm: re-align Local Housing Allowance rates with local rents and don't remove the £20 a week Universal Credit, (ended October 2021). The Government must also ensure people who are still receiving 'legacy' benefits, many of whom are disabled or carers, are no longer excluded from this vital improvement to support. • Build more homes for social rent. It should be noted that this is a commissioned charity report. It has not been subject to peer review and possible bias has not been taken into account.
	Smith, B. (2019). *Delivering Affordable Housing in Wales in Challenging Times.* Welsh Policy and Politics in Unprecedented Times. Wales Centre for Public Policy/WISERD Conference. 24th May 2019: Swansea. Available here.	This conference presentation was delivered by Bob Smith, Honorary Senior Research Fellow, School of Geography and Planning, Cardiff University. It was delivered at the Wales Centre for Public Policy/WISERD Conference in May 2019. The presentation highlights key issues for housing affordability in Wales. These include: problems of widening house price/earnings ratio; variable demand in differing areas; long-term shifts in housing tenure; rising rents and other issues. The presentation discusses some Welsh policy responses, such as the Welsh Housing Bond and Help-to-Buy scheme.

Intervention	Source	Brief summary of source
		The presentation includes **key recommendations** of an independent review of affordable housing supply. These include: • **Implementing a five year social sector rent policy (2020-21 onwards)** • **Better understanding of housing needs (at different spatial scales)** • **Consolidation/simplification of standards for all new build affordable homes.** It should be noted that this is a conference speech, which might be considered expert opinion, as opposed to a systematic review testing interventions, which would undergo evidence grading.
Ageing well support & social groups **(Includes evidence on Dementia)**	National Institute for Health and Care Excellence. (2015). *Older people independence and mental wellbeing.* NG32. London: NICE. **Available here** **The guidance is up to date (checked 2018).**	This NICE guidance is for local authorities working in partnership with organisations in the public, private, voluntary, community sectors and for the NHS and other service providers with a remit for older people. It covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older and how to identify those most at risk of a decline. **The guidance includes recommendations on principles of good practice; group based activities; one to one activities; volunteering and identifying people most at risk of decline.**

Intervention	Source	Brief summary of source
	National Institute for Health and Care Excellence. (2015). *Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset.* NG16. London: NICE. Available here. **The guidance is up to date.**	This NICE guideline is for commissioners, managers and practitioners with public health as part of their remit, working in the public, private and third sector and the public. The guideline covers mid-life approaches to delay or prevent the onset of dementia, disability and frailty in later life. Its' recommendations aim to increase the amount of time that people can be independent, healthy and active in later life. The **key recommendations** on promoting a healthy lifestyle to reduce the risk of or delay the onset of disability, dementia and frailty by helping people are: • **•stop smoking** • **•be more active** • **•reduce alcohol consumption** • **•improve diet** • **•lose weight and maintain a healthy weight if necessary.**
	National Institute for Health and Care Excellence. (2018). *Dementia: assessment, management and support for people living with dementia and their*	This guideline covers diagnosing and managing dementia (including Alzheimer's disease). It aims to improve care by making recommendations on training staff and helping carers to support people living with dementia. **Interventions to promote cognition, independence and wellbeing:**

Intervention	Source	Brief summary of source
	carers. NG97. London: NICE. Available here **The guidance is up to date.**	• Offer a range of activities to promote wellbeing that are tailored to the person's preferences. • Offer group cognitive stimulation therapy to people living with mild to moderate dementia. • Consider group reminiscence therapy for people living with mild to moderate dementia. • Consider cognitive rehabilitation or occupational therapy to support functional ability in people living with mild to moderate dementia. • Do not offer acupuncture to treat dementia. • Do not offer ginseng, vitamin E supplements, or herbal formulations to treat dementia. • Do not offer cognitive training to treat mild to moderate Alzheimer's disease. • Do not offer interpersonal therapy to treat the cognitive symptoms of mild to moderate Alzheimer's disease. • Do not offer non-invasive brain stimulation (including transcranial magnetic stimulation) to treat mild to moderate Alzheimer's disease, except as part of a randomised controlled trial.
	The Lancet Commissions. (2020*). Dementia prevention, intervention, and care: 2020 report of the Lancet*	This is a 2020 report from The Lancet journal detailing current evidence and information about prevention, intervention, and care of dementia. **Some key messages:**

Intervention	Source	Brief summary of source
	Commission. Volume 396, Issue 10248, P413-446. Available here	• The Lancet add three further risk factors for dementia. They are: excessive alcohol consumption, traumatic brain injury, and air pollution. • 12 modifiable risk factors account for around 40% of worldwide dementias, which consequently could theoretically be prevented or delayed. • Aim to maintain systolic BP of 130 mm Hg or less in midlife from around age 40 years (antihypertensive treatment for hypertension is the only known effective preventive medication for dementia). • Encourage use of hearing aids for hearing loss and reduce hearing loss by protection of ears from excessive noise exposure. • Reduce exposure to air pollution and second-hand tobacco smoke. • Prevent head injury. • Limit alcohol use, as alcohol misuse and drinking more than 21 units weekly increase the risk of dementia. • Avoid smoking uptake and support smoking cessation to stop smoking, as this reduces the risk of dementia even in later life. For those with dementia, recommendations are: • Provide holistic post-diagnostic care • Post-diagnostic care for people with dementia should address physical and mental health, social care, and support. Most people with dementia have other illnesses and might struggle to look after their health and this might result in potentially preventable hospitalisations.

Intervention	Source	Brief summary of source
		• Manage neuropsychiatric symptoms It should be noted that this report is based on varied study designs, including systematic reviews, rather than a systematic review itself. Note should be taken as to the limitations discussed in the report, such as using global figures for dementia risk.
	Canadian Agency for Drugs and Technologies in Health. (2018). *Sensory Rooms for Patients with Dementia in Long-Term Care: Clinical and Cost-Effectiveness, and Guidelines*. Ottawa: CADTH; 2018 Jul. (CADTH rapid response report: summary with critical appraisal). Available here	This report reviews the clinical effectiveness and cost-effectiveness of sensory rooms for patients with dementia in long-term care. **Key findings:** • **Based on the evidence identified in this review, it is not possible to make a definitive conclusion regarding the effectiveness of sensory rooms compared to other treatment modalities for improving symptoms in individuals with dementia.** Generally in the short term, there appeared to be some improvements with therapy using multisensory stimulation environment such as Snoezelen, however the improvements were not significantly different compared with other treatment modalities. • No study assessing the cost-effectiveness of sensory rooms for patients with dementia in long-term care was identified. • Two evidence-based guidelines recommended several non-pharmacological interventions for individuals with dementia, including multisensory stimulation environments.

Intervention	Source	Brief summary of source
		There are several limitations to this review, notably overlap between studies and that the majority of the studies were on older adults (age ≥ 80 years), hence the generalisability of the findings to other age groups may not be appropriate.
	Livingston, G. et al. *A systematic review of the effectiveness and cost-effectiveness of sensory, psychological and behavioural interventions for managing agitation in older adults with dementia*. Health Technology Assessment 2014;18(39). Available here	This review synthesised the evidence for clinical effectiveness and cost-effectiveness of non-pharmacological interventions for reducing agitation in dementia. **Author's conclusions:** **Person-centred care, communication skills and DCM (all with supervision), sensory therapy** activities**, and structured music therapies reduce agitation in care-home dementia residents.** Future interventions should change care home culture through staff training and permanently implement evidence-based treatments and evaluate health economics. There is a need for further work on interventions for agitation in people with dementia living in their own homes. The main limitation of this review was the study size of some included studies: there were only 33 reasonably sized (> 45 participants) randomised controlled trials, and lack of evidence means that the authors cannot comment on many interventions' effectiveness. There were no hospital studies and few studies in people's homes.

Intervention	Source	Brief summary of source
	Lai NM, et al. *Animal-assisted therapy for dementia*. Cochrane Database of Systematic Reviews 2019, Issue 11. Art. No.: CD013243. DOI: 10.1002/14651858.CD013243.pub2. Available here	This review aimed to evaluate the efficacy and safety of animal-assisted therapy for people with dementia. **Authors' conclusions** **The authors found low-certainty evidence that AAT (animal-assisted therapy) may slightly reduce depressive symptoms in people with dementia.** They found no clear evidence that AAT affects other outcomes in this population, with the certainty in the evidence ranging from very-low to moderate depending on the outcome. The authors found no evidence on safety or effects on the animals. Therefore, clear conclusions cannot yet be drawn about the overall benefits and risks of AAT in people with dementia. Further well-conducted RCTs are needed to improve the certainty of the evidence.
	Fernandez, et al. *Effect of doll therapy in managing challenging behaviors in people with dementia: a systematic review*. JBI Database of Systematic Reviews and Implementation Reports: August 2014 - Volume 12 - Issue 8 - p 330-363 doi: 10.11124/jbisrir-2014-1646. Available here	This review evaluated the effects of doll therapy on challenging behaviours (including agitation and verbal or physical aggression) in people with dementia. **Results** Six studies were included in the review. Of the three studies that investigated the impact of doll therapy on agitation and aggressive behaviors among people with dementia, two reported an improvement in agitation and aggressive behaviors and one reported no statistically significant decrease (p=0.07) in aggressive behaviors among residents who used the dolls. In the only study that investigated positive behaviors, statistically significant improvements (p< 0.005)

Intervention	Source	Brief summary of source
		in positive behaviors from baseline (6.32 ± 4.13) to the three months follow-up (14.21 ± 9.86) were observed among residents who used the dolls. In addition, an increase in levels of positive activity among residents who used the dolls was reported in two other studies. **Authors' conclusions** **There is limited evidence to support the use of doll therapy for management of agitation and aggressive behaviors among people with dementia.** This treatment modality however has no side effects and provides a safe comfort measure for people with dementia.
	Noone, C, et al. (2020). *Video calls for reducing social isolation and loneliness in older people: a rapid review*. Cochrane Database of Systematic Reviews. Issue 5. Art. No.: CD013632. DOI: 10.1002/14651858.CD013632. Available here	This rapid review assesses the effectiveness of video calls for reducing social isolation and loneliness in older adults. The participants in the review had an average age of 65 years. The authors of this review included any intervention in which a core component involved the use of the internet to facilitate video calls or video conferencing through computers, smartphones or tablets with the intention of reducing loneliness or social isolation, or both, in older adults. Based on the findings of this review **there is currently very uncertain evidence on the effectiveness of video call interventions to reduce loneliness in older adults.** The evidence regarding the effectiveness of video calls for outcomes of symptoms of depression was very uncertain.

Intervention	Source	Brief summary of source
	Age UK (2018) *All the Lonely People: Loneliness in Later Life*. London: Age UK. Available here	This report from Age UK focusses on further understanding loneliness among people aged 50 and over. It includes sources from the Office for National Statistics and the English Longitudinal Study of Ageing. **Key points of the report include:** • Social activities are an essential component of successful approaches to tackling loneliness, but for many lonely people such activities are only effective when complemented by emotional and practical support to access them. Many neighbourhoods have a variety of social activities that people are either unaware of or unable to access, and that compete rather complement each other. • Neighbourhoods that are welcoming, attractive, feel safe and have amenities for all residents can help prevent people from becoming lonely. • Measuring loneliness requires using both a single-item direct loneliness question and an indirect scale; using only a direct question or an indirect scale will underestimate the prevalence of loneliness. It should be noted that this is a commissioned charity report. It has not been subject to peer review or considered the strength of evidence, and possible bias has not been taken into account.
Asset Based Community	National Institute for Health and Care Excellence. (2016). *Community*	This guideline covers community engagement approaches to reduce health inequalities, ensure health and wellbeing initiatives are effective and help local

Intervention	Source	Brief summary of source
Development / Community Involvement including training & facilitation	*engagement: improving health and wellbeing and reducing inequalities*. NG44. London: NICE. **Available here** **This guidance is up to date.**	authorities and health bodies meet their statutory obligations. This guidance is intended for those who plan, commission, scrutinise or provide local health and wellbeing initiatives in collaboration with local communities. **This guideline makes recommendations on:** • Overarching principles of good practice – what makes engagement more effective? • Developing collaborations and partnerships, approaches to encourage and support alliances between community members and statutory, community and voluntary organisations to meet local needs and priorities • Involving people in peer and lay roles – how to identify and recruit people to represent local needs and priorities • Making community engagement an integral part of health and wellbeing initiatives • Making it as easy as possible for people to get involved.
	Brunton G et al. (2015). Review 2: *Community engagement for health via coalitions, collaborations and partnerships. A systematic review and meta-analysis.* London: EPPI-Centre. **Available here**	This systematic review and meta-analysis undertaken to support the development of NICE guideline 44 looked at **coalitions, collaborations and partnerships**. It addressed the following questions • How effective are community engagement approaches at improving health and wellbeing and reducing health inequalities?

Intervention	Source	Brief summary of source
		• Across disadvantaged groups, how effective are community engagement approaches at encouraging people to participate in activities to improve their health and wellbeing and realise their capabilities? • What processes and methods facilitate the realisation of community and individual capabilities and assets amongst disadvantaged groups? • Are there unintended consequences from adopting community engagement approaches? • What processes identified in the literature are more aligned with effective interventions and which (if any) are more aligned with non-effective interventions? **The review authors concluded that taken together, the findings suggest that community-led or community collaboration projects which design, deliver and evaluate health interventions are associated with larger behavioural outcomes.** Where coalitions, collaborations and partnerships with community members include the use of bidirectional communication, collective decision making and community member or professional training support for intervention provision, a higher extent of community engagement across the project's design, delivery and evaluation was also found. Effective configurations of engagement within collaborations and coalitions generally include peer or lay delivery, and projects with a low extent of engagement were likely to be less effective.

Intervention	Source	Brief summary of source
	Harrison, R et al. (2019). *Asset-Based Community Development: Narratives, Practice, and Conditions of Possibility—A Qualitative Study With Community Practitioners*. SAGE Open. Volume: 9 issue: 1, DOI:/10.1177/2158244018823081. Available here	This primary research- a qualitative study from researchers at four UK universities- sought to better understand the mechanisms through which Asset-Based Community Develpoment (ABCD) operates, and the environmental and relational conditions within which it is likely to be most effective, to increase its effectiveness at improving health and well-being and reducing inequalities. Interviews and focus groups were conducted with 25 people working in third sector and voluntary organizations to begin to improve understanding about ABCD approaches, how they are implemented, and how they are meeting the needs of disadvantaged populations. These individuals had local area knowledge of programs that follow an ABCD approach and which are currently running in the North West of England. **Four overarching themes gave insight into the principles and practices of ABCD**: **Relationships and trust as mechanisms for change, Reciprocity and connectivity: "people not services," Accountability and reducing dependency, and a socially sustainable model.** ABCD is likely to be most effective in supporting vulnerable people where building trust is mirrored by an institutional and relational environment that is trustworthy and facilitative of developing people's capabilities.

Intervention	Source	Brief summary of source
		It should be noted that this study is of qualitative design, a design which explores believes, experiences and attitudes and can be useful for generating hypotheses, rather than assessing the effectiveness of interventions.
Befriending to support access to specialist support / peer groups	National Institute for Health and Care Excellence. (2015). *Older people independence and mental wellbeing*. NG32. London: NICE. **Available here** **This guidance is up to date (checked 2018).**	This NICE guideline recommends befriending as an activity that may help older people maintain their independence and contribute to improving their mental wellbeing.
	National Institute for Health and Care Excellence. (2011). *Common mental health problems: identification and pathways to care.* CG123. London: NICE. **Available here** **This guidance is up to date (checked 2018).**	This NICE guideline is for adults with common mental health disorders. It recommends befriending as an intervention for people with a range of common mental health problems.
	Scottish Intercollegiate Guidelines Network. (2010). *Management of patients with stroke: Rehabilitation, prevention and management of complications, and*	This SIGN guideline recommends the use of community befriending services as source of community support for people who have had a stroke.

Intervention	Source	Brief summary of source
	discharge planning. A national clinical guideline. 118. Edinburgh: SIGN. **Available here** **This guidance is up to date.**	
	National Institute for Health and Care Excellence. (2009). *Depression in adults, recognition and management.* CG90. London: NICE. **Available here** **This guidance is up to date (checked 2021).**	This NICE guideline recommends befriending, by trained volunteers, as an adjunct to pharmacological or psychological treatments for people with longstanding moderate to severe depression. Weekly contact for between two and six months is recommended.
	National Institute for Health and Care Excellence. (2012). *Spasticity in under 19s: management*. CG145. London: NICE. **Available here** **This guidance is up to date (checked 2018).**	This NICE guideline offers best practice advice on the management of spasticity and co-existing motor disorders and their early musculoskeletal complications in children and young people with non-progressive brain disorders. It recommends befriending as an approach to support the child, young person or their parents or carer.

Intervention	Source	Brief summary of source
	Newbigging, K et al. (2020). *The contribution of the voluntary sector to mental health crisis care: a mixed-methods study*. Health Service Delivery Research; 8(29). Available here	This primary research, conducted mainly by researchers from The University of Birmingham, aimed to investigate the contribution of Voluntary Sector (VS)_ organisations to mental health crisis care in England. The VS has been conceptualised as a third 'terrain' of organisations between the state and market, comprising charities and community groups, underpinned by a sector ethos that typically values accessibility, self-organisation, service-user-defined outcomes, informality and relational-based approaches. Across this diverse range of organisations, there is a wide range of approaches and activities, including befriending. A mental health crisis is considered a biographical disruption. Voluntary sector organisations can make an important contribution, characterised by a socially oriented and relational approach. **Five types of relevant voluntary sector organisations were identified: (1) crisis-specific, (2) general mental health, (3) population-focused, (4) life-event-focused and (5) general social and community voluntary sector organisations. These voluntary sector organisations provide a range of support and have specific expertise. The availability and access to voluntary sector organisations varies and inequalities were evident for rural communities; black, Asian and minority ethnic communities.**

Intervention	Source	Brief summary of source
		A limitation of this study was that the survey response was low, reflecting the nature of voluntary sector organisations and demands on their time. It should be noted that this is a descriptive study, so evaluating outcomes from voluntary sector organisation support was beyond the scope of the study.
	Burroughs, H et al. (2019). *Non-traditional support workers delivering a brief psychosocial intervention for older people with anxiety and depression*: the NOTEPAD feasibility study. Health Service Delivery Research 2019; 7(25). Available here	This feasibility study was designed to determine whether or not support workers (SWs) can be trained to deliver a community-based psychosocial intervention to older people with anxiety and/or depression. Results: Recruitment (and retention) of the SWs was possible; the training, support materials and manual were acceptable to them, and they delivered the intervention as intended. Recruitment of practices from which to recruit patients was possible, but the recruitment target (100 patients) was not achieved, with 38 older adults randomised. Retention at 4 months was 86%. The study was not powered to demonstrate differences in outcomes. Older people in the intervention arm found the sessions with SWs acceptable, although signposting to, and attending, groups was not valued by all participants. GPs recognised the need for additional care for older people with anxiety and depression, which they could not provide. Participation in the study did not have an impact on routine care, other than responding to the calls from

Intervention	Source	Brief summary of source
		the study team about risk of self-harm. GPs were not aware of the work done by SWs with patients. **Conclusions:** **Support workers recruited from Age UK employees can be recruited and trained to deliver an intervention, based on the principles of behavioural activation (BA), to older people with anxiety and/or depression. The training and supervision model used in the study was acceptable to SWs, and the intervention was acceptable to older people.** It should be noted that is is a feasibility study, designed to assess of the practicality of a proposed plan or method. A key limitation is that target recruitment was not achieved. The authors note that further development of recruitment strategies is needed before this intervention can be tested in a fully powered randomised controlled trial.
	Jopling, K and Jones, D. (2021). *Lessons from befriending in the time of Covid-19*. The Mercer's Company and Independent Age. Available here	This report was commissioned jointly by The Mercer's Company and Independent Age, two charities. **The report recommends that organisations involved in befriending should:** • • Carefully plan and manage their transition to a blended model • • Put appropriate mental health support in place for volunteers and staff

Intervention	Source	Brief summary of source
		• Build on their inclusion efforts and lessons from this period Organisations which fund befriending should: • Resource sufficient levels of staffing and support for volunteers • Recognise that organisations will be 'double running' for an extended period, and fund this transition process accordingly • Support the organisations they fund to address common challenges such as transition, mental health and inclusion. It should be noted that this is a commissioned charity report. Methods used to produce it include interviews, online events and a survey Its methods are not transparent or reproducible. It has not been subject to peer review and possible bias has not been taken into account.
Breastfeeding peer support	McFadden, A et al. (2017). *Support for healthy breastfeeding mothers with healthy term babies*. Cochrane Database of Systematic Reviews. Issue 2. Art. No: CD001141. DOI: 10.1002/14651858.CD001141.pub5. Available here	This systematic review describes forms of breastfeeding support which have been evaluated in controlled studies, the timing of the interventions and the settings in which they have been used and to examine the effectiveness of different modes of offering similar supportive interventions. Results of the analyses continue to confirm that all forms of extra support analysed together showed a decrease in cessation of 'any breastfeeding', which includes partial and exclusive breastfeeding (moderate-quality evidence) and for stopping breastfeeding before four to six weeks (moderate-quality evidence).

Intervention	Source	Brief summary of source
		Authors' conclusions: When breastfeeding support is offered to women, the duration and exclusivity of breastfeeding is increased. **Characteristics of effective support include: that it is offered as standard by trained personnel during antenatal or postnatal care, that it includes ongoing scheduled visits so that women can predict when support will be available, and that it is tailored to the setting and the needs of the population group.** **Support is likely to be more effective in settings with high initiation rates.** Support may be offered either by professional or lay/peer supporters, or a combination of both. Strategies that rely mainly on face-to-face support are more likely to succeed with women practising exclusive breastfeeding.
Carers support (respite)	National Institute for Health and Care Excellence. (2020). *Supporting adult carers*. NG150. London: NICE. Available here **This guidance is up to date.**	This guideline covers support for adults (aged 18 and over) who provide unpaid care for anyone aged 16 or over with health or social care needs. **Key recommendations/ overarching principles include:** • The right to information and support • Carers should be actively identified to receive information about their rights.

Intervention	Source	Brief summary of source
		• Carer's assessments should be carried out by local authorities and social care organisations. • Help carers stay in, enter or return to work, education and training • Local authorities should ensure carers are kept regularly informed about available community services and other sources of support and advice and how to access them • Training should be provided to enable carers to provide care safely • Consider providing carers with psychosocial and psychoeducational support • Provide support during changes to the caring role • Provide support for carers during end of life care and after the person dies
	Liu Z, Sun YY, Zhong BL. (2018). *Mindfulness-based stress reduction for family carers of people with dementia.* Cochrane Database of Systematic Reviews. Issue 8. Art. No.: CD012791. DOI: 10.1002/14651858.CD012791.pub2. Available here	This systematic review aimed to assess the effectiveness of Mindfulness-based stress reduction (MBSR) in reducing the stress of family carers of people with dementia. Mindfulness-based stress reduction programmes were compared with either active controls (those matched for time and attention with MBSR, i.e. education, social support, or progressive muscle relaxation), or inactive controls (those not matched for time and attention with MBSR, i.e. self-help education or respite care). Compared with active controls, MBSR may reduce depressive symptoms of carers at the end of the intervention (low-quality evidence). Compared with

Intervention	Source	Brief summary of source
		inactive controls, MBSR showed no clear evidence of any effect on depressive symptoms (low-quality evidence). **In conclusion, low-quality evidence suggests that MBSR may reduce carers' depressive symptoms and anxiety, at least in the short term.**
Childcare (breakfast clubs)	Christensen, CB et al. (2019). *The effect of introducing a free breakfast club on eating habits among students at vocational schools*. BMC Public Health. Volume 19, Article number: 369. Available here	The objective of this cluster randomised controlled study was to assess the effect of a free breakfast club intervention on dietary habits among students at vocational schools. The study included students (n = 318) from four vocational schools in Denmark. Food frequency questionnaires were used to measure eating habits at baseline, first, and second follow-up, after 7 and 14 weeks respectively, in a clustered randomized controlled intervention of four months. **The authors concluded that provision of free breakfast at vocational schools can improve the dietary quality of breakfast and decrease breakfast skipping. However, the sustainability of the intervention is a critical issue that needs to be further studied and addressed.** Limitations: Due to time and financial constraints, the questionnaire was not validated, an omission that carries the risk of the questionnaire not measuring what was intended.

Intervention	Source	Brief summary of source
		Danish vocational and educational programmes are in general gender segregated. The gender segregation is illustrated in this study, in which the majority of participants were male (95.6%). Because the sample does not resemble the general population or other types of educational programmes (e.g., health care and pedagogy), this is a study limitation that limits its external validity.
	Franklin, J et al. (2021). *The economic cost-effectiveness of the Magic Breakfast model of school breakfast provision*. London: Pro Bono Economics. Available here	Magic Breakfast is a registered charity delivering healthy breakfasts, targeted at schools with a high proportion of disadvantaged children, and providing support to their schools. Pro Bono Economics aims to support charities by help them measure, understand and better articulate their impact, influence and inform policy and make best use of their data. This study looks at longer-term economic benefits, and what these academic impacts mean for reduced costs incurred for special educational needs, truancy and exclusions as well as improvements in earnings from employment up to the age of 60. **The study finds that providing disadvantaged pupils completing Key Stage 1 in England/Primary 3 in Scotland with one year's supply of school breakfast provision could generate long-term economic benefits in excess of £9,000 per child.**

Intervention	Source	Brief summary of source
		A limitation of this study is that its assessment is based on an evaluation of the impact of the programme over a single year, specifically for those children completing Key Stage 1 of primary school. As such, the analysis may not provide an accurate assessment of the cost-effectiveness of the programme over multiple years or for children in different age groups. It should be noted that this is a commissioned charity report, which is not peer reviewed and does not take into account possible bias.
Childcare	Melhuish, E. (2016). *Longitudinal research and early years policy development in the UK*. ICEP 10, 3. https://doi.org/10.1186/s40723-016-0019-1. Available here	This article examines longitudinal data to consider how research evidence has contributed to early years policy change in the last two decades. Early childhood education and care (ECEC) in the UK is a mixed economy, in that it is partly financed and organised by the central and local government, partly by private individuals and organisations, and partly by voluntary organisations (e.g., community groups, charities). **Key findings include:** When children entered primary school, the EPPSE study (Sammons et al. 2002, 2003) found that: • **Two to three years of high-quality early years education can provide up to 8 months of developmental advantage in literacy-related outcomes**

Intervention	Source	Brief summary of source
		compared to children who enter school with no pre-school experience, with similar effects on other cognitive and social outcomes. • While high-quality ECEC experience provided a boost, the greatest predictor of success was the home learning environment (HLE), i.e., the learning opportunities provided at home had the largest effect on child outcomes. • The quality of ECEC is correlated with staff qualifications, and higher quality was related to better outcomes for children. It should be noted that this is an observational study, rather than a randomised controlled trial. It does not seek to uncover cause and effect relationships but rather find correlations and possible links between data and outcomes. This study has a single author; it has not considered limitations to the study or possible bias.
	Er, V. (2018). *Association of diet in nurseries and physical activity with zBMI in 2-4-year olds in England: a cross-sectional study.* BMC public health18.1: 1262. Available here	The study aimed to examine the relationships of diet in childcare settings and daily physical activity (PA) of preschoolers with body mass index z-score (z-BMI). It looked at 150 children aged 2-4-years participating in the Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) UK study to examine the associations of their diet in childcare settings and daily PA with z-BMI.

Intervention	Source	Brief summary of source
		Key results: Among children who consumed one main meal or snack at childcare, 34.4% and 74.3% met the standards on fruits and vegetables and high sugar or fat snacks, respectively. Adherence to Children's Food Trust (CFT) guidelines was not associated with zBMI. Only 11.4% of children met recommended UK guidelines of three hours per day of physical activity. **The authors concluded that the low proportion of children meeting the standards on fruits and vegetables and high sugar or fat snacks and recommended physical activity levels highlight the need for more work to support nurseries and parents to improve preschool children's diet and activity.** Limitations of study: Parents were asked to report their children's food intake using a home food diary but there was a low response rate and many filled in the diary on a different date from the nursery observation. Therefore, the authors were not able to estimate the daily dietary intake of children and compare their dietary intake by setting (nursery vs. home). Unlike dietary indices such as the Healthy Eating Index (HEI), Diet Quality Index (DQI) or the Mediterranean Diet Score (MDS), the NAP SACC UK Nutrition Best

Intervention	Source	Brief summary of source
		Practice Standard has not been validated and may not be suitable for examining the relationship between diet quality and zBMI. It should be noted that this is a cross-sectional study: associations between an outcome and factors identified through such studies may be thought of as potential correlations, however further research would be required to determine the nature of any relationship.
Education support (SALT)	Morgan, AT, Murray, E, Liégeois, FJ. (2018). *Interventions for childhood apraxia of speech*. Cochrane Database of Systematic Reviews. Issue 5. Art. No.: CD006278. DOI: 10.1002/14651858.CD006278.pub3. **Available here**	This systematic review aimed to assess the efficacy of interventions targeting speech and language in children and adolescents with Childhood Apraxia of Speech (CAS) as delivered by speech and language pathologists/therapists. This review includes only one randomised controlled trial (RCT). This study recruited 26 children aged 4 to 12 years, with mild to moderate CAS of unknown cause, and compared two interventions: the Nuffield Dyspraxia Programme-3 (NDP-3); and the Rapid Syllable Transitions Treatment (ReST). Both the NDP-3 and ReST therapies demonstrated improvement at one month post-treatment. For three outcomes the effect was marginally greater for NDP-3 than ReST: accuracy of production on treated words; speech production consistency, and accuracy of connected speech. **The authors concluded that there is limited evidence that, when delivered intensively, both NDP-3 and ReST may effect improvement in word accuracy in 4- to 12-year-old children with CAS, measured by the accuracy**

Intervention	Source	Brief summary of source
		of production on treated and non-treated words, speech production consistency and the accuracy of connected speech. The authors judged all core outcome domains to be low risk of bias. They downgraded the quality of the evidence by one level to moderate due to imprecision, given that only one RCT was identified.
	Brignell, A et al. (2018). *Communication interventions for autism spectrum disorder in minimally verbal children.* Cochrane Database of Systematic Reviews. Issue 11. Art. No.: CD012324. DOI: 10.1002/14651858.CD012324.pub2. **Available here.**	This systematic review sought to assess the effects of communication interventions for ASD in minimally verbal children. This review includes two RCTs (154 children aged 32 months to 11 years) of communication interventions for Autism Spectrum Disorder (ASD) in minimally verbal children compared with a control group (treatment as usual). **The authors conclude that there is limited evidence that verbally based and Augmentative Communication (ACC) interventions improve spoken and non-verbal communication in minimally verbal children with ASD.** A substantial number of studies have investigated communication interventions for minimally verbal children with ASD, yet only two studies met inclusion criteria for this review, and the authors considered the overall quality of the evidence to be very low.
	Pennington, L et al. (2016). *Speech therapy for children with dysarthria acquired before three years of age*.	This systematic assessed whether any speech and language therapy intervention aimed at improving the speech of children with dysarthria is more effective in increasing children's speech intelligibility or communicative

Intervention	Source	Brief summary of source
	Cochrane Database of Systematic Reviews. Issue 7. Art. No.: CD006937. DOI: 10.1002/14651858.CD006937.pub3. **Available here**	participation than no intervention at all , and to compare the efficacy of individual types of speech language therapy in improving the speech intelligibility or communicative participation of children with dysarthria. No randomised controlled trials or group studies were identified. **This review found no evidence from randomised trials of the effectiveness of speech and language therapy interventions to improve the speech of children with early acquired dysarthria.** Rigorous, fully powered randomised controlled trials are needed to investigate if the positive changes in children's speech observed in phase I and phase II studies are generalisable to the population of children with early acquired dysarthria served by speech and language therapy services.
Supported employment	Suijkerbuijk, YB et al. (2017). *Interventions for obtaining and maintaining employment in adults with severe mental illness, a network meta-analysis.* Cochrane Database of Systematic Reviews. Issue 9. Art. No.: CD011867. DOI: 10.1002/14651858.CD011867.pub2. **Available here**	This systematic review assesses the comparative effectiveness of various types of vocational rehabilitation interventions and to rank these interventions according to their effectiveness to facilitate competitive employment in adults with severe mental illness. **The authors concluded that supported employment and augmented supported employment were the most effective interventions for people with severe mental illness in terms of obtaining and maintaining employment, based on both the direct comparison analysis and the network meta-analysis, without increasing the risk of adverse events.**

Intervention	Source	Brief summary of source
		These results are based on moderate- to low-quality evidence, meaning that future studies with lower risk of bias could change these results. Augmented supported employment may be slightly more effective compared to supported employment alone. However, this difference was small, based on the direct comparison analysis, and further decreased with the network meta-analysis, meaning that this difference should be interpreted cautiously.
	Fong, C.J. et al. (2021). *Interventions for improving employment outcomes for persons with autism spectrum disorders: a systematic review update*. Campbell Systematic Reviews. Volume 17, Issue 3. DOI:10.1002/cl2.1185. **Available here**	The objective of this review is to determine the effectiveness of employment interventions in securing and maintaining employment for adults and transition-age youth with Autism Spectrum Disorder (ASD), updating two reviews by Westbrook et al. The systematic review update identified three studies that evaluated employment outcomes for interventions for individuals with ASD. All three studies identified in the review suggest that vocation-focused programs may have positive impacts on the employment outcomes for individuals with ASD. Wehman et al. indicated that participants in Project SEARCH had higher employment rates than control participants at both 9-month and 1-year follow-up time points. Adding autism spectrum disorder supports, Project SEARCH in Wehman et al.'s study also demonstrated higher employment rates for treatment participants than control participants at postgraduation, 3-month follow-up, and 12-month follow-up. Smith et al. found that virtual reality job interview training

Intervention	Source	Brief summary of source
		was able to increase the number of job offers treatment participants received compared to control participants. **The authors concluded that given that prior reviews did not identify interventions with actual employment outcomes, the more recent emergence of evaluations of such programs is encouraging.** This suggests that there is a growing body of evidence regarding interventions to enhance the employment outcomes for individuals with ASD but also greater need to conduct rigorous trials of vocation-based interventions for individuals with ASD that measure employment outcomes. The authors note that because of the few studies in the review, and the relatively small sample sizes, readers should not overly generalise the findings from the review.
Employment (NEET)	Price, S and Shaw, H. (2020). *What works to improve participation in good work?* Summary of systematic evidence mapping. Cardiff: Public Health Wales NHS Trust. **Available here**	This summary provides an overview of the direction of evidence answering the question "What works to improve participation in work in order to improve health and reduce health inequalities?" **The systematic mapping summary found that a number of interventions may help to get people into work. They include:** • Apprenticeships • Welfare to work programmes • Active labour market programmes

Intervention	Source	Brief summary of source
		• Exhaustion of unemployment benefits • Policies to increase access to finance e.g. loan subsidies or guarantees • Employment interventions for cancer survivors • Supported employment for those with severe mental illness • Access to grants, loans and subsidies to support innovation • Mental health interventions for those with mental health problems. A number of interventions may help to keep people in work. They include: • For people with musculoskeletal conditions, individually focused interventions to support return to work, and workplace focused interventions to reduce time to return to work • Employment interventions to help cancer survivors stay in work and multidisciplinary interventions to help people with cancer stay in or return to work • Problem solving therapies to reduce sickness absence in people with adjustment disorder • Work directed interventions added to clinical interventions for people with depression to reduce sickness absence. It should be noted that this is not a systematic review and does not consider the quality of the evidence. The full evidence maps (available here) should be

Intervention	Source	Brief summary of source
		consulted and full evidence reviews read to inform decisions. Bear in mind that the interventions may not be relevant to every setting or population.
	Learning and Work Institute. (2020). *Evidence review: What works to support 15 to 24-year olds at risk of becoming NEET?* Leicester: Learning and Work Institute. **Available here**	The primary focus of the review was on interventions implemented from 2010 to 2020 that aim to improve attainment and employment, progression and engagement. The quality and nature of the evidence in this review has been considered, and the authors present studies with robust causal evidence in order to identify **approaches which have been effective in supporting young people across attainment and employment, progress and engagement outcomes. They include:** • Multiple interventions and 'wrap around' approaches work effectively for disadvantaged learners to improve attainment and job prospects. • Traineeships, supported internships and apprenticeship programmes can deliver positive employment and earnings outcomes for young people at risk of becoming NEET. • Basic skills support can improve progress and reduce the risk of NEET. • Access to work experience can result in long-term employment and earning gains. • Mentoring and counselling can effectively support pupils at risk of becoming NEET.

Intervention	Source	Brief summary of source
		• Multiple interventions which target motivational and confidence skills building can improve engagement, but flexibility of intervention delivery is key. • One-to-one and tailored engagement can support disengaged young people to return to education, training and employment. • Learning Communities can help 16-18 year olds at key transition points to increase their educational engagement. • Financial incentives support educational progress, but further testing in a UK context is required.
Equipment - telecare	Gathercole, R et al. (2021). *Assistive technology and telecare to maintain independent living at home for people with dementia: the ATTILA RCT.* Health Technology Assessment, 25(19). **Available here**	This randomised controlled trial aimed to establish whether or not assistive technology and telecare assessments and interventions extend the time that people with dementia can continue to live independently at home and whether or not they are cost-effective. Caregiver burden, the quality of life of caregivers and of people with dementia and whether or not assistive technology and telecare reduce safety risks were also investigated. **The authors' conclusions are:** **A full package of assistive technology and telecare did not increase the length of time that participants with dementia remained in the community, and nor did it decrease caregiver burden, depression or anxiety, relative to a basic package of assistive technology and telecare.**

Intervention	Source	Brief summary of source
		Use of the full assistive technology and telecare package did not increase participants' health and social care or societal costs. Quality-adjusted life-years based on participants' EuroQol-5 Dimensions questionnaire responses were reduced in the intervention group compared with the control group; groups did not differ in the number of quality-adjusted life-years based on the proxy-rated EuroQol-5 Dimensions questionnaire. Limitations: The extent of missing data at follow-up precluded investigation of longer-term effects of the technology on caregiver outcomes. Furthermore, loss to follow-up in the caregiver data set was non-random, introducing some degree of bias. This is because dropout among some caregivers was partly due to the care recipient moving into residential care or dying. Furthermore, power analysis was conducted on the study primary outcome (time to institutionalisation), rather than on caregivers' outcomes. Therefore, it is possible that the analyses were statistically underpowered.
Equipment (child safety)	Stewart, TC et al. (2016). *Home safe home: Evaluation of a childhood home safety program*. The journal of trauma and acute care surgery, Vol.81 (3), p.533-540. **Available here**	The London Health Sciences Centre Home Safety Program (HSP) provides safety devices, education, a safety video, and home safety checklist to all first-time parents for the reduction of childhood home injuries. The objective of this study was to evaluate the HSP for the prevention of home injuries in children up to 2 years of age.

Intervention	Source	Brief summary of source
		The HSP was evaluated through a mixed-mode survey using both Internet and telephone surveys. **Removing hazards, supervision, and installing safety devices are key facilitators in the reduction of home injuries. Parents found the HSP useful to identify hazards, learn new strategies, build confidence, and provide safety products. Initial finding suggests that the program is effective in reducing home injuries in children up to 2 years of age.** This is primary, mixed methods research, involving both qualitative (surveys) and quantitative (statistical analysis) methods. The authors note several limitations to the study, notably only 20% of first-time parents responded, which may limit the generalisability of the survey results, favouring a more safety conscious group of parents.
	Wang, Y et al. (2020). *Varying Effect of a Randomized Toddler Home Safety Promotion Intervention Trial by Initial Home Safety Problems*. Maternal & Child Health Journal, Apr2020; 24(4): 432-438.DOI: 10.1007/s10995-019-02845-x. **Available here**	The study examined whether effective safety interventions targeting low-income families of toddlers varied by initial home safety problems. **This study found that the effects of the safety promotion intervention among low-income families with toddlers varied by initial home safety problems. Among families with multiple home safety problems, the intervention resulted in relatively large effects, whereas the effects for families with no/few home safety problems were small and not significant.**

Intervention	Source	Brief summary of source
		A key limitation of this study was that the safety intervention focused on toddlers from low-income families, a population at high risk of unintentional injuries. Generalisation of the findings to toddlers of other socio-economic status should be made with caution.
	National Institute for Health and Care Excellence. (2010). *Unintentional injuries: prevention strategies for under 15s*. PH29. London: NICE. **Available here** **This guidance is up to date (checked 2019).**	This NICE guideline is concerned with preventing unintentional injuries in those under 15 years and **recommends the installation of the following home safety equipment** • **Hard-wired or 10-year, battery-operated smoke alarms** • **Thermostatic mixer valves for baths** • **Window restrictors** • **Carbon monoxide alarms.**
	National Institute for Health and Care Excellence. (2010). *Unintentional injuries in the home: interventions for under 15s*. PH30. London: NICE. **Available here** **This guidance is up to date (checked 2019).**	This NICE guideline focuses on prevention of injuries in the home in those aged under 15 years. Recommendations focus on home safety assessments, supplying and installing home safety equipment and providing education when carrying out these activities. This guidance recommends offering home safety equipment including door guards, cupboard locks, safety gates, smoke and carbon monoxide alarms, thermostatic mixing valves and window restrictors.
Falls prevention	Royal College of Occupational Therapists. (2020). *Occupational therapy in the prevention and management of*	The aim of this practice guideline is to provide specific evidence-based recommendations that describe the most appropriate care or action to be taken by occupational therapists working with adults who have fallen, are at risk of

Intervention	Source	Brief summary of source
	falls in adults. Practice Guideline, Second Edition. London: Royal College of Occupational Therapists Ltd. **Available here**	falling or are fearful of falling. The recommendations are intended to be used alongside the therapist's clinical expertise in their assessment of need and implementation of interventions. **There are a total of 17 recommendations in four key recommendations categories:** **i. Keeping safe at home: reducing risk of falls.** **ii. Keeping active: reducing fear of falling.** **iii. Falls management: making it meaningful.** **iv. Occupational therapy intervention: impact and cost effectiveness.**
	National Institute of Health and Care Excellence. (2013). *Falls in older people: assessing risk and prevention*. CG161. London: NICE. **Available here** **This guidance is currently up to date (checked 2019 and will be updated).**	This NICE guideline includes recommendations for preventing falls in people aged 65 years and over. It makes recommendations on assessment and interventions.
	Guirguis-Blake, J.M MD. (2018). *Interventions to Prevent Falls in Older Adults.* Updated Evidence Report and	This systematic review aimed to assess the effectiveness and harms of fall prevention interventions in community-dwelling older adults.

Intervention	Source	Brief summary of source
	Systematic Review for the US Preventive Services Task Force. **Available here**	It focussed on three main interventions: multifactorial, exercise and vitamin D supplementation. **The authors concluded that multifactorial and exercise interventions were associated with fall-related benefit, but evidence was most consistent across multiple fall-related outcomes for exercise. Vitamin D supplementation interventions had mixed results, with a high dose being associated with higher rates of fall-related outcomes.** This review was limited to community-dwelling older adults and interventions that could be implemented in or referred from primary care. Trials were excluded that specifically recruited participants with neurologic diagnoses and other specific diagnoses, such as vitamin D insufficiency and osteoporosis. As such, the conclusions may not be applicable to those populations.
Healthy lifestyle support (smoking cessation)	National Institute for Health and Care Excellence. (2018). *Stop smoking interventions and services*. NG92. London: NICE. **Available here** **This guidance is up to date.**	This guideline covers stop smoking interventions and services delivered in primary care and community settings for everyone over the age of 12. **This guideline includes recommendations on:** • Commissioning and providing stop smoking interventions and services • Monitoring stop smoking services • Evidence-based stop smoking interventions • Engaging with people who smoke • Advice on e-cigarettes

Intervention	Source	Brief summary of source
		• People who want to quit • People who are not ready to quit • Telephone quitlines • Education and training • Campaigns to promote awareness of local stop smoking services • Closed institutions • Employers
	National Institute for Health and Care Excellence. (2013). *Smoking: harm reduction.* PH45. London: NICE. **Available here** **This guidance is up to date (checked 2017).**	This NICE guidance focuses on harm reduction and is for people who may not be able (or do not want) to stop smoking in one step. This includes those who may want to stop smoking, without necessarily giving up nicotine and those who may not be ready to stop smoking but want to reduce the amount they smoke. It makes **recommendations** on • Raising awareness of licensed nicotine containing products • Self help materials • Choosing a harm reduction approach • Behavioural support • Advising on licensed nicotine containing products • Supplying licensed nicotine containing products • Follow up appointments • Supporting temporary abstinence • People in closed institutions

Intervention	Source	Brief summary of source
		• Commissioning stop smoking services • Education and training for practitioners • Point of sale promotion of licensed nicotine containing products • Manufacturer information on licensed nicotine containing products.
	National Institute for Health and Care Excellence. (2013). *Smoking: acute, maternity and mental health services.* PH48. London: NICE. **Available here** **This guidance is up to date (checked 2017).**	This NICE guidance aims to support smoking cessation, temporary abstinence from smoking and smoke free policies in all secondary care settings. **It recommends:** • Strong leadership and management to ensure premises remain smoke free. • All hospitals have an on-site stop smoking service. • Identifying people who smoke, offering advice and support to stop. • Providing intensive behavioural support and pharmacotherapy as an integral component of secondary care. • Integrating stop smoking support in secondary care with support provided by community-based services. • Ensuring staff are trained to support people to stop smoking while using secondary care services. • Supporting staff to stop smoking or to abstain while at work. • Ensuring there are no designated smoking areas or staff-facilitated smoking breaks for anyone using secondary care services.

Intervention	Source	Brief summary of source
	National Institute for Health and Care Excellence. (2010). *Smoking: stopping in pregnancy and after childbirth.* PH26. London: NICE. **Available here** **This guidance is up to date (partially updated 2018).**	This NICE guidance focuses on stopping smoking in pregnancy and after childbirth. The eight recommendations include advice on: • How NHS professionals and others working in the public, community and voluntary sectors can identify women (including teenagers) who smoke when they attend an appointment or meeting. • How to refer them to NHS Stop Smoking Services (or the equivalent). • How NHS Stop Smoking Services staff (and staff from equivalent, non-NHS services) should contact and support all women who have been referred for help. • How to help their partners or 'significant others' who smoke. • When and how nicotine replacement therapy and other pharmacological support should be offered. • Training for professionals.
	National Institute for Health and Care Excellence. (2010). *Smoking prevention in schools.* PH23. London: NICE. **Available here** **This guidance is up to date (checked 2013 and will be partially updated).**	This source focuses on action that can be taken in schools to prevent the uptake of smoking in children and young people **The five recommendations in this NICE guidance include the following advice:** • The smoking policy should support both prevention and stop smoking activities and should apply to everyone using the premises (including the grounds).

Intervention	Source	Brief summary of source
		• Information on smoking should be integrated into the curriculum. For example, classroom discussions could be relevant when teaching biology, chemistry, citizenship and maths. • Anti-smoking activities should be delivered as part of personal, social, health and economic (PHSE) and other activities related to Healthy Schools or Healthy Further Education status. • Anti-smoking activities should aim to develop decision-making skills and include strategies for enhancing self-esteem. Parents and carers should be encouraged to get involved and students could be trained to lead some of these programmes. • All staff involved in smoking prevention should be trained to do so. • Educational establishments should work in partnership with outside agencies to design, deliver, monitor and evaluate smoking prevention activities.
	National Institute for Health and Care Excellence. (2008). *Smoking preventing uptake in children and young people.* PH14. London: NICE. **Available here.** **This guidance is up to date (checked in 2014 and will be updated).**	The recommendations in this NICE guidance focus on mass media and point of sale recommendations that may help prevent the uptake of smoking in children and young people.

Intervention	Source	Brief summary of source
	National Institute for Health and Care Excellence. (2007). *Smoking workplace interventions.* PH5. London: NICE. **Available here.** **This guidance is up to date (checked in 2014).**	This NICE guidance addresses workplace health promotion with reference to smoking and what works in motivating and changing employees' behaviour. **The recommendations include the following:** • Employers should develop a smoking cessation policy, provide employees with information on local stop smoking support services, publicise the interventions above and allow staff time off to attend smoking cessation services. • Employees and their representatives should encourage employers to provide staff who smoke with advice, guidance and support on quitting. • Employees who want information, advice or support to stop smoking should contact a local service such as the NHS Stop Smoking Services. • Smoking cessation services should offer one or more of the recommended services listed above, delivered by trained staff and tailored to the person's needs. They should also offer employers support to help their employees quit. If demand exceeds the resources available, services should focus on small and medium-sized enterprises.
	Hartmann-Boyce, J et al. (2021). *Behavioural interventions for smoking cessation: an overview and network meta-analysis.* Cochrane Database of Systematic Reviews. Issue 1. Art. No.: CD013229. DOI:	This review of reviews summarises the evidence from Cochrane Reviews that assessed the effect of behavioural interventions designed to support smoking cessation attempts and to conduct a network meta-analysis to determine how modes of delivery; person delivering the intervention; and the nature, focus, and intensity of behavioural interventions for smoking cessation influence the likelihood of achieving abstinence six months after attempting to stop smoking;

Intervention	Source	Brief summary of source
	10.1002/14651858.CD013229.pub2. **Available here**	and whether the effects of behavioural interventions depend upon other characteristics, including population, setting, and the provision of pharmacotherapy. **The authors conclude that behavioural support for smoking cessation can increase quit rates at six months or longer, with no evidence that support increases harms. This is the case whether or not smoking cessation pharmacotherapy is also provided, but the effect is slightly more pronounced in the absence of pharmacotherapy. Evidence of benefit is strongest for the provision of any form of counselling, and guaranteed financial incentives.** Evidence suggested possible benefit but the need of further studies to evaluate: individual tailoring; delivery via text message, email, and audio recording; delivery by lay health advisor; and intervention content with motivational components and a focus on how to quit.
Healthy lifestyle support (healthy eating/weight loss support)	National Institute for Health and Care Excellence. (2015). *Preventing excess weight gain*. NG7. London: NICE. **Available here.** **This guidance is currently up to date (checked in 2017 and will be updated).**	This guidance covers children (after weaning) and adults and is concerned with maintenance of a healthy weight and the prevention of excess weight gain. **The recommendations aim to:** • Encourage people to make changes in line with existing advice • Encourage people to develop physical activity and dietary habits that will help them maintain a healthy weight and prevent excess weight gain • Encourage people to monitor their own weight and associated behaviours

Intervention	Source	Brief summary of source
		• Promote the clear communication of benefits of maintaining a healthy weight and making gradual changes to physical activity and diet • Ensure messages are tailored to specific groups • Ensure activities are integrated with the local strategic approach to obesity.
	National Institute for Health and Care Excellence. (2010). *Weight management before, during and after pregnancy*. PH27. London: NICE. **Available here.** **This guidance is up to date (checked in 2017 and will be amalgamated into other guidance).**	This guidance addresses dietary and physical activity interventions for weight management before, during and after pregnancy. The six recommendations in this NICE guideline are based on approaches that have been proven to be effective for the whole population. **They include advice on:** • How to help women with a BMI of 30 or more to lose weight before and after pregnancy – and how to help them eat healthily and keep physically active during pregnancy. • How to help all pregnant women eat healthily and keep physically active. • The role of community-based services. • The professional skills needed to achieve the above.
	National Institute for Health and Care Excellence. (2013). *Weight management: lifestyle services for overweight or obese children and young people.* PH47. London: NICE. **Available here.**	This NICE guidance makes recommendations on lifestyle weight management services for overweight and obese children and young people. **The recommendations cover:** • Planning services • Commissioning programmes • Core components of lifestyle weight management programmes

Intervention	Source	Brief summary of source
	This guidance is up to date (checked in 2017 and will be partially updated).	• Developing a tailored programme plan to meet individual needs • Encouraging adherence • Raising awareness of programmes • Formal referrals to programmes • Providing ongoing support • Programme staff: training, knowledge and skills • Training in how to make programme referrals • Supporting programme staff and those making programme referrals • Monitoring and evaluating programmes.
	National Institute for Health and Care Excellence. (2014). *Weight management: lifestyle services for overweight or obese adults.* PH53. London: NICE. **Available here.** **This guidance is up to date (checked in 2017 and will be amalgamated into other guidance).**	The focus in this NICE guidance is on lifestyle weight management programmes for overweight and obese adults that: • Accept self-referrals or referrals from health or social care practitioners • Are provided by the public, private or voluntary sector • Are based in the community, workplaces, primary care or online **The recommendations include planning services and commissioning programmes; core components of lifestyle weight management programmes; developing a tailored programme plan to meet individual needs; encouraging adherence and raising awareness of programmes.**

Intervention	Source	Brief summary of source
	National Institute for Health and Care Excellence. (2012). *Obesity working with local communities.* PH42. London: NICE. **Available here.** **This guidance is up to date (checked in 2017).**	This NICE guidance covers community-wide action to prevent overweight and obesity in adults and children. **The 14 recommendations cover:** • Developing a sustainable, community-wide approach to obesity • Strategic leadership • Supporting leadership at all levels • Coordinating local action • Communication • Involving the community • Integrated commissioning • Involving local businesses and social enterprises operating in the local area • Local authorities and the NHS as exemplars of good practice • Planning systems for monitoring and evaluation • Implementing monitoring and evaluation functions • Cost effectiveness • Organisational development and training • Scrutiny and accountability.
Healthly lifestyle support	Ulian, R (2018). *Effects of health at every size® interventions on health-related outcomes of people with overweight and obesity: a systematic review*. Obesity Reviews, Vol 19 (12),	This study aimed to summarize the health-related effects of Health at Every Size® (HAES®)-based interventions on people with overweight and obesity. **This review showed that HAES®-based interventions were effective in improving some cardiovascular outcomes, e.g. total and LDL cholesterol.**

Intervention	Source	Brief summary of source
("Health at Every Size®")	Doi.org/10.1111/obr.12749. **Available here**	**Still, further evidence is necessary for other outcomes such as triglycerides, fasting glucose levels and blood pressure. This approach could enhance eating behaviour, energy intake and diet quality of participants.** **Moreover, positive physiological changes were found such as increases in oxygen consumption and physical activity level. Eventually, major improvements were also seen in the quality of life, stress perception and depression level.** Nevertheless, the studies included in this review varied largely in terms of follow-up, intervention characteristic, sample size, methodological quality and outcomes. As HAES® appears to be a promising approach for obesity management, further well-powered and well-controlled studies should be performed to compare its efficacy to that of more traditional interventions (i.e. prescriptive intervention), which have been shown to be generally ineffective in the long run.
Healthy lifestyle support	National Institute for Health and Care Excellence. (2014). *Physical activity: exercise referral schemes.* PH54. London: NICE. **Available here.**	This NICE guidance is for adults and focuses on exercise referral schemes that try to increase physical activity among people who are inactive or sedentary and are otherwise healthy or who have an existing health condition or other risk factors for disease.

Intervention	Source	Brief summary of source
(physical activity)	**This guidance is up to date (checked in 2018).**	
	National Institute for Health and Care Excellence. (2009). *Physical activity for children and young people.* PH17. London: NICE. **Available here.** **This guidance is up to date (checked in 2018).**	This NICE guidance addresses physical activity, active play and sport for pre-school and school age children and young people in family, pre-school, school and community settings. **It makes recommendations on:** • How to promote the benefits of physical activity and encourage participation • High level strategic planning • The importance of consultation with children and young people and how to set about it • Planning and providing spaces, facilities and opportunities • Training people to run programmes and activities • How to promote physically active travel such as cycling and walking.
	National Institute for Health and Care Excellence. (2013). *Physical activity brief advice for adults in primary care.* PH44. London: NICE. **Available here.** **This guidance is up to date (checked in 2016).**	**The recommendations in this NICE guidance cover:** • Identifying adults who are inactive • Delivering and following up on brief advice • Incorporating brief advice in commissioning • Systems to support brief advice • Information and training to support brief advice

Intervention	Source	Brief summary of source
		The guidance aims to support routine provision of brief advice on physical activity in primary care.
	National Institute for Health and Care Excellence. (2012). *Physical activity walking and cycling.* PH41. London: NICE. **Available here.** **This guidance is up to date (checked in 2019).**	This NICE guidance is concerned with encouraging people to increase the amount they walk or cycle for travel or recreation purposes. **The recommendations cover:** • Local programmes • Policy and planning • Schools, workplaces and the NHS.
	National Institute for Health and Care Excellence. (2018). *Physical activity and the environment*. NG90. London: NICE. **Available here** **This guidance is up to date and replaces NICE guideline PH8.**	This guideline covers how to improve the physical environment to encourage and support physical activity. The aim is to increase the general population's physical activity levels. **The guideline includes recommendations on:** • Strategies, policies and plans to increase physical activity in the local environment • Active travel • Public open spaces • Buildings • Schools

Intervention	Source	Brief summary of source
	National Institute for Health and Care Excellence. (2008). *Physical activity in the workplace*. PH13. London: NICE. **Available here**. **This guidance is up to date (checked in 2019 and is being updated).**	This NICE guidance is about improving health in the workplace by encouraging employees to be physically active **Recommendations for employers include:** • Develop an organisation-wide plan and introduce and monitor an organisation-wide, multi-component programme to encourage and support employees to be more physically active. (This could be part of a broader programme to improve health.) • Encourage employees to walk, cycle or use another mode of transport involving physical activity to travel part or all of the way to and from work (for example, by developing a travel plan). • Help employees to be physically active during the working day, for example, by encouraging them to take the stairs or walk to external meetings.
	National Institute for Health and Care Excellence. (2008). Mental *wellbeing in over 65s: occupational therapy and physical activity interventions.* PH16. London: NICE. **Available here.** **This guidance is up to date (checked in 2018 and will be updated).**	This NICE guidance is for primary and residential care and focuses on the role of occupational therapy and physical activity interventions in the promotion of mental wellbeing for older people. **Recommendations include:** • Offer tailored, community-based physical activity programmes. These should include moderate-intensity activities (such as swimming, walking, dancing), strength and resistance training, and toning and stretching exercises. • Advise older people and their carers how to exercise safely for 30 minutes a day on 5 or more days a week, using examples of everyday activities such as

Intervention	Source	Brief summary of source
		shopping, housework and gardening. (The 30 minutes can be broken down into 10-minute bursts.) • Promote regular participation in local walking schemes as a way of improving mental wellbeing. Help and support older people to participate fully in these schemes, taking into account their health, mobility and personal preferences.
Healthy lifestyle support (substance misuse support)	National Institute for Health and Care Excellence. (2017). *Drug misuse prevention: targeted interventions*. NG64. London: NICE. **Available here** **This guidance is up to date and replaces NICE guidance PH4.**	This guideline covers targeted interventions to prevent misuse of drugs, including illegal drugs, 'legal highs' and prescription-only medicines. It aims to prevent or delay harmful use of drugs in children, young people and adults who are most likely to start using drugs or who are already experimenting or using drugs occasionally. **The guideline includes recommendations on:** • Delivering drug misuse prevention activities as part of existing services • Assessing whether someone is vulnerable to drug misuse • Providing skills training for children and young people who are vulnerable to drug misuse • Providing information to adults who are vulnerable to drug misuse • Providing information about drug use in settings that people who use drugs or are at risk of using drugs may attend.
	National Institute for Health and Care Excellence. (2019). *Alcohol interventions*	This guideline covers interventions in secondary and further education to prevent and reduce alcohol use among children and young people aged 11 up to

Intervention	Source	Brief summary of source
	in secondary and further education. NG135. London: NICE. **Available here** **This guidance is up to date and replaces NICE guidance PH7.**	and including 18. It also covers people aged 11 to 25 with special educational needs or disabilities in full-time education. It will also be relevant to children aged 11 in year 6 of primary school. **The guideline includes recommendations on:** • Planning alcohol education • Delivering universal alcohol education • Targeted interventions.
	National Institute for Health and Care Excellence. (2010). *Alcohol use disorders prevention.* PH24. London: NICE. **Available here.** **This guidance is up to date (checked in 2019 and being updated).**	This NICE guidance is for government, industry and commerce, the NHS and all those whose actions affect the population's attitude to – and use of – alcohol. This includes commissioners, managers and practitioners working in: • Local authorities • Education • The wider public, private, voluntary and community sectors. **The guidance includes recommendations for both policy and practice and covers:** • Licensing. • Resources for identifying and helping people with alcohol-related problems.

Intervention	Source	Brief summary of source
		• Children and young people aged 10 to 15 years – assessing their ability to consent, judging their alcohol use, discussion and referral to specialist services. • Young people aged 16 and 17 years – identification, offering motivational support or referral to specialist services. • Adults – screening, brief advice, motivational support or referral.
	McGovern, R et al. (2021). *Effectiveness of psychosocial interventions for reducing parental substance misuse*. Cochrane Database of Systematic Reviews. Issue 3. Art. No.: CD012823. DOI: 10.1002/14651858.CD012823.pub2. **Available here**	This systematic review assessed the effectiveness of psychosocial interventions in reducing parental substance use (alcohol and/or illicit drugs, excluding tobacco). **The authors found moderate-quality evidence that psychosocial interventions probably reduce the frequency at which parents use alcohol and drugs. Integrated psychosocial interventions which combine parenting skills interventions with a substance use component may show the most promise.** Whilst it appears that mothers may benefit less than fathers from intervention, caution is advised in the interpretation of this evidence, as the interventions provided to mothers alone typically did not address their substance use and other related needs. The authors found low-quality evidence from few studies that interventions involving children are not beneficial.

Intervention	Source	Brief summary of source
	Steele, DW et al. *Interventions for Substance Use Disorders in Adolescents: A Systematic Review*. Comparative Effectiveness Review No. 225. AHRQ Publication No. 20-EHC014. Rockville, MD: Agency for Healthcare Research and Quality. May 2020. DOI: https://doi.org/10.23970/AHRQEPCCER225. **Available here**	This systematic review (SR) synthesizes the literature on behavioural, pharmacologic, and combined interventions for adolescents aged 12 to 20 years with problematic substance use or substance use disorder. Conclusions: **Brief interventions: Motivational Interviewing (MI) reduces heavy alcohol use (low Strength of Evidence (SoE)), alcohol use days (moderate SoE), and substance use–related problems (low SoE) but does not reduce cannabis use days (moderate SoE).** **Non-brief interventions: Family Focused Therapy (Fam) may be most effective in reducing alcohol use (low SoE).** More research is needed to identify other effective intensive behavioural interventions for alcohol use disorder. Intensive interventions did not appear to decrease cannabis use (low SoE). Some interventions (Cognitive Behavioural Therapy (CBT), CBT+MI, and CBT+MI+ Contingency Management (CM)) were associated with increased cannabis use (low SoE). Both MI and CBT reduce combined alcohol and other drug use (low SoE).

Intervention	Source	Brief summary of source
		Combined CBT+MI reduces illicit drug use (low SoE).
Healthy lifestyle support (sexual health)	National Institute for Health and Care Excellence. (2007). *Sexually transmitted infections and under 18s conceptions prevention*. PH3. London: NICE. **Available here.** **This guidance is up to date (checked in 2018 and will be updated).**	**Recommendations in this NICE guidance include the following:** • Assess people's risk of having a sexually transmitted infection (STI), when the opportunity arises. For example, this could happen when someone attends for contraception, or to register as a new patient. • Offer advice to people at high risk of an STI in a structured discussion, or arrange for them to see someone who is trained to give this type of advice. The discussion should cover ways to help people reduce the risks. • Help people with an STI to get their partners tested and treated. This might involve referring the person to a specialist. People with STIs and their partners should receive information about the infection they have. This guidance is intended for professionals responsible for, or who work in, sexual health services including general practitioners and professionals working in contraceptive services, genitourinary medicine and school clinics.
	National Institute for Health and Care Excellence. (2014). *Contraceptive services for under 25s.* PH51. London: NICE. **Available here.**	This NICE guidance is for NHS and other commissioners, managers and practitioners who have a direct or indirect role in, and responsibility for, contraceptive services. This includes those working in local authorities, education and the wider public, private, voluntary and community sectors. It may also be of interest to young people, their parents and carers and other members of the public. **The recommendations include advice on:**

Intervention	Source	Brief summary of source
	This guidance is up to date (checked in 2017).	• How to assess local need and commission comprehensive services. • Offering culturally appropriate, confidential, non-judgemental, empathic advice tailored to the needs of the young person. • Ensuring young people understand that their personal information and the reason why they are using the service will be kept confidential. • Providing contraceptive services after pregnancy and abortion. • Encouraging young people to use condoms as well as other forms of contraception. • How schools and other education settings can provide contraceptive services.
	National Institute for Health and Care Excellence. (2017). Sexually transmitted infections: condom distribution schemes. NG68. London: NICE. **Available here** **This guidance is up to date.**	This guideline covers condom distribution schemes. The aim is to reduce the risk of sexually transmitted infections (STIs). **This guideline includes recommendations on:** • Targeting services • Multicomponent condom distribution schemes for young people in health, education, youth and outreach settings • Single component schemes.

Intervention	Source	Brief summary of source
	Jawad, A et al (2019). *Interventions using social networking sites to promote contraception in women of reproductive age.* Cochrane Database of Systematic Reviews. Issue 3. Art. No.: CD012521. DOI: 10.1002/14651858.CD012521.pub2. **Available here**	This systematic review evaluates the effectiveness of interventions using Social Networking Sites (SNSs) to promote the uptake of and adherence to contraception in reproductive-age women. **Despite the prevalence of SNSs, the authors found little scientific evidence to support the use of SNSs to improve contraceptive use or adherence among women.**
	Staley, H et al. (2021). *Interventions targeted at women to encourage the uptake of cervical screening*. Cochrane Database of Systematic Reviews. Issue 9. Art. No.: CD002834. DOI: 10.1002/14651858.CD002834.pub3. **Available here**	This systematic review assesses the effectiveness of interventions aimed at women, to increase the uptake, including informed uptake, of cervical screening. **The authors concluded there is moderate-certainty evidence to support the use of invitation letters to increase the uptake of cervical screening.** Low-certainty evidence showed lay health worker involvement amongst ethnic minority populations may increase screening coverage, and there was also support for educational interventions, but it is unclear what format is most effective. The majority of the studies were from developed countries. Overall, the low-certainty evidence that was identified makes it difficult to infer which interventions were best, with exception of invitational interventions, where there appeared to be more reliable evidence.

Intervention	Source	Brief summary of source
Healthy schools support	Langford R et al. (2014). *The WHO health promoting school framework for improving the health and well-being of students and their academic achievement.* Cochrane Database Systematic Reviews. Issue 4. Art. No: CD008958. doi: 10.1002/14651858.CD008958.pub2. **Available here**	The review authors found that interventions using the WHO Health Promoting Schools (HPS) approach were able to reduce students' body mass index (BMI), increase physical activity and fitness levels, improve fruit and vegetable consumption, decrease cigarette use, and reduce reports of being bullied. However, they found little evidence of an effect on BMI when age and gender were taken into account and no evidence of effectiveness on fat intake, alcohol and drug use, mental health, violence, and bullying others. The review authors did not have enough data to draw conclusions about the effectiveness of the HPS approach for sexual health, hand-washing, cycle-helmet use, eating disorders, sun protection, oral health or academic outcomes. Few studies discussed whether the health promotion activities, or the collection of data relating to these, could have caused any harm to the students involved. **The review authors concluded that the results of this review provide evidence for the effectiveness of some interventions based on the HPS framework for improving certain health outcomes but not others.** More well-designed research is required to establish the effectiveness of this approach for other health topics and academic achievement.
	Neil-Sztramko, SE et al. (2021). *School-based physical activity programs for promoting physical activity and fitness in children and adolescents aged 6 to 18*.	The purpose of this systematic review update is to summarise the evidence on effectiveness of school-based interventions in increasing moderate to vigorous

Intervention	Source	Brief summary of source
	Cochrane Database of Systematic Reviews. Issue 9. Art. No.: CD007651. DOI: 10.1002/14651858.CD007651.pub3. **Available here**	physical activity and improving fitness among children and adolescents 6 to 18 years of age. Results show that **school-based physical activity interventions probably result in little to no increase in time engaged in moderate to vigorous physical activity and may lead to little to no decrease in sedentary behaviour (low-certainty evidence). School-based physical activity interventions may improve physical fitness reported as maximal oxygen uptake (low-certainty evidence). School-based physical activity interventions may result in a very small decrease in BMI z-scores (low-certainty evidence) and may not impact BMI expressed as kg/m² (low-certainty evidence).** Given the variability of results and the overall small effects, school staff and public health professionals must give the matter considerable thought before implementing school-based physical activity interventions. Given the heterogeneity of effects, the risk of bias, and findings that the magnitude of effect is generally small, results should be interpreted cautiously.
Looked after children / support for care leavers	National Institute for Health and Care Excellence. (2010). *Looked after children and young people.* PH28. London: NICE. **Available here.** (Refreshed May 2015)	This NICE guidance is for all those who have a role in promoting the quality of life (that is, the physical health, and social, educational and emotional wellbeing) of looked-after children and young people. The recommendations cover local strategy and commissioning, multi-agency working, care planning and

Intervention	Source	Brief summary of source
	This guidance is up to date (checked 2017 and an update planned).	placements, and timely access to appropriate health and mental health services. In particular, the **recommendations** aim to: • Promote stable placements and nurturing relationships • Support the full range of placements, including with family and friends • Encourage educational achievement • Support the transition to independent living • Meet the particular needs of looked-after children and young people, including those from black and minority ethnic backgrounds, unaccompanied asylum seekers, and those who have disabilities.
	National Institute for Health and Care Excellence. (2016). *Transition from children's to adults' services for young people using health or social care services.* NG43. London: NICE. **Available here.** **This guidance is up to date.**	This NICE guideline covers the period before, during and after a young person moves from children's to adults' services. It is relevant to both health and social care providers. The guideline includes **recommendations** on: • Overarching principles for good transition • Planning transition • Support before and after transfer • The supporting infrastructure for transition
	What Works for Children's Social Care. (2019). *Educational interventions for looked after children and young people*. Cardiff: The Children's Social Care	This is an evidence summary, based on a systematic review examining educational interventions for looked-after children and young people. **Summary of key points:**

Intervention	Source	Brief summary of source
	Research and Development Centre (CASCADE). **Available here**	• While the systematic review reports findings from randomised controlled trials, differences in the quality of the conduct and reporting of studies limited the extent to which effectiveness could be determined. • Five papers reported three randomised controlled trials of Teach Your Children Well, which is an intervention that includes direct tuition on reading, language and maths skills and behaviour management techniques. • Mixed findings were reported for Teach Your Children Well and academic skills. • When children were taught individually by foster carers, improvements were reported for sentence comprehension and maths skills. At group level, variation was noted between 25- and 30-week delivery. At 25 weeks, improvements were reported on reading and spelling while at 30-weeks, improvements were reported for reading, spelling and maths skills. • Educational interventions aimed at pre-school children appeared to have a positive effect on the development of academic skills, including early literacy skills. • Where interventions were not associated with improvements in academic skills it was suggested that looked after children and young people may have a range of needs which require specialist trained providers. • The review highlights the need for theoretically-driven educational interventions and evaluations looking at which interventions work for different age ranges or specific groups of children looked after and in what contexts.

Intervention	Source	Brief summary of source
		• Improvements are needed in the methodological quality of study design so that conclusions can be drawn on the effectiveness and development of educational interventions.
Parenting support	Robling, M et al. (2021).*The Family Nurse Partnership to reduce maltreatment and improve child health and development in young children: the BB:2 6 routine data-linkage follow-up to earlier RCT*. Public Health Research; 9 (2). **Available here**	The objectives of this follow-up study were to establish the medium-term effectiveness of the Family Nurse Partnership in reducing maltreatment and improving maternal health (second pregnancies) and child health, developmental and educational outcomes (e.g. early educational attendance, school readiness). The intervention comprised up to a maximum of 64 home visits by specially trained family nurses from early pregnancy until the firstborn child was 2 years of age, plus usually provided health and social care support. The comparator was usual care alone. **The authors concluded that there is no observable benefit of the programme for maltreatment or maternal outcomes, but it does generate advantages in school readiness and attainment at Key Stage 1.**
	Barlow, J et al (2016). *Group-based parent training programmes for improving emotional and behavioural adjustment in young children*. Cochrane Database of Systematic Reviews, Issue 8. Art. No.:	This systematic review examined whether group-based parenting programmes are effective in improving the emotional and behavioural adjustment of young children (maximum mean age of three years and 11 months. It also assessed whether parenting programmes are effective in the primary prevention of emotional and behavioural problems.

Intervention	Source	Brief summary of source
	CD003680. DOI: 10.1002/14651858.CD003680.pub3. **Available here**	**The findings of this review, which relate to the broad group of universal and at-risk (targeted) children and parents, provide tentative support for the use of group-based parenting programmes to improve the overall emotional and behavioural adjustment of children with a maximum mean age of three years and 11 months, in the short-term.** There is a need for more research regarding the role that these programmes might play in the primary prevention of both emotional and behavioural problems, and their long-term effectiveness.
	O'Hara, L et al. (2019). *Video feedback for parental sensitivity and attachment security in children under five years*. Cochrane Database of Systematic Reviews, Issue 11. Art. No.: CD012348. DOI: 10.1002/14651858.CD012348.pub2. **Available here**	This systematic review assessed the effects of video feedback on parental sensitivity and attachment security in children aged under five years who are at risk for poor attachment outcomes. **The authors concluded that there is moderate-certainty evidence that video feedback may improve sensitivity in parents of children who are at risk for poor attachment outcomes due to a range of difficulties.** There is currently only little, very low-certainty evidence regarding the impact of video feedback on attachment security, compared with control: results differed based on the type of measure used, and follow-up was limited in duration. There is no evidence that video feedback has an impact on parental stress or anxiety (low- and very low-certainty evidence, respectively). Further evidence is

Intervention	Source	Brief summary of source
		needed regarding the longer-term impact of video feedback on attachment and more distal outcomes such as children's behaviour (very low-certainty evidence). Further research is needed on the impact of video-feedback on paternal sensitivity and parental reflective functioning, as no study measured these outcomes. This review is limited by the fact that the majority of included parents were mothers.
Skills development (cooking)	Blamey, A and Gordon, J. (2015). *A review of practical cooking skills activities which focus on promoting an affordable healthy balanced diet for adults, young people and their families within low-income communities in Scotland.* Edinburgh: NHS Health Scotland. **Available here**	This review, described as taking a realist approach, was undertaken to understand how the contexts and mechanisms within community cookery skills activities help achieve or improve the outcomes for participants from low-income communities. The outcomes of interest included the development of skills, knowledge and confidence around preparing and cooking healthy and affordable meals, intentions to change behaviour, and non-nutritional outcomes. **The review authors concluded that the cooking skills courses and activities included in the review (most of which were funded via Community and Food Health Scotland) appear from course feedback to have been engaging and enjoyable experiences for those who participated.** The review authors said that notwithstanding the limitations in the outcome data, participants who have completed course feedback and evaluation forms consistently self-reported short–term improvements in confidence, knowledge,

Intervention	Source	Brief summary of source
		intentions to change and in some instances behaviour change. Many of the strategies were aimed primarily at 'non cooking outcomes' or mediators of future cooking outcomes such as self-efficacy or food's role in social interaction. The causal linkages between these mediators and cooking outcomes require further testing. The review authors stated that there was some good evaluation and reporting practice but there was a lack of clarity and specificity in many of the plans and implementation reports.
	Segrott, J. et al. (2017). *Implementation of a Cooking Bus intervention to support cooking in schools in Wales, UK.* Health Education, 117(3), pp. 234-251. **Available here**	The purpose of this paper is to examine how a mobile classroom (Cooking Bus) sought to strengthen connections between schools and cooking, and drawing on the concept of the sociotechnical network, theorise the interactions between the Bus and school contexts. **The authors found that the Cooking Bus forged connections with schools through aligning intervention and schools' goals, focussing on pupils' cooking skills, training teachers and contributing to schools' existing cooking-related activities.** The Bus expanded its sociotechnical network through post-visit integration of cooking activities within schools, particularly teachers' use of intervention cooking kits. It should be noted that this is a qualitative study, using questionnaires, a design which explores believes, experiences and attitudes and can be useful for generating hypotheses, rather than assessing the effectiveness of interventions.

Intervention	Source	Brief summary of source
Skills development (life skills in chronic mental illness)	Tungpunkom, P et al. (2012). Life skills programmes for chronic mental illnesses. *Cochrane Database Systematic Review* Issue 1. Art. No: CD000381. doi: 10.1002/14651858.CD000381.pub3. **Available here**	This systematic review compared life skills training with occupational therapy and peer support for people with chronic mental illness. Outcomes included life skills, mental state and quality of life. **The review authors concluded that currently there is no good evidence to suggest life skills programmes are effective for people with chronic mental illnesses.**
	Lean, M. et al. (2019). *Self-management interventions for people with severe mental illness: Systematic review and meta-analysis*. The British Journal of Psychiatry, 214 (5), 260-268. doi:10.1192/bjp.2019.54. **Available here**	This systematic review evaluated the effectiveness of self-management interventions for adults with severe mental illness (SMI). **The authors found that there is evidence that the provision of self-management interventions alongside standard care improves outcomes for people with SMI. Self-management interventions should form part of the standard package of care provided to people with SMI and should be prioritised in guidelines**: research on best methods of implementing such interventions in routine practice is needed. A particular limitation of this study was that although all studies included in this review were randomised controlled trials (RCTs), there was variation in the reporting of sequence generation, allocation concealment and blinding of participants and personnel was not always consistent. This increases possible risk of bias.

Intervention	Source	Brief summary of source
Specialist support (domestic abuse)	National Institute for Health and Care Excellence. (2014). Domestic *violence and abuse: multi-agency working*. PH50. London: NICE. **Available here** **This guidance is up to date (checked 2018).**	This NICE guidance aims to identify, prevent and reduce domestic violence and abuse. It includes a recommendation on providing specialist services for children and young people and the provision of specialist advice, advocacy and support as part of a comprehensive referral pathway.
	Public Health England. (2019). *A whole-system multi-agency approach to serious violence prevention*. London: Public Health England. **Available here**	The aim of this resource is to propose a practical approach that will facilitate partners' understanding and response to serious violence (including domestic) as it is affecting their local communities. **It offers examples of relevant case studies and local initiatives**, such as IRIS: a well evidenced scheme which trains primary care colleagues in GP surgeries to identify early signs of domestic abuse (DA) and provides a direct referral into a domestic violence worker linked to the practice. Another example is the 'The Intervention Initiative', a free evidence-based education programme designed to prevent sexual coercion and domestic abuse in university settings.

Intervention	Source	Brief summary of source
		This resource is intended to stimulate local action through engagement with a wide range of partners and stakeholders in local health and justice systems, including local authorities and health professionals.
	Rivas, C et al. (2019). *A realist review of which advocacy interventions work for which abused women under what circumstances*. Cochrane Database of Systematic Reviews, Issue 6. Art. No.: CD013135. DOI: 10.1002/14651858.CD013135.pub2. **Available here**	This systematic review assesses advocacy interventions for intimate partner abuse in women, in terms of which interventions work for whom, why and in what circumstances. **The authors found moderate and high confidence in evidence for the importance of considering both women's vulnerabilities and intersectionalities and the trade-offs of abuse-related decisions in the contexts of individual women's lives. Decisions should consider the risks to the woman's safety from the abuse.** Whether actions resulting from advocacy increase or decrease abuse depends on contextual factors (e.g. severity and type of abuse), and the outcomes the particular advocacy intervention is designed to address (e.g. increasing successful court orders versus decreasing depression). The authors have low confidence in evidence regarding the significance of physical dependencies, being pregnant or having children. There were links between setting (high confidence), and potentially also theoretical underpinnings of interventions, type, duration and intensity of advocacy, advocate discipline and outcomes (moderate and low confidence). A good therapeutic alliance was important (high confidence); this alliance might be improved when advocates are

Intervention	Source	Brief summary of source
		matched with abused women on ethnicity or abuse experience, exercise cultural humility, and remove structural barriers to resource access by marginalised women. The review authors identified significant challenges for advocates in inter-organisational working, vicarious traumatisation, and lack of clarity on how much support to give a woman (moderate and high confidence). To work effectively, advocates need ongoing training, role clarity, access to resources, and peer and institutional support.
Specialist support (mental health and emotional wellbeing)	National Institute for Health and Care Excellence. (2012). Social *and emotional wellbeing: early years*. PH40. London: NICE. **Available here** **This guidance is up to date (checked 2017).**	This NICE guideline aims to define how the social and emotional wellbeing of vulnerable children aged under 5 years can be supported through home visiting, childcare and early education.
	National Institute for Health and Care Excellence. (2008). *Social and emotional wellbeing: primary education*. PH12. London: NICE. **Available here**	This NICE guidance is for teachers and school governors, and staff in local authority children's services, primary care and child and adolescent mental health services. It makes recommendations on supporting social and emotional wellbeing of children in primary education.

Intervention	Source	Brief summary of source
	This guidance was checked in 2017 and will be updated.	
	National Institute for Health and Care Excellence. (2009). *Social and emotional wellbeing in secondary education.* PH20. London: NICE. **Available here** **This guidance was checked in 2017 and will be updated.**	This NICE guidance addresses the social and emotional wellbeing of children and young people in secondary education. Recommendations include organisation wide approaches and specific help for those most at risk, or showing signs, of problems. The guidance is for those who have a direct or indirect role in, and responsibility for, the social and emotional wellbeing of young people in secondary education.
	National Institute for Health and Care Excellence. (2015). *Older people: independence and mental wellbeing*. NG32. London: NICE. **Available here** **This guidance is up to date (checked in 2018).**	This NICE guidance is for local authorities working in partnership with organisations in the public, private, voluntary and community sectors and for the NHS and other service providers with a remit for older people. It covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older and how to identify those most at risk of a decline. The guidance includes recommendations on principles of good practice; group based activities; one to one activities; volunteering and identifying people most at risk of decline.

Intervention	Source	Brief summary of source
	Townshend, K et al. (2016). *The effectiveness of mindful parenting programs in promoting parents' and children's wellbeing*. JBI Database of Systematic Reviews and Implementation Reports: March 2016 - Volume 14 - Issue 3 - p 139-180 doi: 10.11124/JBISRIR-2016-2314. **Available here**	The primary objective of this review was to systematically evaluate the effectiveness of mindful parenting programs in promoting children's, adolescents' and parents' wellbeing, particularly in relation to the intensity of symptoms associated with internalizing (depression, anxiety, stress) and externalizing (conduct) disorders. **The authors concluded that at present, there is insufficient evidence to conclude that mindful parenting programs can improve parents' and children's wellbeing because of the methodological quality of the few studies that met the inclusion criteria.**
	Mackenzie, K, and Williams, C. (2018). *Universal, school-based interventions to promote* *mental and emotional wellbeing: what is being done in the UK and does it work? A systematic review*. BMJ Open 2018; 8:e022560. doi:10.1136/ bmjopen-2018-022560. **Available here**	This systematic review aimed to assess the quality, content and evidence of efficacy of universally delivered (to all pupils aged 5–16 years), school-based, mental health interventions designed to promote mental health/well-being and resilience, using a validated outcome measure and provided within the UK in order to inform UK schools-based well-being implementation. **The current evidence suggests there are negligible to small effects of universal, school-based interventions in the UK that aim to promote emotional or mental well-being or the prevention of mental health difficulties.** Robust, long-term methodologies need to be pursued ensuring adequate recording of fidelity, the use of validated measures sensitive to

Intervention	Source	Brief summary of source
		mechanisms of change, reporting of those lost to follow-up and any adverse effects.
Specialist support (self harm)	National Institute for Health and Care Excellence. (2011). *Self harm in over 8s*. CG133. London: NICE. **Available here** **Guideline checked in 2019 and will be updated.**	This NICE clinical guideline offers advice on the longer term management of self harm. It is concerned with with the longer-term psychological treatment and management of both single and recurrent episodes of self-harm. It includes recommendations on assessment and interventions. It is relevant to health and social care professionals.
	Witt, KG et al (2021*). Psychosocial interventions for self-harm in adults*. Cochrane Database of Systematic Reviews. Issue 4. Art. No.: CD013668. DOI: 10.1002/14651858.CD013668.pub2. **Available here**	This systematic review assessed the effects of psychosocial interventions for self-harm (SH) compared to comparison types of care (e.g. treatment-as-usual, routine psychiatric care, enhanced usual care, active comparator) for adults (aged 18 years or older) who engage in SH. Overall, there were significant methodological limitations across the trials included in this review. **Given the moderate or very low quality of the available evidence, there is only uncertain evidence regarding a number of psychosocial interventions for adults who engage in SH. Psychosocial therapy based on Cognitive Behavioural Therapy (CBT) approaches may result in fewer individuals repeating SH at longer follow-up time points, although no such effect was found at the post-intervention assessment and the quality of evidence, according to the GRADE criteria, was low.**

Intervention	Source	Brief summary of source
		Given findings in single trials, or trials by the same author group, both Mindfulness Based Therapy (MBT) and group-based emotion regulation therapy should be further developed and evaluated in adults. Dialectical Behaviour Therapy (DBT) may also lead to a reduction in frequency of SH. Other interventions were mostly evaluated in single trials of moderate to very low quality such that the evidence relating to the use of these interventions is inconclusive at present.
	Witt, KG et al (2021). *Interventions for self-harm in children and adolescents*. Cochrane Database of Systematic Reviews. Issue 3. Art. No.: CD013667. DOI: 10.1002/14651858.CD013667.pub2. **Available here**	This systematic review assessed the effects of psychosocial interventions or pharmacological agents or natural products for SH compared to comparison types of care (e.g. treatment-as-usual, routine psychiatric care, enhanced usual care, active comparator, placebo, alternative pharmacological treatment, or a combination of these) for children and adolescents (up to 18 years of age) who engage in SH. **Given the moderate or very low quality of the available evidence, and the small number of trials identified, there is only uncertain evidence regarding a number of psychosocial interventions in children and adolescents who engage in SH. Further evaluation of DBT-A is warranted.** Given the evidence for its benefit in adults who engage in SH, individual CBT-based psychotherapy should also be further developed and evaluated in children and adolescents.

Intervention	Source	Brief summary of source
Skills development – support for young people to develop independent living skills	O'Donnell, R et al. (2020). *The impact of transition interventions for young people leaving care: a review of the Australian evidence*. International Journal of Adolescence and Youth. Vol.25, No 1, 1076-1088.DOI.org/10.1080/02673843.2020.1842216. **Available here**	The aim of this systematic scoping review was to examine the characteristics of interventions that support young peoples' transition from care and into independence, delivered in Australia, and to evaluate their impact. **The authors found that transitional programmes that provide long-term, consistent, and integrated coordinated support that is tailored to an individual's needs can foster improved independent living outcomes post-transition. However, to date, current interventions are less successful in targeting and improving health outcomes.** Given the adverse health outcomes for young people transitioning from care, it is essential that such programmes are adapted or developed to increase emphasis on facilitating improvements in health outcomes (e.g., mental, physical, and social health), in addition to fostering outcomes that are indicative of independent living (e.g., housing). The quality assessment for the 11 studies is as follows: a total of 8/11 studies (73%) were of high quality, and the remaining three studies were of low quality. All three quantitative studies were low in quality due to a high rate of nonresponse bias, a lack of valid, reliable, or pre-tested measurements, and statistical analyses were not often described nor justified. Contrastingly, all qualitative studies were of high quality due to adequate data collection methods and well supported interpretation of results. The mixed methods studies were of high quality as they provided an adequate rationale for adopting a mixed method

Intervention	Source	Brief summary of source
		design to address the research question, and integrated their interpretation of both qualitative and quantitative components into the results. The authors note some limitations of this study, notably small sample sizes and studies limited to one state within Australia. As the study was not conducted in the UK, its generalisability to a Wales/UK context is uncertain.
	Everson-Hock, E. et al. (2011). *Supporting the transition of looked-after young people to independent living: a systematic review of interventions and adult outcomes*. Child: care, health and development, 37(6), pp. 767-79. **Available here**	This systematic review aimed to synthesize evidence on the effectiveness of transition support services (TSSs) that are delivered towards the end of care for looked-after young people (LAYP) on their adult outcomes, including education, employment, substance misuse, criminal and offending behaviour, parenthood, housing and homelessness and health. **Taken as a whole, the available literature suggests that no real conclusions on the effectiveness of TSSs can be made at this stage due to mixed evidence in terms of positive, negative and neutral impact on outcomes and varying study quality, and because few formal evaluations of existing TSSs have been conducted.** Most were based on specific agency programmes and therefore have been small-scale, exploratory, non-random, retrospective and without comparison groups. Thus, although useful for programme planning, their utility for demonstrating programme effectiveness is highly limited.

Intervention	Source	Brief summary of source
Telecare and telehealth	Totten, AM et al. (2019). *Telehealth for Acute and Chronic Care Consultations*. Comparative Effectiveness Review No. 216. AHRQ Publication No. 19-EHC012-EF. Rockville, MD: Agency for Healthcare Research and Quality. **Available here**	The aim of this systematic review was to identify and summarize the available evidence on the effectiveness of telehealth consultations, and to explore using decision modelling techniques to supplement the review. **The authors concluded that in general, the evidence indicates that telehealth consultations are effective in improving outcomes or providing services, with no difference in outcomes; however, the evidence is stronger for some applications, and less strong or insufficient for others.** However, as specific details about the implementation of telehealth consultations and the environment were rarely reported, it is difficult to assess generalisability. Exploring the use of a cost model underscored that the economic impact of telehealth consultations depends on the perspective used in the analysis. The increase in both interest and investment in telehealth suggests the need to develop a research agenda that emphasizes rigor and focuses on standardized outcome comparisons that can inform policy and practice decisions.
	Karlsen, C et al. (2017). *Experiences of community-dwelling older adults with the use of telecare in home care services: a qualitative systematic review*, JBI Database of Systematic Reviews and Implementation Reports: Volume 15 - Issue 12 - p 2913-2980 doi:	The aim of this review was to identify and synthesize the best available qualitative evidence of community-dwelling older adults' experience with the use of telecare in home care services. **The authors found that experiences with the use of telecare are diverse. Findings indicate telecare systems can promote safety and security to age in place that is a wish of many older adults. However, "one size does not**

Intervention	Source	Brief summary of source
	10.11124/JBISRIR-2017-003345. **Available here**	**fit all"-** Telecare systems must fit individual needs, and be supported by service providers to accommodate sustainable use over time.
Volunteering	Stuart, J., et al. (2020) *The Impacts of Volunteering on the Subjective Wellbeing of Volunteers: A Rapid Evidence Assessment*. What Works Centre for Wellbeing and Spirit of 2012. **Available here**	This rapid evidence assessment (REA) examines what is known about the impacts of volunteering on the subjective wellbeing of volunteers. The review aims to support the work of practitioners, policy makers and funders in their design and delivery of volunteering opportunities and programmes. **Key findings**: The impacts of volunteering on subjective wellbeing: • Most of the evidence on the impacts of volunteering on the subjective wellbeing of volunteers points to a positive association between the two, including improved life satisfaction, increased happiness and reduced symptoms of depression. • The authors cannot definitively conclude, however, that volunteering categorically enhances subjective wellbeing. A small number of studies claim reverse causality – higher wellbeing makes individuals more likely to volunteer rather than volunteering causing higher wellbeing. • A number of studies use advanced statistical strategies and control for a range of factors that might affect subjective wellbeing, providing us with more

Intervention	Source	Brief summary of source
		confidence that volunteering leads to enhanced subjective wellbeing for volunteers. • This does not mean that volunteering always leads to improved wellbeing. • The evidence tentatively suggests that some volunteering activities can lead to anxiety, stress or burnout. • There is a significant gap in the evidence on the negative effects of volunteering on the wellbeing of volunteers.
	Husk, K. et al. (2016). *Participation in environmental enhancement and conservation activities for health and well-being in adults: a review of quantitative and qualitative evidence*. Cochrane Database of Systematic Reviews. Issue 5. Art. No.: CD010351. DOI: 10.1002/14651858.CD010351.pub2. **Available here**	This systematic review assesses the health and well-being impacts on adults following participation in environmental enhancement and conservation activities (EECA). **The authors concluded that there is little quantitative evidence of positive or negative health and well-being benefits from participating in EECA. However, the qualitative research showed high levels of perceived benefit among participants.** Quantitative evidence resulted from study designs with high risk of bias and qualitative evidence lacked reporting detail. The majority of included studies were programme evaluations, conducted internally or funded by the provider.
	National Institute for Health and Care Excellence. (2015). *Older people*	This NICE guidance covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older and how to identify those most at risk of a decline. It includes recommendations on volunteering.

Intervention	Source	Brief summary of source
	independence and mental wellbeing. NG32. London: NICE. **Available here** **Guidance is up to date (checked in 2018).**	
Transition support	National Institute for Health and Care Excellence. (2016). *Transition from children's to adults' services for young people using health or social care services*. NG43. London: NICE. **Available here.** **Guidance is up to date.**	This NICE guideline covers the period before, during and after a young person moves from children's to adults' services. It is relevant to both health and social care providers. The guideline includes recommendations on: • Overarching principles for good transition • Planning transition • Support before and after transfer • The supporting infrastructure for transition.
	Campbell, F et al (2016). *Transition of care for adolescents from paediatric services to adult health services*. Cochrane Database of Systematic Reviews, Issue 4. Art. No.: CD009794. DOI: 10.1002/14651858.CD009794.pub2. **Available here**	This systematic review evaluated the effectiveness of interventions designed to improve the transition of care for adolescents from paediatric to adult health services. The available evidence (four small studies; N = 238), covers a limited range of interventions developed to facilitate transition in a limited number of clinical conditions, with only four to 12 months follow-up. These follow-up periods may not be long enough for any changes to become apparent, as transition is a lengthy process.

Intervention	Source	Brief summary of source
		There was evidence of improvement in patients' knowledge of their condition in one study, and improvements in self-efficacy and confidence in another, but since few studies were eligible for this review, and the overall certainty of the body of this evidence is low, no firm conclusions can be drawn about the effectiveness of the evaluated interventions. There is considerable scope for the rigorous evaluation of other models of transitional care, reporting on clinical outcomes with longer term follow-up.