Department of Health & Social Care Reviews Facility
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What helps to support people affected by Adverse Childhood Experiences?

A review of evidence

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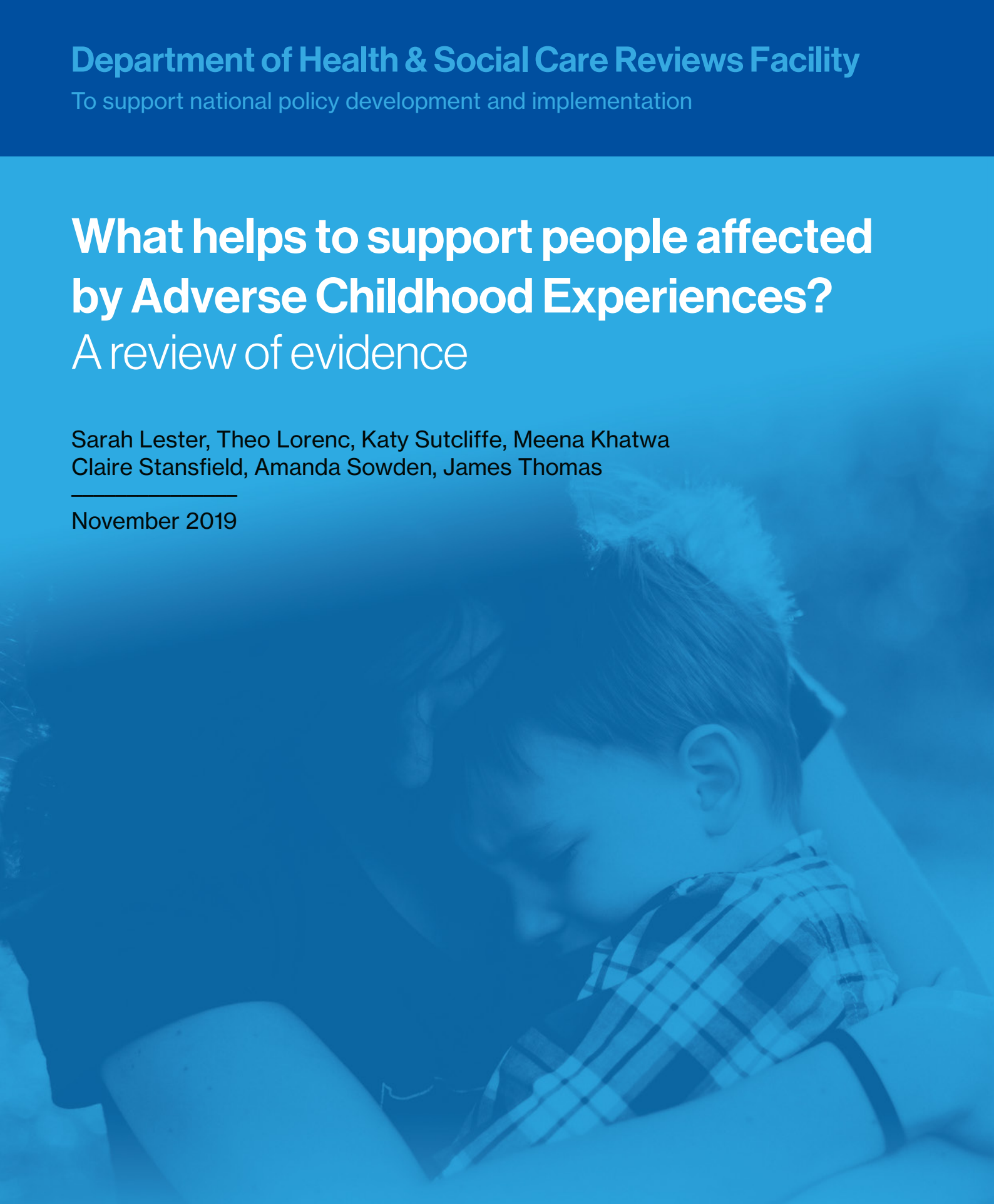

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ABBREVIATIONS	
ACE	**Adverse Childhood Experience**
CBT	**Cognitive Behavioural Therapy**
CDC	**Centers for Disease Control and Prevention**
EMDR	**Eye Movement Desensitisation and Reprocessing Therapy**
nRCT	**Non-Randomised Controlled Trial**
OoHC	**Out-of-Home-Care**
PTSD	**Post-Traumatic Stress Disorder**
RCT	**Randomised Controlled Trial**
RoB	**Risk of Bias**
RoR	**Review of Reviews (used to describe the systematic review of systematic reviews)**
SMD	**Standardised Mean Difference**
TAU	**Treatment as Usual**

GLOSSARY	
Externalising behaviours	**Maladaptive behaviours towards the environment, such as physical, aggressive, disruptive or oppositional behaviour**
Internalising behaviours	**Symptoms associated with anxiety and depression such as fearfulness and sleeplessness**
Limited evidence	**Findings based on less than three studies (as used in overview of interventions)**
Mixed results	**Results which are partly effective and partly not, either within primary studies (e.g. on different outcome measures within a single domain) or between primary studies in a review (as used in overview of interventions)**
Psychoeducation	**Interventions which aim to empower people by providing information and coping strategies to help them better understand and face their problems**
Psychosocial	**Psychological development in, and in interaction with, the social environment**

The words 'children' and 'young people' are used in a fluid sense in this report and at times are used as relational terms to parents and carers as opposed to solely denoting a person who is under the age of 18.

Executive Summary

Background

Adverse Childhood Experiences (ACEs) are defined as stressful experiences during childhood which may harm a child or negatively affect their living environment. ACEs include: physical, sexual or emotional abuse; neglect; domestic violence in the home; homelessness or living in care; parental mental health problems or substance abuse; and parents who are absent through imprisonment, separation or death. ACEs have been linked to a wide range of negative outcomes in later life.

Overall aims

The objective of the review was to gather, assess and present evidence on what helps to mitigate the harmful impacts of ACEs, or to promote positive outcomes, across the life course.

The project comprises three strands:

1. **Views synthesis:** a systematic review of UK qualitative evidence on the views and experiences of people affected by ACEs provides an in-depth exploration of the kinds of support that young people affected by ACEs find most helpful.
2. **Overview of interventions to support people affected by ACEs:** a systematic review of systematic reviews (RoR) on the effectiveness of interventions gives a broad overview of the best available systematic review evidence on interventions for people affected by ACEs.
3. **Stakeholder consultation:** consultation with seven young people with lived experience of ACEs provides a check on how relevant the evidence included in our reviews is to current experiences of young people affected by ACEs in the UK. Figure 1 below, illustrates the three strands of the work.

Figure 1: The three strands of the project

Review questions

For the **views synthesis** we sought to understand what people affected by ACEs in the UK feel are supportive and protective factors that help to mitigate the negative consequences of ACEs. We asked:

Q1) What are the impacts of ACEs on people's everyday lives?
Q2) What strategies do individuals employ to mitigate the negative impacts of ACEs?
Q3) What services are needed to address the negative impacts of ACEs?
Q4) How should services for people affected by ACEs be delivered?

For the **overview of interventions** we set out to answer the following review question:

Q5) What is known from systematic reviews about the effectiveness of interventions for children and young people (3-18 years) who have been exposed to Adverse Childhood Experiences (ACEs)?

For the **stakeholder consultations** we held open-ended discussions with the young people to consider:

Q6) What are the kinds of problems they experience?
Q7) How might ACEs affect young people differently?
Q8) What types of support do they feel would help them to overcome these issues?

Methods

For the views synthesis we identified relevant studies from within existing systematic reviews of qualitative research relating to ACE populations. We included qualitative studies published in or after 2008 reporting the views of people from the UK exposed to ACEs about coping and/or resilience. We appraised study quality and relevance; appraisals were translated into an overall 'usefulness' rating. Studies that attained a 'gold standard' or 'high' usefulness rating were included in the synthesis. We extracted information on the study aims, participants, key themes and findings. We used thematic synthesis to inductively code, compare and interpret study findings.

For the overview of interventions we applied a systematic review of reviews (RoR) methodology to summarise evidence from existing systematic reviews on the effectiveness of any intervention to improve any outcome for people exposed to ACEs in childhood (age 3-18). Data on the prevention of ACEs were not included. We searched 23 database sources for systematic reviews published from 2007 to March 2018. We used a 'best evidence' methodology whereby only reviews meeting a minimum quality threshold were included in the synthesis. We conducted a narrative synthesis categorised by intervention type.

For the stakeholder consultations we held a three-hour workshop with seven young people aged 16-24 years from UK with lived experience of ACEs. In the workshop we held open-ended discussions about the kinds of problems they experience and the types of support that they feel would help them to overcome these issues. We worked with a specialist in stakeholder engagement with young people to develop a series of activities to enable and encourage young people's participation in the discussions.

Findings

What helps to support young people affected by ACEs?

Despite the complexities and variations of ACE impact, we found commonalities in terms of people's experiences and needs. As such, the evidence review suggests that the ACE construct provides a meaningful framework for professionals working with young people, parents and families.

However, when comparing the evidence on people's experiences and needs with the evidence from the overview of interventions we identified several areas of discordance which hinders the possibility of definitively addressing the question of what helps to support young people affected by ACEs.

Whilst the current systematic review evidence base on interventions shows that crisis-point services such as psychological therapies may provide some short-term benefits for people affected by ACEs, these types of interventions don't reflect the kinds of services that the qualitative evidence suggests are needed to address the extent and complexity of their needs.

Views synthesis findings

21 qualitative studies were included in our thematic synthesis which addressed the following questions:

What are impacts of ACEs on people's everyday lives?

The most profound impacts of ACEs appear to be on people's social wellbeing. Low self-esteem, emotional distress and mental health problems compromised people's sense of self. Adverse experiences often led to harbouring low expectations and issues around trusting others and problems in forming and maintaining relationships. Alongside a fear of being judged or blamed and institutional prejudices this fed into social isolation. Practical obstacles, such as financial hardship, being a young carer, and inconsistent care placements and schooling were also noted.

What strategies do individuals employ to mitigate the negative impacts of ACEs?

Three key strategies emerged – coping, dealing and sharing. Coping related to internal strategies to manage emotions such as anger or guilt. Dealing related to practical strategies young people employed to deal with adversities in their lives. These comprised both positive and negative ways of responding to adverse experiences such as health-harming behaviours as a way to cope with emotions or taking pride in supporting and caring for other family members. Sharing involved seeking help or support from others. Tacit understanding from peers or adults and safe 'silent' spaces played a vital role in meeting the needs of people affected by ACEs.

What services are needed to address the negative impacts of ACEs?

Services were conceived as needing to 'fill the gaps' left by ACEs (emotional and practical).

Emotional support: Services were seen by some young people as being important for fostering peer support through, for example, group therapy sessions. A need for support from trusted adults was highlighted. Effective and valued service providers were described as displaying empathy, being non-judgemental, and being active listeners.

Practical support: Forms of practical support included: information to help people understand and address their problems; help to manage everyday challenges such as engaging with the school or benefits system; and respite from the challenges faced.

How should services for people exposed to ACEs be delivered?

Widespread scepticism about services and providers suggest that the ways in which services are delivered may be critical to their uptake. Efforts to foster trust by service providers were seen as a necessary precursor to developing effective relationships. Continuity and dependability of service providers helped to engender trust by enabling understanding and individualised care. Young people valued being involved in the discussions and decisions that affect them as well as having some flexibility and control over how they were supported. Supportive relationships with professionals are key to effective engagement and delivery.

Overview of interventions findings

A total of 98 reviews met the inclusion criteria for the overview; these were then quality-assessed. Thirty-one reviews met our quality threshold and were included in the synthesis. The reviews covered all ACE populations, with most evidence on looked-after children and young people, and children who have been sexually abused.

The bulk of the data focuses on individual psychological interventions and on mental health or behaviour outcomes. These data indicate that there is good evidence for the effectiveness of the following for at least some populations: cognitive behavioural therapy and other psychological therapies for mental health outcomes; psychoeducation for mental health outcomes; and parent or foster carer training for behaviour outcomes.

However, there is a limited amount of evidence, and more mixed findings, on interventions which address the broader contexts of children's and young people's lives, including: interventions aimed at parents; cross-sector support; housing and life skills interventions; and educational interventions. There is also limited evidence on broader outcomes such as social functioning or life circumstances.

Stakeholder consultation

Discussions with the young people about the kinds of problems they experience, how ACEs affect young people differently, and the types of support that would help them to overcome these issues generated the following main themes:

- The inflexibility of the school system and teachers' lack of understanding
- The impact of ACEs varies depending on various factors such as: gender, stage of life, family structure, geographic location, socioeconomic and ethnic background
- Practical skills and community recreation help to improve confidence and self-care
- Limitations of counselling therapies

Discussion

Despite the complexity of the impact of ACEs people described common needs and experiences. However, when comparing the evidence on people's experiences and needs with the evidence about available interventions areas of discordance were identified:

First, the importance of day-to-day practical and emotional support underpinned by relationships with a trusted adult (or mentor/ peer(s)) was consistently highlighted in the qualitative evidence. By contrast, the evidence relating to interventions focused on individualised 'crisis point' approaches. In the short term these psychological interventions did improve mental health but failed to address the multifaceted and ongoing needs identified by young people in the views synthesis and the stakeholder work.

Second, whilst the views evidence highlighted that young people valued consistency and stability, many of the interventions evaluated in systematic reviews were short-term in nature and so were unable to address this need. While we included adult survivors and interventions to retrospectively address ACEs in our scope, very few studies took this approach.

Third, whilst the qualitative evidence revealed that children and young people felt the attributes of supportive adults were more important for providing effective support than their professional role, the interventions evaluated in the systematic reviews tended to be delivered by staff otherwise unknown to the young person in community or clinical settings.

Our findings suggest that ACE populations tend to be studied in isolation, so there is a need for research on how ACEs cluster. Similarly, there was a lack of research on interventions that empower young people affected by ACEs by helping to build life skills. The importance of relationships with a trusted adult is key to both emotional and practical support and so evidence on efforts to foster such relationships would also be highly valuable.

1 Background

1.1 Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) have been defined as stressful experiences occurring during childhood that directly harm a child or affect the environment in which they live. They represent a variety of negative experiences in the home during childhood; for example, physical and sexual abuse, and emotional and physical neglect; or growing up in a house with a poor family environment as a result of domestic violence, imprisonment, substance abuse or family breakdown (Bellis et al., 2015a).

1.2 The impact of ACEs

Exposure to childhood maltreatment and adverse environments can cause toxic stress that may affect children's brain development, especially in the early years, but also into adolescence (Keverne, 2014, Sethi et al., 2013). ACEs have been associated with lasting changes in nervous, endocrine and immune systems which are observable in childhood and persist into adult life (Danese and McEwen, 2012). These resulting significant biological changes in children can exert long-term effects on health across the life-course, such as long-term morbidity from non-communicable disease (Danese and McEwen, 2012). Through differences in physiological development and uptake of health-harming and risk-taking behaviours, individuals who experience ACEs are at greater risk of poor mental and physical health outcomes, and even premature mortality, compared with those who do not experience ACEs (Bellis et al., 2015b, Danese and McEwen, 2012).

1.3 The extent of ACEs in the UK

Studies in the UK have found that around 47% of the population report at least one ACE; 24% to 27% report more than one, and 8% to 14% report at least four (Bellis et al., 2015a, Bellis et al., 2014). The most commonly reported ACEs in these studies were verbal abuse and parental separation, with parental incarceration and drug use the least common; however, even the latter have a prevalence of around 4%. Data from the USA show similar or somewhat higher prevalence rates (Felitti et al., 1998, Dong et al., 2004).

The different ACEs appear to be highly correlated, with people reporting one ACE much more likely to also report others (Dong et al., 2004, Dong et al., 2003, Dube et al., 2001, Dube et al., 2002, Ford et al., 2014). Clustering of ACEs is strongly linked to socioeconomic disadvantage; Bellis and colleagues' findings indicate that the proportion of people experiencing four or more ACEs is almost three times as high in the most deprived quintile of neighbourhoods as in the least deprived, although it should be borne in mind that there is also substantial prevalence in middle and higher quintiles, and most people exposed to multiple ACEs are not in the most deprived segment (Bellis et al., 2015b). Experiencing multiple ACEs is associated with much higher risk of ill-health (Hughes et al., 2017). As well as these cross-sectional correlations, there is some evidence for inter-generational transmission of ACEs. That is, children and young people who are exposed to ACEs are at higher risk of perpetrating violence or abuse, and of developing substance abuse and mental health problems, as adults (Capaldi et al., 2012, Whitaker et al., 2008, Costa et al., 2015).

Research on ACEs has proliferated over the past ten years, with year on year increases between 2010 and 2018 (see figure 2).

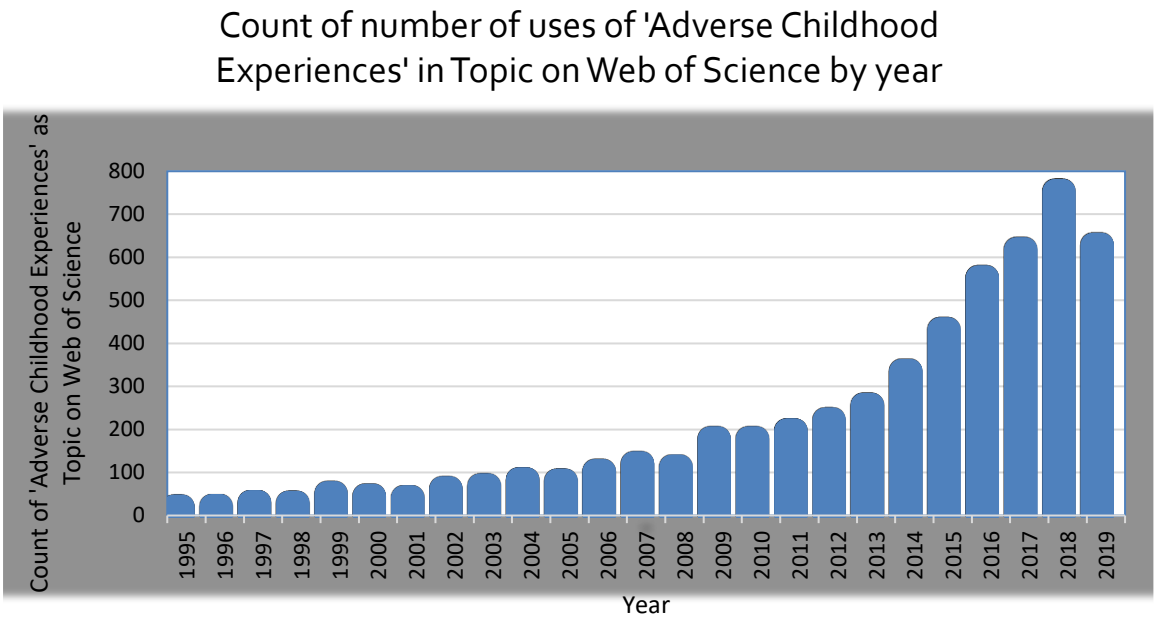

Figure 2: Count of number of uses of 'Adverse Childhood Experiences' on Topic in Web of Science by year (produced August 2019). Web of Science is a platform which provides access to a wide range of interdisciplinary databases.

The distribution and consequences of ACEs are now reasonably well documented, although it is worth noting that there may be additional confounding factors which have not been measured or controlled for in the epidemiological research. While we know those exposed to ACEs are at greater risk of poorer health, less is known about what works to prevent or mitigate these negative consequences or to promote positive outcomes. Previous reviews have looked at specific ACE populations but have not covered the whole spectrum of ACEs (one previous review (Korotana et al., 2016) aimed to cover all ACE populations, but in practice mainly looks at abuse and neglect).

There is a need for a broad overview of evidence on what helps to support people affected by ACEs, and an understanding of how relevant available systematic review evidence is to the current UK context. A synthesis of UK views will help to generate understanding of how ACEs affect people in their everyday life and to give a clearer picture of the types of support that will best address their needs. A broad review of evidence will also help us to understand how significant the gaps in the current evidence base might be.

1.4 Definitions of ACEs

The concept of ACEs is hard to define in terms of a specific list of populations (Kalmakis and Chandler, 2014). Consequently, and problematically, researchers have not always applied consistent definitions of ACEs in their work (McLaughlin, 2016).

The term ACEs was first popularised by the Centers for Disease Control and Prevention (CDC)'s large-scale epidemiological study (Felitti et al., 1998). The CDC definition includes psychological or physical abuse, sexual abuse, violence towards the mother, and living with household members who were imprisoned, problem drinkers or drug users, or had a mental health problem. Broadly, these can be divided into two overarching categories of abuse and neglect on one hand, and household adversity on the other.

More recent UK research has adopted a slightly broader definition, including child neglect and parental bereavement, and looked-after children (Allen and Donkin, 2015). Our definition was informed by this work.

Through discussions with the DHSC we included children and young people who are homeless to our definition of ACEs.

We used the most recent definition of domestic violence - encompassing, but not limited to, physical, psychological, sexual, financial and emotional abuse and controlling, coercive or threatening behaviours (Home Office, 2013)).

For children and young people living in care, also referred to as looked-after children, we defined this as living either in a care setting or elsewhere, including kinship care. We did not include adopted children within our definition. We acknowledge that being placed in care can of course be a protective factor in young people's lives. However, while not necessarily an adversity in and of itself, there is a high likelihood of ACEs leading to a care placement, alongside the potential trauma resulting from separation from family members and displacement.

For the full definition of ACEs that we adopted for this review see Section 2.2.

1.5 Policy in the UK

Preventing and addressing ACEs are current policy priorities in Scotland and Wales. Public health authorities in both countries have established ACEs 'Hubs'(Adverse Childhood Experiences, NHS Health Scotland; and ACE Support Hub, Cymru Well Wales) to promote shared learning around ACEs research and practice. An inter-agency, holistic approach which advocates prevention and early help for those affected by ACEs are at the centre of both government's agendas (A Nation with Ambition: the Government's Programme for Scotland 2017-18 (2017); Couper and Mackie (2016); Well-Being of Future Generations (Wales) Act 2015).

While there has been recognition of the need to address ACEs in order to improve children's and young people's health outcomes (Lemer et al. 2012), UK policy regarding ACEs beyond the devolved nations appears to be more piecemeal. Co-operation between agencies to promote children's wellbeing is a statutory obligation under Section 10 of the Children Act 2004. This forms a core part of many policy initiatives which could be, at least partially, linked to ACEs, such as the *Troubled Families Programme* (Department for Communities and Local Government, 2017). *Working Together to Safeguard Children* (Department for Education, 2018) sets out the government's plan for the replacement of Local Safeguarding Children Boards with a new system of multi-agency arrangements as established by the Children and Social Work Act 2017.

The *Transforming the Response to Domestic Abuse: Consultation Response and Draft Bill* (HM Government, 2019) shows how responses to domestic abuse can be improved by working across agencies and intervening at the earliest opportunity. Notably, it fully acknowledges the potential harm that exposure to domestic abuse can have on children. This is in line with the Serious Crime Act 2015 which made it explicit that cruelty to children which causes psychological suffering can be a crime.

1.6 Debates around the ACE framework

There are many contested areas within ACE discourse. The ACE questionnaire - which was first applied by Felitti et al. (1998) to retrospectively study the relationship of ACEs to disease in adulthood, has been criticised for comprising subjective, self-report measures which do not take into account timelines, context, or the severity and frequency of adverse experiences (Mersky et al.,2017, Corcoran and McNulty, 2018).

The individualised use of the ACEs questionnaire or checklist in health,social care, policing and education practice, which is still in its infancy, has raised ethical concerns. While routine enquiry into ACEs may serve as a potentially useful way to understand a person more holistically, for example, to improve health visitors' understanding of new mothers and their families (Hardcastle and Bellis, 2019), it also warrants the question of

how people are expected to act after the enquiry (Kelly-Irving and Delpierre, 2019). In his critique of ACE screening practices Finkelhor warns of the dangers of not having adequate resources and training in place to respond appropriately to the unearthing of past, potentially traumatic, childhood experiences (Finkelhor, 2018).

Research into the (mis)application ACEs in practice is yet to keep up with the epidemiological studies and little is known about the unintended harm this could bring to both children and adults. The usefulness, limitations and risks of screening for ACEs, for example using four ACEs as a threshold for providing interventions, require much closer scrutiny and consideration (Bateson et al. 2019).

Academics have criticised the proliferation of fatalistic narratives around ACEs, which tend to reference deterministic, rather than probabilistic, links between ACEs and poorer later life outcomes. An overemphasis on 'faulty' neurodevelopment and irrevocable damage risks pathologising and stigmatising children and families unnecessarily through misuse of the evidence (White, 2018). Callaghan (2019) argues that through reducing adversity to an atomised family level devoid of wider social or economic factors, the ACE concept fuels a 'failure to protect', victim-blaming culture which disproportionately affects mothers. Kelly-Irving and Delpierre (2019) also recognise the potential dangers around individualising ACE-related problems which are likely to be socially complex, and argue that interventions must be aimed at the structural social context in which children are exposed to ACEs rather than placing responsibility on the individual or family level.

2 Brief methods

The objective of this evidence review is to synthesise evidence on what helps to support people affected by Adverse Childhood Experiences. The project comprises three strands:

1. **Views synthesis:** a systematic review of UK qualitative evidence on the views and experiences of people affected by ACEs, providing an in-depth exploration of the kinds of support that young people affected by ACEs find most helpful.
2. **Overview of interventions to support people affected by ACEs:** a systematic review of systematic reviews (RoR) on the effectiveness of interventions, giving a broad overview of the best available systematic review evidence on interventions for people affected by ACEs.
3. **Stakeholder consultations:** consultation with seven young people affected by ACEs, providing a check on how relevant the research evidence is to current experiences in the UK.

This chapter provides a brief overview of the methods used to conduct these three strands of work. A more detailed account of the methods for each strand is provided in Section 7.

2.1 Policy stakeholder engagement

Reviews Facility team members (SL, TL and KS) met regularly with DHSC policy analysts and representatives from Public Health England (PHE) to ensure the review remained closely aligned with their needs and emerging policy requirements.

2.2 Concepts and definitions used in this review

We adopted the definition of ACEs used by the US Centres for Disease Control (CDC) (Felitti et al., 1998) which covers categories of abuse, neglect and household adversity (i.e. adversity affecting household members directly, and children or young people indirectly). Based on the findings of more recent UK research we extended this definition to include children affected by parental bereavement and looked-after children (Allen and Donkin, 2015). In addition, based on discussions with the policy team, we included homeless children and young people. Thus, our definition of ACEs included:

- Abuse and neglect:
    - sexual abuse
    - physical abuse
    - verbal or emotional abuse
    - neglect
- Household adversity, where a parent or guardian:
    - is a victim of intimate partner violence
    - is in prison or on probation
    - has a mental health problem
    - abuses alcohol or drugs
    - is separated or divorced
    - has died
- Children and young people living in care
- Homeless children and young people.

2.3 Review questions

For the views synthesis we asked:

Q1) What are the impacts of ACEs on people's everyday lives?
Q2) What strategies do individuals employ to mitigate the negative impacts of ACEs?
Q3) What services are needed to address the negative impacts of ACEs?
Q4) How should services for people affected by ACEs be delivered?

For the overview of interventions we asked:

Q5) What is known from systematic reviews about the effectiveness of interventions for children and young people (3-18 years) affected by ACEs?

For the stakeholder consultations we asked young people:

Q6) What are the kinds of problems young people experience?
Q7) How might ACEs affect young people differently?
Q8) What types of support would help young people overcome these issues?

2.4 Study identification

Systematic reviews were the source of evidence for both the views synthesis and the overview of interventions. The views synthesis used reviews as a means to identify primary qualitative studies from the UK; the synthesis is based on the findings of the primary studies. For the overview of interventions we used the findings of reviews themselves as the source of evidence.

Step 1: Searching for systematic reviews

To identify relevant systematic reviews we searched 18 electronic bibliographic databases in March 2018. The databases cover research on healthcare, mental health, social care, social science, education, child and adolescent development, and systematic reviews. We also searched five online resources including NHS Evidence, and identified relevant reviews within two NICE guidelines (NICE 2016, NICE 2017). The full details of search sources are reported in Section 7. An example search strategy is reported in Appendix A.

Step 2: Screening reviews for inclusion

We screened the titles and abstracts of all references identified by our searches using the following criteria:

1) Is the reference a systematic review?
2) Does the review report effectiveness, cost-effectiveness or qualitative data?
3) Does the review include (an) ACE population(s)?
4) Does the review examine interventions for people affected by ACEs? (overview of interventions)
5) Does the review report outcomes for children or young people (aged 3-18, or adults who experienced ACEs between those ages) affected by ACEs? (overview of interventions)
6) Does the review report data from OECD member countries?
7) Is the review report available in English?
8) Was the review published in 2007 or later?
9) Is a full report of the review available?

Full reports of all references meeting the criteria, or where it was unclear whether they met the criteria, were retrieved and re-screened using the full text. Further detail on these criteria and the screening process can be found in Section 7.

Step 3: Extracting primary studies for the views synthesis

As noted above, for the views synthesis the identified systematic reviews were used as a resource to identify UK-based qualitative studies. The references of all potentially relevant studies included in qualitative systematic reviews were extracted and imported into EPPI-Reviewer software for further screening.

2.5 Critical appraisal of included studies

Views synthesis: Included studies were appraised using quality and relevance criteria developed and used in previous reviews conducted by the DHSC Policy Reviews Facility (Rees et al. 2009; Shepherd et al. 2010) and informed by principles of good practice for conducting social research with the public (Harden et al. 2004). An overarching rating of study 'usefulness' was made based on the assessments for both reliability and relevance. Due to a large number of studies on looked-after children we included only studies achieving a 'gold standard' usefulness rating, for other ACE populations we included studies receiving either a 'high' or 'gold standard' usefulness rating. Further details on the process can be found in Section 7. The full appraisal tool can be found in Appendix B.

Overview of interventions: The AMSTAR tool was used to assess review quality (Shea et al., 2017). We translated the AMSTAR results into an overall score out of 11 (see Appendix C for details of scoring system). We categorised reviews according to the ACE populations included and then used the following procedure to include reviews in the synthesis: in a first stage, only reviews with a score of 5.5 or higher were included; in a second stage, where a population had no reviews with a score of 5.5 or higher, we included the single highest-scoring review for that population. Remaining reviews were not data-extracted or included in the synthesis.

2.6 Data extraction and synthesis

Views synthesis: We used a standardised form to extract details from each study including the aims, participant numbers and characteristics. Thematic synthesis (Thomas and Harden 2008) was used to inductively code and describe the findings (i.e. participant quotes, author descriptions and author discussion and conclusion points). Three reviewers independently extracted data and created codes reflecting identified themes (SL, KS, MK). We read and re-read papers and applied line-by-line coding to capture descriptive themes. Frequent meetings were held to discuss and refine emerging themes and findings, and to identify analytic themes.

Overview of interventions: We used a standardised form to extract data from each review about search dates, review questions, included study designs, populations and outcomes. A narrative synthesis was undertaken: where we grouped data according to the types of intervention and the types of outcome (mental health, behaviour, social and family outcomes).

In an attempt to distil and communicate this complex set of evidence we have produced a summary statement about the overall findings and key findings statements. Summary statements indicate the number of reviews, the populations covered and the overall direction of evidence.

Key findings statements are based on the single review which provided the highest quality and most reliable evidence for each population. Quality was determined by AMSTAR score and considered in combination with several other factors. Where several reviews cover the same population, intervention type and outcome category, findings are based on the highest-quality (and from the more recent if reviews have the same quality score), or on the highest-quality review which conducted meta-analysis (if the highest-quality review did not and another review did).

The phrase 'limited evidence' is used to characterise findings based on less than three studies. The phrase 'mixed results' is used to characterise results which are partly effective and partly not, either within primary

studies (for example, on different outcome measures within a single domain) or between primary studies in a review.

2.7 Stakeholder consultations

For the stakeholder consultations we worked with a specialist in stakeholder engagement with young people. We recruited young people through professional and social media networks, and by making contact with mentors and engagement and policy leads at relevant organisations.

We held a three hour workshop with seven young people aged 16-24 years from UK with lived experience of ACEs in May 2018.

Working alongside our specialist we developed a series of activities to enable and encourage young people's participation in the discussions.

Discussion was open-ended and facilitated in a way which allowed for either written, verbal, individual or group contribution; or a mixture of all of these modes. Discussion was informal and free-flowing but was structured around the following broad questions:

Q1) What kinds of problems might young people affected by ACEs experience?
Q2) How might ACEs affect young people differently?
Q3) What types of support would help to overcome these problems?

3 Views synthesis: Supportive and protective factors identified by people affected by Adverse Childhood Experiences

This section presents the findings from the views synthesis. Sections 3.1 and 3.2 describe the flow of literature and the studies which we included. Our full synthesis is presented in Section 3.3.

3.1 Flow of literature through the review

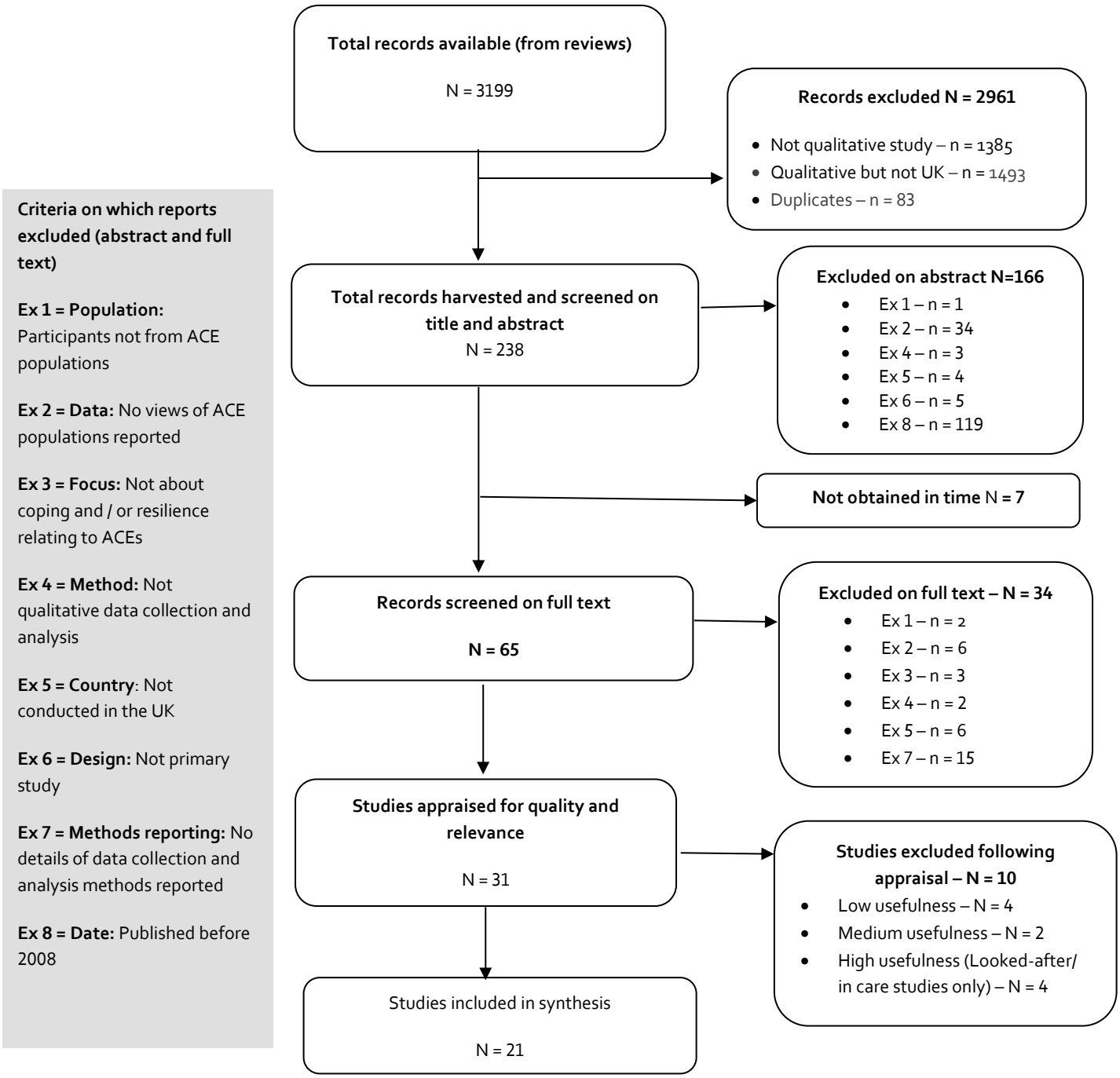

Figure 3: Flow of literature through the views synthesis review

We checked 3199 references contained within 71 reviews and identified 238 references that were potentially UK-based qualitative studies. We screened the titles and abstracts for these references and attempted to retrieve the full texts for 72 potentially relevant studies. Of these we were able to retrieve 65 in time to conduct our analyses. Following full-text screening 31 studies were appraised for quality and relevance, resulting in 21 studies being included in our views synthesis. A list of excluded studies can be found in Appendix D. A diagram showing the flow of literature through the review is presented above in Figure 2.

3.2 Details of included studies

This section provides a brief overview of the 21 included views studies. Details of individual studies can be found in Appendix E and they are presented in table 1 in Section 3.2.3.

3.2.1 *Topic focus of studies*

The studies had different aims or foci. Many sought to explore views about a particular service (n=8) or intervention such as childhood bereavement services, therapy for sexual abuse survivors or social services in general. Some focused on the experience of living with ACEs (n = 6) whilst others focused on the impact of ACEs on specific areas of people lives including their self-identity (n=5), education (n=1) or health needs (n=1).

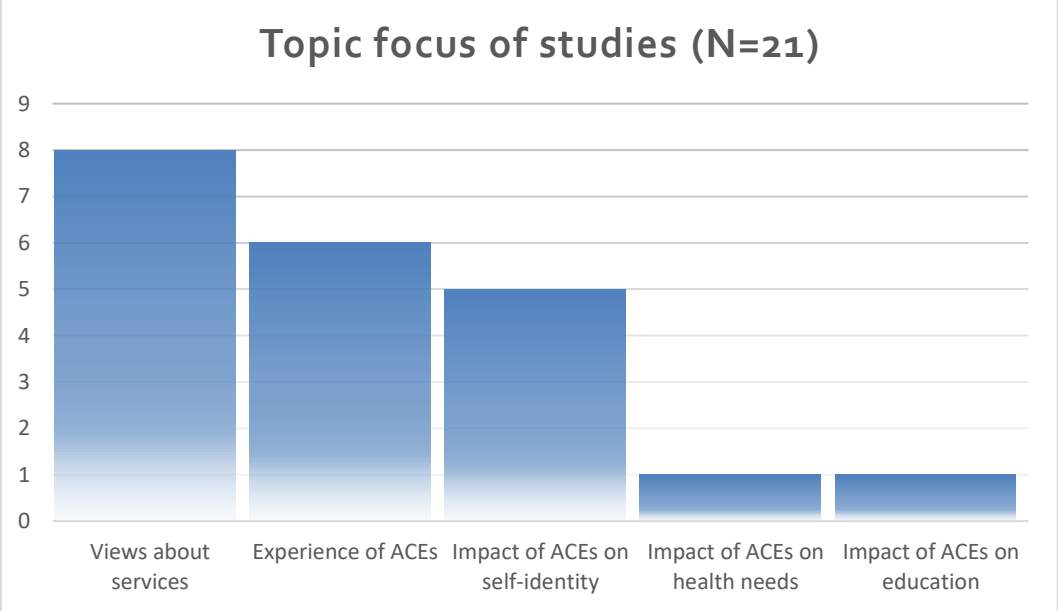

Figure 4: Topic Focus of studies in views synthesis

3.2.2 *Characteristics of study participants*

276 people were included across the 21 studies. Sample sizes ranged from four to 50 participants with most studies having between 10 and 25 participants. Six studies included the views of parents or service providers but findings reported here relate exclusively to the characteristics and views of participants with direct experience of ACEs.

ACE populations

Each study focused on a specific ACE population. Whilst some studies indicated that participants may have experienced multiple ACEs only one provided details and no study had a stated aim to focus on participants with multiple ACEs. Almost half of the studies focused on young people who were fostered, looked-after or leaving care (n=9). Other studies focused on people who had experienced: sexual abuse (n=3); parental mental illness (n=3); parental drug and alcohol misuse (n=2); exposure to domestic violence (n=1); abuse (unspecified) (n=1); parental bereavement (n=1); and homelessness (n=1). No studies focused on people who had experienced parental incarceration or divorce.

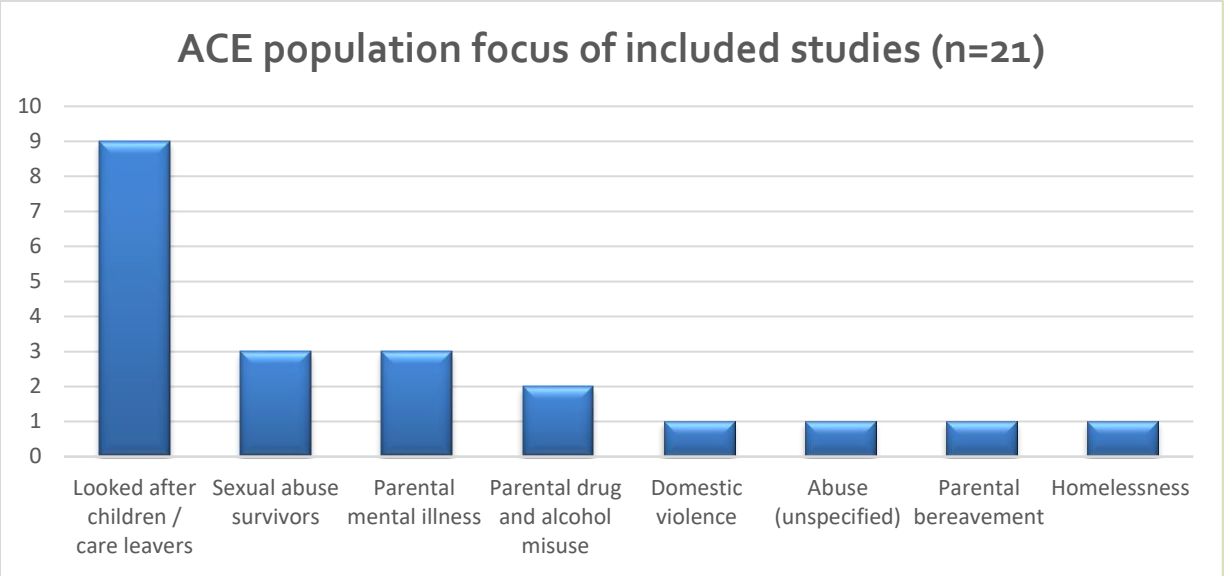

Figure 5: ACE population focus of included studies in views synthesis

Participants' age, ethnicity, sex and socioeconomic status

Most studies focused on young people (n=18), while a small number focused on adult survivors of child sexual abuse (n=3). Of the studies that focused on young people eight focused predominantly on older adolescents and care leavers (i.e. those aged 16 years or older), seven focused predominantly on senior school-aged children (i.e. those aged 11-16 years) and just two studies included younger participants aged below 11 years. One study on young people did not specify their ages.

With regards to ethnicity nine studies did not specify the ethnicity of participants, six reported their participants to be exclusively white British and the remaining six reported participants from a range of ethnic backgrounds. One study specifically focused on the experience of young people from a minority ethnic background.

17 studies included both males and females, while three studies focused on females only. One study did not report the sex of participants.

The socioeconomic status of participants was not stated in 17 studies. The remaining five focused on the employment status of participants (n=3) or their parents (n=2) to indicate socioeconomic status. Four studies included participants with a range of socioeconomic backgrounds, whilst the fifth which focused on homeless young people stated that all participants were unemployed.

3.2.3 *Table of included studies (n=21)*

The following table provides the numbers used to refer to studies throughout our analysis below (detailed evidence tables can be found in **Appendix E)**:

N	AUTHOR(S)	STUDY TITLE
1	**Barn**	Care leavers and social capital: understanding and negotiating racial and ethnic identity.
2	**Bee et al.**	Defining quality of life in the children of parents with severe mental illness: A preliminary stakeholder-led model.
3	**Brewer & Sparkes**	Young people living with parental bereavement: insights from an ethnographic study of a UK childhood bereavement service.
4	**Chouliara et al.**	Talking therapy services for adult survivors of childhood sexual abuse (CSA) in Scotland: Perspectives of service users and professionals.
5	**Collins & Barker**	Psychological Help-Seeking in Homeless Adolescents.
6	**Driscoll**	Supporting care leavers to fulfill their educational aspirations: Resilience, relationships and resistance to help.
7	**Fraser et al.**	Exploring the Impact of Parental Drug/Alcohol Problems on Children and Parents in a Midlands County in 2005/06.
8	**Gaskell**	"If the social worker had called at least it would show they cared". Young care leaver's perspectives on the importance of care.
9	**Grant et al.**	Young people supporting parents with mental health problems: Experiences of assessment and support.
10	**Griffiths et al.**	Living with parents with obsessive—Compulsive disorder: Children's lives and experiences.
11	**Houmoller et al.**	Juggling Harms: Coping with Parental Substance Misuse.
12	**Jobe & Gorin**	'If kids don't feel safe they don't do anything': young people's views on seeking and receiving help from Children's Social Care Services in England.
13	**Katz**	Beyond the physical incident model: How children living with domestic violence are harmed by and resist regimes of coercive control: Children's experiences of coercive control.
14	**Luke & Coyn**	Fostering self-esteem: Exploring adult recollections on the influence of foster parents.
15	**Madigan et al.**	Feeling the same or feeling different? An analysis of the experiences of young people in foster care.
16	**Matthews & Sykes**	Exploring health priorities for young people leaving care.
17	**McMurray et al.**	Shards of the old looking glass: Restoring the significance of identity in promoting positive outcomes for looked-after children
18	**Montgomery et al.**	Feminist narrative study of the maternity care experiences of women who were sexually abused in childhood
19	**Munro et al.**	Evaluation of the staying put: 18+ family placement programme: Final report.
20	**Saha et al.**	A narrative exploration of the sense of self of women recovering from childhood sexual abuse
21	**Winter**	The perspectives of young children in care about their circumstances and implications for social work practice

Table 1: Numbers and references of studies included in the views synthesis

3.3 Findings

Summary of views synthesis findings

- Q1: What are the impacts of ACEs on people's everyday lives?

The most profound impacts of ACEs appear to be on people's self-identity and their relationships with others. Practical obstacles, such as financial hardship and being a young carer were also noted.

- Q2: What strategies do individuals employ to mitigate the negative impacts of ACEs?

Three key strategies for mitigating the impact of ACEs emerged – coping, dealing and sharing. Coping related to internal strategies to manage emotions such as anger or guilt. Dealing related to practical strategies young people employed to deal with adversities in their life. Sharing involved seeking help or support from others.

Q3: What services are needed to address the negative impacts of ACEs?

Services were conceived as needing to 'fill the gaps' left by ACEs. Gaps were identified in relation to both emotional and practical support.

- Q4: How should services for people exposed to ACEs be delivered?

Supportive relationships with professionals were felt to be key to effective engagement and delivery. Effective relationships with professionals were undermined where trust, dependability and continuity were lacking.

The following sections provide our detailed findings in relation to each of the four questions.

3.4 Q1: What are impacts of ACEs on people's everyday lives?

To provide some context for understanding approaches to coping and resilience (Q2), and to highlight needs with regards to services (Q3 and Q4) we first examined the perceived negative impacts of ACEs on people's lives. The most profound impacts of ACEs appeared to be on people's self-identity and relationships with others. Three key themes were identified - a compromised sense of self; compromised relationships with others; and compromised relationships with society - illustrating how people perceived ACEs as undermining their social wellbeing at various levels.

3.4.1 *Compromised Sense of Self*

ACEs were felt to cause emotional distress, low self-esteem and mental-health problems all of which compromised people's sense of self.

3.4.1.1 <u>Emotional distress: 'there are lots of things that you bottle up'</u>

People affected by ACEs experience a complex mixture of emotions such as stress[2,6], disappointment[5,7,9], shame[5,10,11,18,20], guilt[3,14,18,20,21] and "a lack of belongingness"[1].

Anger and sadness were the most commonly reported responses to a range of adversities: a parent's death[3]; parents' drinking or addictive behaviours[7,11] ; being homeless and shunned by family and friends[5]; and the social restrictions imposed through domestic abuse[13]. Emotions were described as building up and, at times, overflowing; a young person who was parentally bereaved explained that without the necessary outlet *"there are lots of things that you bottle up"* [3] (p.286).

Young people in foster care described various emotions that affected their identity[14-17], namely feelings of *"powerlessness, […] jealousy, hopelessness, feeling 'weird' and feeling out of place"* [15] (p.399). The act of being placed in foster care provoked feelings of rejection: *"I felt unwanted, I felt useless"* [14] (p. 405). Feelings of being let down, betrayed and neglected ran through the narratives:

> *"She wasn't sorry for being drunk the morning after … it was a bit upsetting really [when Mum was drinking] because she wasn't really there like she was before … I went up [to the pub] and found her drunk and she wouldn't come home. I was angry with her."* [11] (young person, p.855).

3.4.1.2 Low self-esteem: 'I don't do well with positive stuff'

Participants in ten studies spoke about having low self-esteem[2,4,5,12,14-16,18,20,21]. This manifested itself in various ways, such as: self-hatred, feeling undeserving of happiness, not having the confidence to speak out, and not being able to recognise their own strengths or achievements.

A low sense of self-worth fed into a tendency to self-blame. Care leavers described feeling like it was 'all their fault' that they had been placed in care[14,21]. Women who had been sexually abused as children spoke of the enormous emotional burden[4,18,20], as one participant described, they had been *"carrying the guilt of everything…right from when [they were] very young"* [20] (p.105).

The effects of being consistently let down, bullied and neglected were pervasive. People spoke of feeling disempowered, lacking agency or control over their lives and 'feeling small' [4,5,9, 11,15,17,19,21]. One person described how she was *'dumped in a place she'd never flipping heard of'* [15] (p.398) revealing a sense of being disregarded. People described feeling somehow 'less' than others:

> *"Everyone else deserved things and talked about their rights and things … but they didn't exist for me … I am someone who is so insignificant that you wouldn't want them at the bottom of your shoe"* [20] (p.106).

3.4.1.3 Mental Health Problems: 'you just don't feel good'

In many studies participants exposed to ACEs made explicit references to having either past or ongoing mental health problems such as depression or anxiety[2-5,10,16-18,20]. Two care leavers, although not directly asked, revealed that they had attempted suicide[14]. Homeless adolescents commonly reported experiencing depression or 'low affect':

> *"You just get depressed and quiet and don't talk to anyone, you want everyone to stay out of your way basically. You just don't feel good. Sometimes you don't even care about anything, in that mode, you know there were times when I was like that."* [5] (p.376).

Children of parents with mental illness were particularly aware of their propensity to feel anxious or depressed about their parent's condition and the potential for them to develop mental health symptoms of their own[2,10]. Women who had been subjected to childhood sexual abuse described an overwhelming build-up of emotion and sense of disorientation[4,18,20]. Before receiving intensive therapy *"distress led them to develop a sense of self characterised by feelings of being 'suicidal', 'unbalanced' and 'out of control''* [20] (author description, p.104).

3.4.2 *Compromised Relationships with Others*

In addition to the compromised sense of self, described above, school, placement and home instability as well as a lack of trust in others led to problems forming healthy relationships. Caring responsibilities and financial hardships acted as additional barriers to maintaining a social life[1,2,6-9,11,14,15,19].

3.4.2.1 Inconsistency as the norm: 'school is like, stay away. I don't go'

Young people affected by ACEs commonly described histories of upheaval: multiple and unstable placements in various geographical locations, alongside multiple school exclusions and inconsistent schooling[1,6,8,9,11,14,15,19].

For example, one participant explained that she had *"moved about 20 times in different foster placements"* [19] (p.47). A young care leaver described poor school attendance as the norm for children living in care: *"Kids in care just don't go to school"* [8] (p.143) and a young person living with parental mental illness matter-of-factly stated: *"I got bullied so school is like, stay away, I don't go."* [9] (p.276).

Irregular schooling obviously hampered young people's chances of building up social networks and trusting relationships but the peer relationships of those who did attend school were also negatively affected by ACEs. For example:

> *"They alienate you, and like it's difficult for me to make friends [...] I feel like they alienate you because we're in care but they don't make it obvious that it's because of that cos we're different."* [15] (p.395).

Young people affected by household dysfunction described how their chaotic home lives separated them out from their peers and made it hard for them to do 'normal' things that others took for granted:

> *"It's embarrassing because all your friends have got normal parents and you haven't... knowing that like, you're not going to have a birthday party or you can't invite your mate around for dinner because it's just, it's not appropriate and their parents won't let them. It's horrible, it really is."* [11] (p.28)

3.4.2.2 Trust: 'anyone could be a potential person to hurt you'

Having been let down and betrayed, young people affected by ACEs often harboured low expectations about other peoples' intentions or ability to help them. They found it difficult to trust others[1,5,6,9,11,12,14,18]. This lack of trust influenced how people affected by ACEs navigated relationships with peers, adults and professionals.

> *"I just think 'yeah, that person's just saying that and y'know, they don't really mean it and you see everyone as enemy - anyone could be a potential person to hurt you because the trust is not there."* [18] (adult participant, p.57).

Many young people affected by ACEs are not only denied the experience of having a caregiver they can trust, but often the caregiver whose role it should be to protect them is also the source of their emotional distress [8,14,15].

> *"And that [mother's violence] obviously makes you feel like crap, she's supposed to be your mam and supposed to love you ..."* [14] (p.405)

3.4.2.3 Being a young carer: 'I do need to start seeing him as my little brother'

All studies with participants whose parents abused substances or had mental illness spoke about having caring responsibilities that affected their social life. Responsibilities could involve anything from attending to parental distress and providing emotional support, to carrying out household chores[2,7,9-11].

Caring responsibilities were complex and often involved not only looking after a parent, but a range of other relatives, including younger siblings or grandparents. The pressures of bearing such great responsibility resulted in cutting short normal childhood experiences and taking on adult responsibilities from a young age:

> *"Peter had found himself caught up in arguments between his parents that were difficult to resolve. Neither parent was well enough to support the other so Peter became their primary source of support, something for which in the early stages he felt ill-equipped"* [9] (author description, p.276)

Girls, especially, described taking on considerable caring responsibilities, which could mean having to down-prioritise their own needs:

> "*I do need to start seeing him as my little brother… rather than like, my baby.*" [11] (young person, p.40).

Being a young carer took up time and contributed to children and young peoples' social isolation. Young carers of parents with mental health problems spoke of losing friends or having no time to maintain friendships within their peer group[9]. A tension was evident between children's wish to uphold their family and caring responsibilities and their need to engage in out of the home recreational activities that would help them to maintain relationships with their friends or peers[2,11].

3.4.2.4 Financial hardships: 'we literally have no food in our house'

Children and young people in both studies on parental substance misuse, and in one study about parental mental illness referred to the negative impact of financial hardship on their life[2,7,11]. This was often framed in terms of money funding parents' drink or drug addictions rather than going on food for the house[7,11], or lack of provisions as a result of a reduced household income[2]. A lack of resources also meant children and young people had to take on extra responsibilities, which further encroached on their freedom. For example, a young person living with parental substance abuse explained: "*I had to get a job so I could feed my sister*"[7] (p.855).

Financial instability was identified as a problem not only in terms of meeting short term physiological needs, but also as a substantial barrier to enabling recreational activities, either as a family or with friends, and as a potential source of stigma.

> "*…we literally have no food in our house […] it's not something I normally share*" [2] (young person, p.6)

3.4.3 *Compromised relationships with society*

Stigma, prejudice and social taboos fed into young people with ACEs' experiences in everyday life. Societal attitudes and representations affected how they anticipated society would treat them which in turn led to a fear of being judged or punished, a sense of being different and ultimately social isolation.

3.4.3.1 Stigma: 'I thought that everyone would just hate me'

In addition to foster children's tendency to self-blame (see 'low self-esteem') participants who were homeless or who had been sexually abused as children also described feeling like they were somehow responsible for what had happened and that this warranted punishment[5,18,20].

Women receiving maternity care were worried about being labelled or judged for sharing their experiences of childhood sexual abuse. They had genuine concern that telling someone could have catastrophic real-world effects, such as having their baby taken away: "*I thought that everyone would just hate me and think I was a terrible person and that I didn't deserve to have this baby…*" [18] (p.57).

Children of parents who abuse substances were worried about the impression their friends and others may have of their parents, and also by extension of themselves[10,11]. Young people agreed that mental illness (such as OCD) "*doesn't go down very well with other people*" [10] (p.75). Stigma around substance misuse posed a threat to young people's social standing, and they feared the repercussions of people finding out about their homelife:

> "*And I was worried that she'd [boyfriend's Mum] kind of say, I don't think this girl is very good for you. Look at her Mum…you know, she's probably going to turn out like that. So I was really worried about telling him*" [11] (p.29).

Discriminatory attitudes and negative representations were rife for young people affected by ACEs. A young person in foster care heard peers describe the life of someone placed in care as *"totally fucking wasted"*, with no future life chances [15] (p.394). This appeared to be a common perception, as one author stated: *"the lack of aspirations for looked-after children was felt by many of the young people to be endemic within both the education system and the care system itself."* [8] (p.143).

Another young person in care was subjected to stigmatising language equating them with vermin: *"at the start of high school this boy was saying I came from a dump and that I'm a rat…"* [15] (p.393). Pernicious attitudes and assumptions affected young people's lives greatly and reinforced feelings of powerlessness:

> *"It's hard cos if people think you're different then you're different and there's nothing you can do about it."* [15] (p.397).

3.4.3.2 Social isolation: 'you think you're the only one it's happened to'

Social isolation was a unifying theme throughout almost all of the studies and across the various problems that young people with ACEs have been shown to experience [2-5,8,9,11-13,15,18,20,21].

A young person who lost their parent to suicide described how they had felt alone in their experience before becoming involved with a bereavement service:

> *"Because living in a little town it doesn't really happen very often so you think you're the only one it's happened to"* [3] (p.288).

A sense of social isolation was particularly apparent for women who had been sexually abused in childhood. Unaddressed feelings around childhood sexual abuse combined with the force of social taboos led to a *"discontinuity of their selves from the world"* [20] (author description, p.105).

People exposed to ACEs felt emotionally and functionally separate from their peers in a multitude of ways: in their compromised sense of self, the barriers they faced in forming relationships and in the attitudes, representations and systemic injustices they encountered.

3.5 Q2: What strategies do individuals employ to mitigate the negative impacts of ACEs?

Three overarching themes were identified - Coping, Dealing and Sharing - that reflect the key strategies used by people to mitigate the negative impacts of ACEs. Coping refers to the internal strategies used to manage the emotional impact of ACEs. Dealing refers to practical strategies to address problems. Sharing refers to the challenges and benefits of reaching out for support. It was evident from the papers that each strategy could be a 'double edged sword'; each could have both positive and negative consequences.

3.5.1 *Coping*

Internal coping mechanisms were used by young people exposed to ACEs to manage emotions such as anger or guilt. Experiences of such coping strategies were found in 11 studies. [3,5,7,9,11,13,15,17,18,20]

3.5.1.1 Channelling Emotions – 'I used to start kicking people'

People exposed to ACEs described highly emotionally charged coping strategies which proved to have both positive and negative effects. At times, people affected by ACEs used aggressive or destructive behaviours to channel emotion and calm or cool themselves[3,5,7]. A boy who was living with his aunt admitted that he had been:

> *"…a bit of a pest for a while. I used to start kicking people, I was just being a pest because I got took away from Mum for a long time. I was angry with my Mum for being taken away"* [7] (p.857).

A homeless adolescent described wanting to start fights *"just to cool off the steam"* [5] (p.376). Anger was at times self-directed and would fuel destructive, health-harming coping strategies:

> *"When a problem does occur I can go straight out and drink. That's one way of escaping it but it always comes back in the end."* [5] (p.376)

In contrast to destructive ways of coping, emotions were also harnessed for pragmatic and positive effect: *"I just need to get a place to stay, get my head together and get a job or into some course"* [5] (p.375). Others harnessed emotional strength from their past adversity in order to appreciate their present. For example:

> *"I'm just grateful for who I've got now… so it's always focusing on the positive things now"* [3] (p.288).

3.5.1.2 <u>*Wearing the mask – 'Act like a normal kid… I didn't let it show'*</u>

To mask emotions was also a common coping strategy adopted by young people, as described in eight studies [3,10,11,13,15,17,18,20]; for example: *''Even though I was having them problems at home I didn't let it show in school. I'd still come in and do my work and act like a normal kid (…). I didn't let it show at all and I didn't say anything''* [11] (p.28). Not only did people withdraw and internalise their own feelings such as: *"to curl up and be part of the wallpaper"* [18] (p.56) some were also instructed by parents with mental health or substance abuse problems to keep it *'a secret'* [11] or were *'banned from talking about [it]'* [10]. Whilst masking can be seen as a positive coping strategy in that it avoids anticipated negative reactions from others (see Stigma) this juggling act in front of others can add to the immense pressures that these young people face and raises concerns about the long-lasting impact it can have. A woman who was sexually abused in childhood described the heavy emotional toll of putting on a façade around the time of becoming a mother:

> *"I laughed when visitors came and I smiled and put the right face on. But inside…(sniffs, four second silence). Inside I was - just silently screaming."* [18] (p.57)

Four studies[11,15,18, 20] show that from a young age, coping strategies are developed and implemented to present a dual world in which the young person chooses what to reveal (and conceal) about their lives: *"Because I just think, like, then people would know my life, kind of thing. I'd rather them see me…my athletics life and my new life"* [11] (p.29). This was also demonstrated by a young person who feared being judged for being in foster care and so referred to her foster father as her 'dad' on social networking sites [15]. These strategies reveal the importance that young people place on being able to control how much, or what kinds of things, people know about their lives.

Masking also manifested itself in needing to excel, to be *'a high flyer'* [20] or a *'star patient'* [18]. Drawing again on the idea of the double-edged sword these narratives could be inferred as positive or negative experiences. Keeping busy was an effective way for people exposed to ACEs to cope into their adulthood, for example, by doing *"a lot of voluntary work"* [20] (p.105). In some cases however, pushing oneself in order to please others was ultimately an avoidance mechanism to put off self-examination:

> *"I … was very academic at school, worked very hard as well and my goal was to achieve a good career and go to a good university and climb the ladder and marry well and have a nice house, all the things you dream of as a child but it came from my parents as well, I don't think I allowed time to consider who I was and what I really wanted in life"* [20] (p.106).

3.5.2 *Dealing*

This theme groups and describes the shift from internal coping to finding practical ways of dealing with a variety of adversities and striving for a 'normal' life. 12 studies provided data on dealing strategies[2-5,7,9-11,13,17,19,21].

3.5.2.1 Bonding with family in adversity - 'my mum being happy… doing things together'

It was evident from the findings[2,4,9-11,13,17] that given the adversities that young people faced they demonstrated a high degree of resilience and sought to shore-up precarious family situations. There were examples of demonstrative positive actions which reaffirmed an emotional connection between child and parent, such as: finding comfort in normal things like walking to the fish and chip shop together[2], offering cups of tea to a hungover parent[11] or just offering a cuddle to show support[13]. These strategies were used by the child even when they were dealing with hostile behaviour from parents[2]. Strong bonds were also nurtured with siblings, such as a young person who spent time with her sister who was in a residential home, having laughs and pillow fights[17]. One author concluded that children were constantly striving for a normal family life, regardless of obstacles, because it gave them: "*a sense of belonging as well as a sense of security*"[11] (p.33).

3.5.2.2 Shouldering Responsibility – 'it's difficult to find anyone who would help'

Nine papers [1,2,5,7,9-11, 19,21] showed that responsibility was heavily placed on the young person who had to deal with circumstances beyond their control. This was demonstrated in many ways from leaving home, managing the home and looking after siblings and parents. With each type of experience there are positive and negative examples, which again show the complex duality of dealing with responsibility, as the following three sub-themes show.

Self-reliance

Homeless adolescents used self-reliance as a way of avoiding the pressure of being grateful to someone. They implied that there was a price to pay if you sought help:

> "*You've got to be careful with people offering help. Some of them are just in it for themselves and you can end up being taken advantage of. Anyway, it's difficult to find anyone who would help.*"[5] (p.375).

Some participants expressed that they didn't like to ask for help because they were ashamed it might be seen as a sign of weakness[5,18,20]. "*I like to look like I'm on my feet, doing that, handling my shit, not all, 'oh, let me stay at your place, I don't know where to go.*"[5] (p.378). However for young people transitioning from care to living independently this was a daunting experience, as many expressed feelings of fear and not being emotionally ready or lacking practical life skills[1, 19].

Being in charge

Four papers showed examples of taking charge of a situation as a practical strategy to deal with daily stresses and immediate challenges[2,7,9,11]. Examples included: hiding or checking for tablets[7], protecting a parent from their abusive partners [7,11]: "*if I knew that he had hurt my Mum, I would go straight down there. I'd be straight down the stairs and hurt him*"[11] (p.23).

The young carer

Children showed assertiveness and took initiative in a supportive or caring role in various ways[7,9-11,21]: helping to manage their parent's OCD[10] ; being *'pivotal'* in their mother's detoxification support[7] ; or going to doctors with a parent battling depression and being critical of clinicians: "*She's not well, but she's not an invalid*"[9]

(p.275). For young people living in a household affected by substance abuse, looking after younger siblings was described as a motivating force, something that helped them 'get through' their adversity[11].

Young people engaged in altruistic behaviour which showed a mature and selfless approach to dealing with a stressful home life[9,10] (p.275). For example, this young person displayed resilience in the multiple caring roles they adopted to support their mother and extended family who had multiple and complex needs:

> *"Like with my mum, I have to help her get a shower. I have to help her around the house. I have to help her out of bed in a morning and that. With my granddad, he's got arthritis and he finds it quite hard dealing with my nan, because my nan had a stroke five years ago and she can't speak and she's paralysed, and so I just go round there and he has a lie down and I cook him his tea and that, and I look after my nan for the day to take it off his hands"* [9] (p.275).

However, as illustrated in being a young carer there are negative impacts of caring for young people.

3.5.2.3 Beyond the confines of home: 'I like going to my Granddad's'

Recreational activities and meeting friends outside the home were described as a valuable diversion and release from problems[2,3 17]; as one young person described '*I like going up to my granddad's and just doing stuff up there. It is nice and quiet and you can just work on cars and get on with it.*' [17] (p. 214). Young people spoke of independently seeking out physical activities and hobbies such as rugby, swimming and playing the piano. One young person directly linked taking up exercise with improved mental health: *"Ever since I started martial arts my panic attacks and anxiety attacks have pretty much gone"* [3] (p.286). These activities were cathartic, stress-relieving mechanisms and a form of respite from complex home-lives[2,3]:

> *"I was quite an angry child because of dad and I remember that sport helped me to get that aggression out and helped me to, in some ways, learn to control it. I played a lot of rugby so it's quite an aggressive sport. It was a way for me to channel it and not make everything else so aggressive*." [3] (p.286)

One study also revealed, that another way to deal with stress at home, was by allowing oneself permission to simply have fun [3]. Young people found that laughing and humour helped to reduce distress, build rapport and enhance mood. In short, they were vital resources in dealing with grief and stress.

3.5.3 *Sharing*

This overarching theme describes the strategy of sharing or seeking support from others and the numerous difficulties of doing so. Sixteen studies reported findings relating to sharing: [2-6,9-18,20].

3.5.3.1 A friend in need is a friend indeed - 'My friends are so important to me'

The vital role of friendships was noted in six studies[3, 11,12,14,15,17] as a source of great help. Relationships with peers provided a sense of normality for young people escaping from hardships at home or in care, for example: *"friendships were instrumental in cultivating happiness after the death of a parent."* [3](author description, p.85). Reciprocation and being able to provide support to others was deemed just as important: *"My mates think I am funny… I'm a good friend"* [17] (p.215). A sense of parity and control was also shown to be vitally important for enabling trusted talk with friends:

> *"When I want to talk about it I'll bring it up and she [friend] will listen and then tell me something so we're kind of confiding together. She won't ask questions but wait for me to tell her".* [11] (young person, p.52)

Friends acted as great sources of emotional support and raised self-esteem[3]. They helped young people move from *"hating themselves"* to feeling good about themselves[14] (p.406). Many young people confided in friends, and they often turned to them first - above relatives or other adults - when reaching out for help [11,12,15].

However, as discussed in the section on stigma, alongside positive experiences there is a negative side, whereby fear played a huge barrier in wanting to share. Issues around trust and not wanting to be perceived differently were large contributing factors which prevented individuals from sharing, or made them wary about doing so [11, 15]. A young person explained that they did not want information about them being in care to be *"spreaded about"* [15] (p.395), implying that this information was something they were selective about 'disclosing'. One study described that many young people living with parental substance abuse *"have been hurt by falling out with trusted friends who then told others about their family life"* [11] (author description, p.48), drawing attention to the fragile nature of some friendships which may not always offer consistency and strength.

3.5.3.2 Silent sharing - 'quiet and safe space just to be'

In addition to vocalised sharing, five studies explored a different approach that young people adopted, which can be described as 'silent sharing'[4,9,12,15,18]. Young people and adult survivors of childhood sexual abuse found ways to feel safe in external spaces alongside others with no pressure to share but just to be[4,11,12]. Such spaces allowed the person affected by ACEs to be in control, *"as sense of agency lies with the young person"* [15] (p.394). Young people's confidence and inclination to share had chance to flourish in this kind of non-pressurised environment and, as one study author noted: *"silent or indirect disclosure in time may lead to trusted talk."* [11] (p.50).

Silent sharing was also found in friendships or between siblings where young people didn't have to disclose any information but their feelings could be easily interpreted and resulted in the type of support that was needed:

> *"We were with each other that much that we pretty much knew what each other needed without having to be told. It's like if I wanted a hug and a shoulder to cry on, she'd know…but if I wanted my space, she'd know."* [11] (p.51)

With silent sharing trust and loyalty is as vitally important as when a young person discloses, as is the knowledge that they are not being judged or blamed: *"She knows everything I've been through and she's met my Mum and she knows that my Mum's not a bad person. Whereas with a proper outsider you think well, maybe, perhaps she thinks my Mum's really bad, and she's not."* [11] (p.50).

Unspoken understandings and safe spaces that friends or other trusted adults offered play a vital role in meeting the needs of people exposed to ACEs. Non-verbal communication or engagement within a non-judgemental safe space endowed people with a feeling of safety and control over when or how they want to share. This could involve sounding out whether someone was a suitable recipient or not:

> *"I would not tell people my problems anyway. I would just hint it. Like bits and bits. Just to find out if – like this person might try not to listen to me and give me advice – or they can't cope with it."* [5] (young person, p.13)

3.6 Q3: What services are needed to address the negative impacts of ACEs?

The previous sections reveal that young people exposed to ACEs face numerous challenges in their lives and adopt different strategies to deal with their situation. However, it is also clear that young people often struggle to cope and experience a lack of support in dealing with challenges. As such, and as one author concluded, services could be conceived as needing to 'fill the gaps' left by ACEs:

> *"The projects filled important gaps in young lives – friendships and strengthened peer relationships, dependable, consistent and continuous relations with adults, a sense of control, opportunities to enjoy themselves and some respite from caregiving responsibilities."* [9] (p.279)

In 20 of the 21 studies[1-12, 14-21] young people described the kinds of services that they felt would help to mitigate the impact of ACEs and the kinds of services they found less helpful.

3.6.1 *Emotional support – 'not just anyone can help'*

Given the emotional pressures that ACEs inflict on the lives of young people and the social isolation they may experience, it is unsurprising that one of the most desired features of services was the provision of supportive relationships. All 20 studies focusing on services noted the value of supportive relationships either with other young people or with adults.

3.6.1.1 Relationships with peers – 'you were with so many people in the same situation'

The findings presented above in the section 'a friend in need is a friend indeed' reveal how relationships with peers, whilst an invaluable source of support for some, were challenging for others due to stigma, shame and practical issues. As such, services may be an important avenue for fostering much needed peer support among young people. In each of the three studies that focused specifically on services that included therapeutic group support [3,9,20] authors emphasised that opportunities to develop peer relationships were universally valued by participants.

> *"All 10 young people we interviewed talked with enthusiasm about their experiences of group work in all its forms, and of the opportunities and benefits it brought to them."* [9] (author description, p. 278)

Connecting young people who had faced similar adversities was experienced as an important mechanism for addressing feelings of stigma and shame.

> *"Being where you were with so many people in the same situation, there were a lot of emotions flying but in a good way and there was never any embarrassment about letting yourself feel upset."* [3] (young person, p.288)

This element of peer support was also valued by a young person who had experience of being in a care home with other kids: *"In a children's home everyone has something in common and it's like 'oh why are you here then, what's your story', you know."* [8] (p.141).

A sense of 'shared experience'[10,11], 'solidarity'[20] or common identity[9] with peers was considered important in helping people to overcome the emotional impact of ACEs. In one study on victims of sexual abuse sharing experiences in a group setting an author noted that participants *"changed their negative self-attributions, minimised their self-blame and unburdened themselves from feelings of guilt and responsibility for abuse"* [20] (author description, p. 111). This experience was seen as vital for helping people rebuild a positive self-identity, for example:

> *"Each participant acknowledged that the group programme had helped them 'take control back' of their lives by helping them to 'regain' their sense of power, self, strength and identity."* [20] (author description, p.109)

3.6.1.2 Relationships with adults – 'the sort of stuff your mum can't do for you'

The vast majority of studies (n=19) commented on the need for social support from trusted adults. Given the significance of this role as expressed in the quote above all ten studies appeared to echo the theme identified by Griffiths and colleagues[10] *that "not just anyone can help"* (p. 77).

Adults known to young people such as extended family members[10,17] and neighbours[6] were noted as being a good source of support. However, the majority of studies (n=13) noted the ability of formal services to provide this type of support either through foster carers [1,6,15,16] or a range of other types of professionals including social workers [7,11,12], project workers [9], support workers [11], outreach workers[17], leaving care personal advisers[19], therapists [4], healthcare professionals [10,18], and teachers [6,7,11]. The attributes that such adults needed in order to provide appropriate social support seemed to be more important than their profession. Attributes commonly expressed as vital for providing support were: displaying empathy [4,5,7,9]; being non-judgemental [3-5]; and being active listeners[4,5,7,9,11,21].

> *"You've got to feel like you can tell them stuff and they'll know where you're coming from and wouldn't judge you for it. And they've got to be able to listen. Some people just don't want to hear what you've been through and just want you to be happy all the time. You can't really talk to someone like that."* [5] (young person, p.379)

Young people in two papers on foster care[1,15] highlighted how being placed in a family with a similar background was important for supporting their self-identity. One participant valued being placed in a family with a similar ethnic background *"It's very important for me to know my own culture"* [1] (p.841). And in another study a participant described how being placed in a family with a different background inhibited the relationship she had with them:

> *"Like when I went on holiday with my foster parents, it was weird, I just feel like out of place all the time … like they're posh and all that and I'm like more of a 'chav'."* [15] (young person, p.397)

In addition to describing specific attributes, young people in six studies [4,5,9,11,17,22] explicitly described needing to feel that professional adult support came from a genuine sense of caring 'not just some act they're putting on'[5] (p.379). In one study it was described as 'beyond the boundaries of professional duty'[6] (p.144) and a number of studies referred to the type of support needed as being akin to parental support[8.9,11]. For example:

> *"Come to think of it now, I suppose they (project workers) are like parents, like parent figures that you can depend on when your mum can't do it for you. The sort of stuff your mum can't do for you they do for you."* [9] (young person, p.278)

Four studies on foster care[1,8, 14,15] highlighted how a sense of authentic caring was key to supporting a young person's self-identity. Foster carers were praised for welcoming young people *"As part of the family, instilling in them a sense of belonging"*[14] (p.407).

3.6.2 *Practical support*

In addition to the need for social and emotional support, a common theme across the studies was a need for practical support to address the challenges they faced. Forms of practical support that services could provide included information to help them understand and address their problems, practical advice to help them manage everyday challenges and respite from the challenges they faced.

3.6.2.1 <u>Information about key issues and services – 'nobody explained why they were taking me away'</u>

Participants in ten studies highlighted a view that services might help by providing information[2-4,7,9,10,12,16,21]. In some studies participants suggested information about the issues they were facing would have been

helpful. In three studies young people with parents with mental health problems [2,9,10] felt information about mental illness would have been valuable in helping them to cope. The authors of one study concluded:

> *"Low mental health literacy was uniquely and consistently identified as exerting a negative impact on children's abilities to cope with and respond to their parent's mental illness."* [2] (author conclusion, p.7).

Similarly, in a study about parental bereavement, participants indicated that they would have valued information about what they might expect to experience in grieving for their parent[3].

In some studies participants expressed a need for information about which services are available to them and better information about the services they are currently receiving. In four papers[2,4,5,12] young people expressed frustration that they were unaware of services that could provide support; as one young person described "*I don't know much about services for people like me"* [5] (p.378). The authors of this study described the lack of awareness of sources of help as '*one of the most striking aspects*' [5] of young people's accounts (p.382). Other authors also commented on the lack of visibility of services for young people in need. For example:

> *"Some young people were unclear which professionals they could have approached for help and felt that professionals who might be able to help were not visible to them when they were looking for someone to disclose to."* [12] (author description, p.433).

Several papers[5,11,12] highlighted how teachers constitute a very visible source of adult support for young people, with several young people reporting receiving both effective[5,11,12] and disappointing,[8,12] support from teachers. These findings suggest that training and support for teachers to act as both supportive adults and a conduit to receiving other forms of support may be an effective option.

In six other studies young people expressed frustration about the lack of information regarding the nature of services with which they were already engaged [4,7,8,12,15,21] . For example, abrupt changes to care without warning: *"you get a letter saying 'I'm sorry I'm not going to be your social worker anymore', and you think hang on, I've never even seen you!"* [8] (p.145). One young person highlighted an extreme example of this *"nobody explained why they were taking me away."*[7](young person, p.856)

Victims of abuse experienced child protection services as a 'blunt instrument' [4] when information was not provided. Another study described how a lack of information about the consequences of disclosure of abuse and social care procedures could lead to young people not disclosing their situation:

> *"Fears about being placed 'in care' often led young people to holding back information from professionals. A number of young people were concerned about and unsure what would happen if they did tell someone about their maltreatment and of the consequences for themselves and/or their families."* [12] (author description, p.433)

In a study on parents with mental health problems young people described feeling 'out of the loop' about how support for their mothers was being organised which hindered their ability to query reasons for interruptions to that support[9]. One author concluded that this finding is not new and that research continues to highlight:

> *"…the need to target more information at young people about forms of abuse and where to seek help […] Young people also lack information about what is happening to them once they are in the child protection system and about the roles of individual professionals"* [12] (author description, p.436)

3.6.2.2 *Practical advice – 'to get a bed somewhere, to get your benefits working right'*

A theme identified in seven studies was the need for support with handling practical responsibilities and problems[2,5,6,8,9,15,18].

In each of these studies young people reported having to take on responsibilities not usually expected of children, such as 'housing and money'[5], 'completion and return of forms sent to families by schools, the benefits agency and so on'[9] or 'to get a bed somewhere, to get your benefits working right'[5]. In one study a young person described this sort of support as "*The thing that's helped the most … Like if I'm getting chucked out of college or there's something happened at college and I don't know how to work something out … (project worker) will get on to the college straight away."*[9] (p.278). One young person living with parental mental illness identified how taking on these responsibilities was a huge challenge in the day to day life of young people but one that could easily be mitigated with the right support: "*Problems that might sometimes seem small, or perhaps smaller if they were solved."*[2] (young person, p.6).

3.6.2.3 *Respite – 'do something different […] that takes your mind off it'*

Building on the concept of respite as a useful mechanism for dealing with ACEs as described in 'Beyond the confines of the home' services were commended for providing this kind of opportunity. In four studies young participants indicated the value of services that provided some respite from their troubles [2,3,9,11].

> "*There were lots of comments about the value of group activity in diverting participants from constantly thinking about their families and their caregiving responsibilities, and from the associated stresses."*[9] (author description, p.279)

Recreational and creative activities such as music[2] and sport[3], and the act of "*[doing] something different, completely different that takes your mind off it"*[3] (p.286) were noted for their dual benefits of relieving stress and providing opportunities for socialising.

3.7 Q4: How should services be delivered?

Whilst participants in 13 studies identified that professional service providers (including foster carers) *could* have a role to play in supporting children to cope with ACEs, there was also some scepticism about services and service providers suggesting that many young people may choose not to engage. Thus, in addition to the question of 'what kinds of services are needed' the data suggest that 'how services should be delivered' may be fundamental to their uptake.

> *The need to foster trust – 'I've had a lot of people mess me around'*

Nine studies[4-9,12,15,17,18] indicated the vital significance of trust, by referring to it as a 'necessary'[5], 'important'[4] or 'fundamental'[9] precursor for effective relationships with service providers. As several authors pointed out children exposed to ACEs have typically experienced 'rejection and abandonment'[5] such that mistrust is only to be expected. As one young person explained:

> "*And if you … can't even trust your own mother you are going to need more than someone coming around saying "I'm a social worker"…. It's going to need more than a name and a nice smile and a cup of coffee."*[6] (young person, p.144)

In seven studies[5-7,9,12,15,18] participants described a reticence to engage with services due to previous negative experiences. Participants in the study with homeless adolescents[5] found that they "*almost universally mistrusted formal sources of help"* and that many had been advised by others to mistrust services.

> "*Personally, I usedn't to get involved with social services. Purely because when I was young my mum used to tell me that the social services were bad people and that if ever I*

complained to them about my mum that they would take me away from her." [5] (young person, p.379)

Thus while the attributes of valued service providers are described above, one author concluded that practitioners also need "*to be aware of issues concerning rejection and abandonment along with the consequent hurt, rage and mistrust."* [5] (p.382)

Continuity and Dependability – 'they just leave you after a while'

In eight studies continuity and dependability arose as important themes relating to trust [4-6,8,9,11,13,19]. Across the studies young people voiced misgivings about services when relationships with professionals were not continuous or could not be relied upon to deliver support:

"*I don't see the point of having Social Workers.. cause they don't really help and they just leave you after a while"* [11] (young person, p.62)

It was noted in six studies[4,6,8,9,11,12] that continuity in relationships is essential for engagement, for example: "*It can take months to build up the confidence to speak more freely about their lives"* [9] (author description, p.279). Continuity was seen as enabling understanding and individualised care which was highly valued. For example:

"*Individuals typically had one project worker assigned to them. […] This also meant that there was a close familiarity with and understanding of each person's needs, preferences and home circumstances, the youngsters concerned readily acknowledging this as something they prized."* [9] (author description, p.277)

By contrast, "*having to repeat painful experiences to a stream of new workers"* [12] (p.435) was noted as particularly upsetting to young people[4,9,11,12]. One author described the potential impact of negative experiences:

"After repeated experiences of having being 'left' by professionals some young people may develop feelings of resignation, which in turn may negatively affect their willingness to engage with professionals at a later stage" [11] (author description, p.61)

As such, several authors[4,6,8,9,11,12,19] concluded that continuity is vital, and in one case 'the most important factor'[12] (p.435) for engendering trust and enabling successful engagement with young people.

Dependability was also seen as fundamental for engendering a trusting relationship with professionals. Young people in several studies described experiences of false promises and being let down by adults who they depended on[5,7,8,12,14]. For example '*I hate it when they say one thing and do another*' [7] (p.856). Availability of professionals was another key component of trusting relationships expressed in five studies[4,8,9,11,12,19]. For example:

"*Many young people in our sample spoke about being unable to contact social workers during the referral process and this led to disillusionment and concern that social workers were not acting to protect them."* [12] (author description, p.435)

By contrast, one author described that people affected by ACEs had a positive experience of having the option of contact between appointments or when on a waiting list: "*because they felt reassured, less isolated, and cared for"* [4] (p.142). Another noted that "*Services which ran an out-of-hours telephone service […] seemed particularly effective at being accessible and approachable"* [11] (p.68).

Delivering continuity appeared particularly important but difficult to achieve during the process of referral to social services[12]. In another study[11] the authors considered the challenge of delivering services that were both accessible and offered continuity. They suggested that encouraging young people to:

> *"Feel a connection with and establish trust in the service organisation, rather than with just one individual […] would help young people manage staff turnover without feeling let down."* [11] (author description, p.68)

Flexibility and Control – 'They don't tell you what to do'

Another key feature of services that was noted for fostering trust and engagement was offering a degree of flexibility and control to young people over how they were supported. Several studies[8,9,11,12,16,19] indicated the value for young people of being able to choose how to engage with services and how to manage the challenges in their lives. This could involve the mode in which services communicated with young people. For example, texting was acknowledged a convenient way of contacting young people and allowing opportunities to stay in touch on their own terms[9].

One young person described flexibility and control as important in response to the question 'what makes a good social worker?'.

> *"When, they don't tell you what to do. Like they listen to you. That they take things slowly and don't rush you into doing stuff."* [11] (Young person and interviewer, p.57-58)

One author noted that young people valued knowing that they were able to withdraw from the service *"at any time without feeling guilty"* [9] and one young person described how they valued having choices about when, where and how discussions might take place: *"If I didn't want to talk, I'll talk about general conversation […] if we'd go somewhere if I didn't want to leave the car, we could stay in the car"* [11] (p.61).

One author noted how involvement in decisions, especially decisions about placements or termination of placements would be of particular significance to young people[19].

Across the 21 studies 17 authors' conclusions focused specifically on the need for those who have been exposed to ACEs to have access to supportive, trusting relationships[1,4-12,14-19,21]. Supportive relationships with professionals were described as 'the cornerstone'[9] of effective engagement and service delivery. There appeared to be a consensus across the studies that services that are "process driven and not designed with the needs of the service user at the forefront" [12] (p.436) need to shift to an approach which puts "*professional's relationships with young people, and young people themselves, at the heart of the safeguarding agenda*" [12] (p.437).

4 Overview: Interventions to support people affected by Adverse Childhood Experiences (RoR)

This section presents the findings from the overview of interventions. Sections 4.1, 4.2, 4.3 describe the steps we took to reach the best evidence synthesis. Section 4.4 presents the categories of interventions and our full findings are presented in 4.5.

4.1 Flow of literature through the review

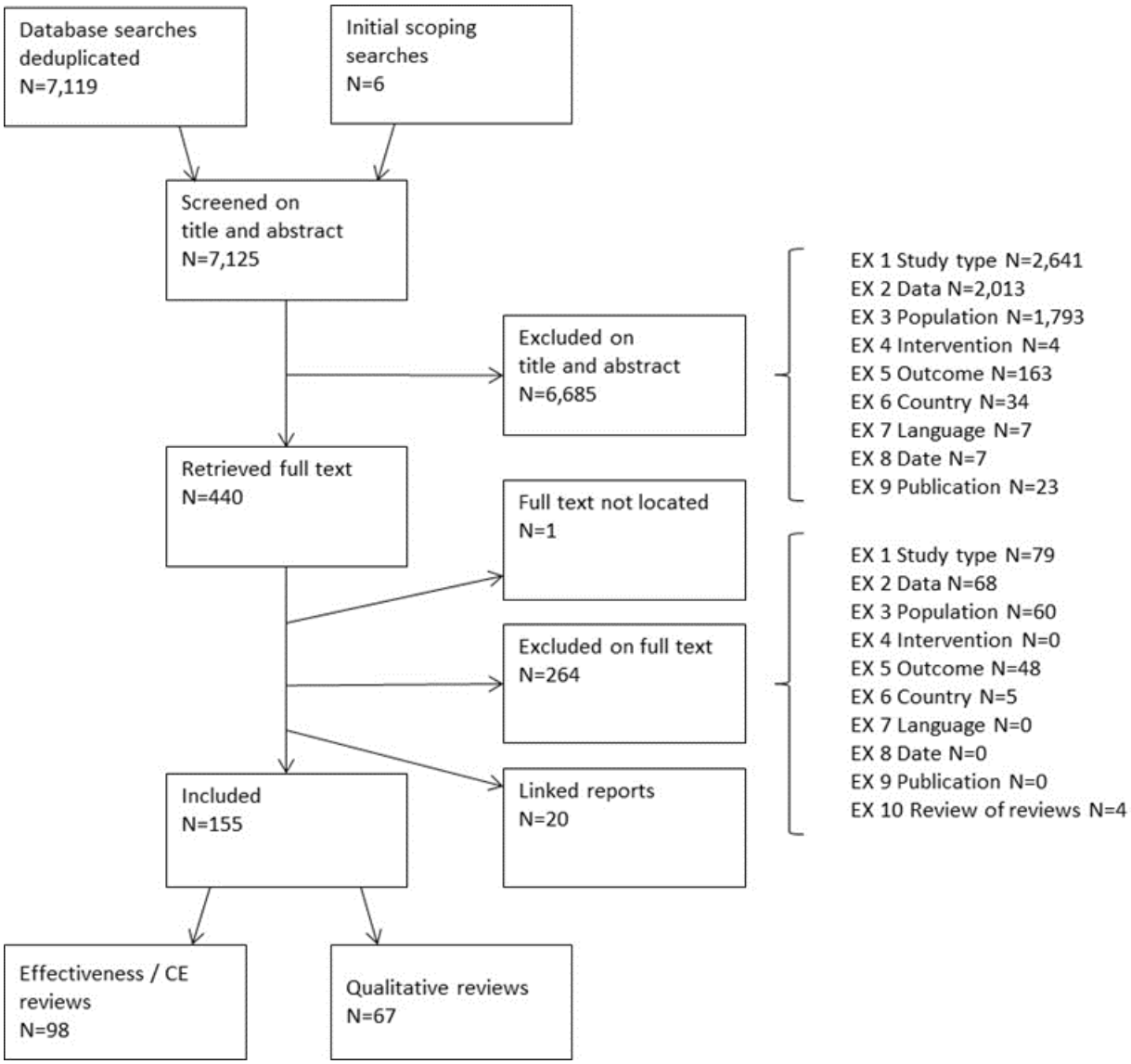

Figure 6. Flow of literature through the review

The searches located 15,179 references, and after duplicates were removed, identified a total of N=7,119 unique records (an additional N=6 records were added from our initial scoping searches). After application of the exclusion criteria, 98 reviews of intervention effectiveness were included. The flow of literature is shown in

Figure 5. Where the same review was reported in two or more different ('linked') reports, data were extracted from both; however, for ease of reference, only one reference for each is given in the results below.

4.2 Quality assessment

The full results of quality assessment are presented in Appendix F. Overall quality was fairly low, with a median AMSTAR score of 3.5 out of 11. Most reviews scored highly on inclusion criteria, search strategy and quality assessment, with lower average scores on other domains.

4.3 Best evidence synthesis

A total of 31 reviews was included in the synthesis. (However, one of these (Parker and Turner, 2013) was an empty review and so reported no primary studies meeting their review inclusion criteria.)

Full AMSTAR scores are presented in Table 4 and included studies are grouped by population in Table 5 in Appendix F.

Table 2 below shows the reviews (arranged by population and in descending order of AMSTAR rating) that were included in our best evidence synthesis. Note that some reviews which included multiple populations appear more than once.

Table 2: Reviews included in the best evidence synthesis grouped by population and in descending order of AMSTAR score.

Abuse / neglect	AMSTAR	Looked-after children	AMSTAR	Homeless	AMSTAR	Parental mental illness	AMSTAR
Macdonald et al. (2016)	10	Jones et al. (2008)	8.5	Coren et al. (2016)	11	Bee et al. (2014)	10
Wilen (2014)	10	Turner et al. (2007)	8	Naranbhai et al. (2011)	10	Beresford et al. (2008)	8.5
Winokur et al. (2014)	10	Everson-Hock et al. (2011)	6.5	Bassuk et al. (2014)	7.5	Loechner et al. (2017)	5.5
Macdonald et al. (2012)	9	Ziviani et al. (2012)	6	Altena et al. (2010)	6.5		
Goldman Fraser et al. (2013)	7.5	Kinsey and Schlosser (2013)	6				
Parker and Turner (2013)	7	Everson-Hock et al. (2012)	6				
Maclean et al. (2016)	6.5	Kemmis-Riggs et al. (2018)	6				
Leenarts et al. (2013)	6	Evans et al. (2017)	5.5				
Montgomery et al. (2009)	5.5						
Wethington et al. (2008)	5.5						

Exposed domestic violence	AMSTAR	Parental alcohol/ drug	AMSTAR	P. incarceration	AMSTAR	Parental death	AMSTAR	Parental separation / divorce	AMSTAR
Macdonald et al. (2016)	10	Broning et al. (2012)	6.5	Troy et al. (2018)	5.5	Bergman et al. (2017)	5	Poli et al. (2017)	3
Howarth et al. (2016)	9.5								
British Columbia Centre of Excellence for Women's Health (2013)	9								

4.4 Classification of interventions

We grouped the data from the reviews into nine broad categories:

- Cognitive-behavioural therapy (CBT)
- Psychological therapies other than CBT
- Psychoeducation
- Interventions aimed at parents
- Parent and foster carer training
- Cross-sector support (for example, case management)
- Educational interventions
- Housing and life skills interventions
- Out-of-home and foster care

These intervention types are characterised further in the narrative synthesis below and full supporting data are presented in the evidence tables in Appendix G.

4.5 Summary and key findings

In order to provide a clear overview of a complex set of evidence we have produced a summary statement and key findings statements for each group of interventions (with the exception of out-of-home and foster care, where the findings are not clearly interpretable in terms of effectiveness).

The key findings statements are based on the single review which provided the most reliable evidence for each combination of intervention type, population and outcome. The selection of the review with the most reliable evidence was based on:

- the quality of the review (AMSTAR score)
- how up-to-date they are
- the approach to synthesis (meta-analyses were prioritised)
- the extent of evidence included (see note on limited evidence below).

Thus, where several reviews cover the same population, intervention type and outcome category, findings are based on the highest-quality (and from the more recent if reviews have the same quality score), or on the highest-quality review which conducted meta-analysis (if the highest-quality review did not and another review did).

Where review findings are based on less than three primary studies, the evidence is stated to be 'limited'. The phrase 'mixed results' is used to characterise results which are partly effective and partly not, either within primary studies (for example, on different outcome measures within a single domain and/or between different time points or subgroups) or between primary studies in a review.

For ease of reading, only substantial outcomes are included in the key findings statements. Key findings statements are also represented graphically in the evidence map in Appendix I. However, we recognise that a more nuanced understanding of evidence available can be gleaned from the full set of reviews. Readers are thus encouraged to read the full report of findings in addition to the key findings statements.

4.6 Findings

The following sections present the findings for each intervention category (as described above in Section 4.4). For each category we first present a box with a summary of the findings and the key findings statements. This is followed by a detailed description of the category and the full set of findings.

4.6.1 *Cognitive Behavioural Therapy (CBT)*

Summary: Cognitive-behavioural therapy (CBT)

Number of reviews: 11 reviews examine the effectiveness of CBT.

Populations covered: Homelessness (n=1), parental mental illness (n=2), maltreatment (n=1), exposure to domestic violence (n=1), sexual abuse (n=3), physical abuse (n=1), abuse and neglect (n=1) various populations (n=1).

Summary of evidence: Examination of the most reliable reviews shows the evidence on CBT to be equivocal; although some evidence suggests that it can improve mental health in particular groups.

Key findings: Cognitive-behavioural therapy (CBT)

The highest quality review on CBT found that:

- it improved mental health outcomes for children who have experienced abuse or neglect [Macdonald 2016; AMSTAR 10; meta-anlaysis].

The highest quality review on CBT found that:

- it did not improve behaviour outcomes for children who have experienced abuse and neglect [Macdonald 2016; AMSTAR 10; meta-analysis].

Limited evidence (less than three studies) from other reviews on CBT suggests:

- it may not improve mental health for children of parents with mental health problems [Bee 2014; AMSTAR 10]
- it may not improve mental health for children exposed to domestic violence [Howarth 2016; AMSTAR 9.5]
- it may have mixed results for mental health for homeless young people [Altena 2010; AMSTAR 6.5].

WHAT IS INCLUDED IN THIS CATEGORY? Any intervention described as Cognitive Behavioural Therapy, including Eye Movement Desensitisation and Reprocessing Therapy (EMDR) and multi-component interventions with a focus on CBT, delivered to the child alone, or alongside their parent(s) or carer(s).

HOW DOES IT WORK? Cognitive-behavioural therapies are built on theories of learning which help people address their emotional, psychological and behavioural problems. They seek to help individuals to identify and challenge their own maladaptive beliefs and behaviours - which can occur as a result of trauma or maltreatment - and replace them with more positive ones. Eye Movement Desensitization and Reprocessing (EMDR) involves the identification and processing of traumatic memories using bilateral stimulation and desensitisation through exposure to images.

POPULATIONS: One review assessed interventions for adult survivors of child sexual abuse (Wilen et al. 2014). All other CBT and EMDR treatments were aimed at children - either alone, or in combination with their non-offending parent(s). Studies covered a range of ACE populations including sexual and physical abuse, homeless young people, parental mental illness, and children exposed to domestic violence.

DELIVERY: Group and individual, or a combination of both. Mainly delivered within health service settings; moderate intensity (8 to 20 sessions); generally delivered by therapists or counsellors.

Altena et al. (2010) found that cognitive-behavioural interventions for homeless youth improved social stability and housing-related outcomes (1 RCT) and reduced drug or alcohol use (1 RCT) and found mixed results for mental health outcomes (1 RCT, 1 nRCT).

Bee et al. (2014) found that child-orientated cognitive-behavioural problem-solving training for children of parents with serious mental illness did not impact on internalising and externalising behaviours, had no impact or adverse effects for cognitive function, and had mixed results for coping skills (1 RCT). This review also found that CBT for children of parents with depression did not improve self-esteem (1 RCT).

Beresford et al. (2008) found that CBT for children of parents with depression had mixed results for depression (2 RCTs) and did not improve behaviour (2 RCTs, 1 nRCT). This review also found that CBT and family intervention did not impact on social functioning (1 RCT), and that CBT combined with psychoeducation did not impact on behaviour (1 RCT).

Goldman Fraser et al. (2013) found that CBT and or EMDR interventions for children with experience of maltreatment (mainly sexual abuse) had mixed results for mental health (5 RCTs) and behaviour problems (5 RCTs).

Howarth et al. (2016) conducted a network meta-analysis which found that CBT for children exposed to domestic violence did not improve mental health.

Leenarts et al. (2013) reviewed a range of cognitive-behavioural interventions (broadly understood) for various populations. Results were incompletely reported, although there are some promising findings from individual studies of broader programmes including CBT elements for some mental health outcomes.

Macdonald et al. (2012) reviewed CBT for children who had experienced sexual abuse. This analysis is included in Macdonald et al. (2016).

Macdonald et al. (2016) reviewed CBT for children who had experienced abuse and neglect. They conducted a meta-analysis for the sexual abuse population, which showed that CBT reduced PTSD (6 RCTs) and anxiety (5 RCTs) both in the short and long term (at least one year), but did not reduce sexualised behaviour (5 RCTs) or externalising behaviour (7 RCTs). Results for depression (5 RCTs) showed that CBT reduced symptoms in the short term and at three to six months, but not at longer-term follow-up (at least a year). They found one economic evaluation which indicated that CBT was cost-effective compared to no treatment. The findings on CBT for other abuse and neglect populations suggested that it reduced PTSD (4 RCTs), depression (3 RCTs) and STI incidence (1 RCT), with more mixed results for anxiety (2 RCTs) and behaviour (5 RCTs).

Montgomery et al. (2009) reviewed interventions for children who had experienced physical abuse. They found that a CBT-based skills group for young men in a group home was effective in improving compliance to rules but did not reduce aggression (1 RCT).

Wethington et al. (2008) evaluated interventions for children exposed to sexual abuse. Their meta-analysis found that individual CBT did not improve mental health (4 studies).

Wilen (2014) reviewed interventions for adults who had experienced sexual abuse during childhood. The review found that CBT reduced depression (1 RCT) and anxiety (1 RCT) but did not reduce PTSD (2 RCTs). The review also found that EMDR reduced symptoms of depression (1 RCT) and anxiety (1 RCT).

4.6.2 *Psychological therapies other than Cognitive Behavioural Therapy (CBT)*

Summary: Psychological therapies other than CBT

Number of reviews: 10 reviews examine the effectiveness of psychological therapies other than CBT.

Populations covered: Homelessness (n=2), parentally bereaved (n=1), exposure to domestic violence (n=2), maltreatment (n=1), looked-after (n=1), abuse and neglect (n=1), sexual abuse (n=1) and physical abuse (n=1).

Summary of evidence: Evidence from the most reliable reviews is equivocal overall but there appears to be some support for psychological therapies for young people who have experienced abuse and neglect.

Key findings: Psychological therapies other than CBT

The highest quality reviews on psychological therapies other than CBT found that:

- they improved mental health outcomes for children who have experienced abuse and neglect [Macdonald 2016; AMSTAR 10*].

However:

- they did not improve mental health outcomes for children exposed to domestic violence [Howarth 2016; AMSTAR 9.5; network meta-analysis]
- or mental health outcomes for adults who have been sexually abused as children [Wilen 2014; AMSTAR 10; network meta-analysis]
- or mental health outcomes for parentally bereaved children [Bergman 2017; AMSTAR 5].

Limited evidence (less than three studies) on psychological therapies suggests:

- they may have mixed results for behaviour outcomes for looked-after children [Kinsey and Schlosser 2013; AMSTAR 6]
- they may not be effective for reducing sexual risk behaviours or drug and alcohol use for homeless young people [Altena 2010; AMSTAR 6.5] [Naranbhai 2011; AMSTAR 10].
-

*While Macdonald 2016 included meta-analysis for CBT (see Section 4.6.1), meta-analysis was not conducted for other intervention categories

WHAT IS INCLUDED IN THIS CATEGORY? Any psychological therapy not described as CBT or EMDR delivered to the child alone, or alongside their parent(s) or carer(s). These included: brief motivational interviewing; family therapy; relational interventions; humanistic or psychodynamic psychotherapy; activity-based therapies such as art therapy, play therapy, expressive writing, animal-assisted therapy and drama.

HOW DOES IT WORK? Brief motivational interviewing applies a person-centred approach to encourage people to make the commitment to change their behaviour. Humanistic therapy focuses on an individual's strengths to help them gain a sense of meaning in their life. Creative therapies are based on the premise that people will become more expressive and communicative through working with a therapist in this way; activity-based therapies such as art or play therapy encourage or enhance a young person's ability to release disturbing experiences safely, for example, through using pictures and/or storytelling.

POPULATIONS: Studies included a range of ACE populations including: homeless young people; children of parents with mental health problems; parentally bereaved children; children exposed to domestic violence; looked-after children and young people; children who have been sexually abused; and children who have been physically abused.

DELIVERY: Group and individual, or a combination of both; focus on children or families; delivered by social workers, psychologists, counsellors or therapists, or other staff; a range of settings (healthcare, home, community settings or shelters). Intervention intensity ranged from a single session to intensive intervention lasting almost a year.

Altena et al. (2010) found that brief motivational interviewing for homeless young people did not reduce drug or alcohol use (2 RCTs).

Bergman et al. (2017) reviewed support interventions for parentally bereaved children, mainly group-based family interventions. They found that these interventions reduced symptoms of traumatic grief (2 RCTs, 1 nRCT), but did not improve mental health outcomes (5 RCTs, 1 nRCT), or internalising or externalising behaviour (5 RCTs), and had mixed results for school-related outcomes (2 RCTs).

British Columbia Centre of Excellence for Women's Health (2013) reviewed interventions for children who were exposed to domestic violence. They found that mother-child psychotherapy reduced behaviour problems and improved mental health outcomes (2 RCTs).

Goldman Fraser et al. (2013) found group psychotherapy for children with experience of maltreatment had mixed results for mental health (1 RCT).

Howarth et al. (2016) conducted a network meta-analysis which found that psychotherapy (alone or in conjunction with psychoeducation) for children exposed to domestic violence did not improve mental health outcomes.

Kinsey and Schlosser (2013) reviewed interventions for children in foster and kinship care. They found that relational interventions such as play therapy had mixed results for behaviour problems (2 RCTs).

Macdonald et al. (2016) reviewed a range of psychological therapies for children who had experienced abuse or neglect. The review found that family therapy reduced behaviour problems but did reduce depression (1 RCT). Group activity-based therapies for children (arts therapy, play therapy, animal therapy) had mixed results for mental health outcomes (3 nRCTs). Multi-systemic family therapy improved mental health outcomes (2 RCTs, 1 nRCT) but did not reduce inappropriate sexual behaviour (1 RCT). Family-based systemic interventions did not reduce depression (1 nRCT) and had mixed results for behaviour (2 RCTs, 1 nRCT). Group therapy for children improved self-esteem (1 RCT, 1 nRCT), had mixed results for behaviour problems (1 RCT, 2 nRCTs), and did not reduce sexually inappropriate behaviour (1 nRCT). Individual or group psychotherapy and counselling for children had mixed results for PTSD (1 RCT, 1 nRCT) and for behaviour problems (1 RCT, 3 nRCTs).

Montgomery et al. (2009) found that group psychodrama for children who have experienced physical abuse had mixed results for internalising behaviours and did not impact on externalising behaviours (1 RCT). Individual play therapy had mixed results for child development outcomes (1 nRCT). Dyadic Developmental Therapy reduced behaviour problems (1 nRCT).

Naranbhai et al. (2011) reviewed interventions to modify sexual risk behaviours in homeless youth. They found that family therapy was not effective for reducing risky sexual behaviour (1 RCT).

Wilen (2014) reviewed psychosocial interventions for adults who had experienced sexual abuse during childhood. This review found that humanistic therapy reduced depression (1 RCT), but did not impact on PTSD (3 RCTs) or global functioning (1 RCT), and that dynamic therapy did not reduce symptoms of PTSD (1 RCT).

4.6.3 *Psychoeducation*

Summary: Psychoeducation

Number of reviews: Nine reviews examine the effectiveness of psychoeducation.

Populations covered: Parental mental illness (n=3), parental substance misuse (n=1), exposure to domestic violence (n=1), abuse and neglect (n=1), homelessness (n=1), parental separation (n=1) and sexual abuse (n=1).

Summary of evidence: Evidence from the most reliable reviews is equivocal overall but there appears to be some support for group psychoeducation in relation to improving mental health outcomes for certain population groups.

Key findings: Psychoeducation

The highest quality reviews on psychoeducation found that:

- it improved mental health outcomes for children who have been exposed to domestic violence [Howarth 2016; AMSTAR 9.5; network meta-analysis]
- and improved mental health outcomes for children of parents with mental health problems [Loechner 2017; AMSTAR 5.5; meta-analysis]

However:

- it did not improve behaviour for children who have been exposed to domestic violence [Howarth 2016; AMSTAR 9.5; network meta-analysis]

There were mixed results for:

- mental health outcomes for children who have experienced abuse or neglect [Macdonald 2016; AMSTAR 10]
- sexual behaviour for homeless young people [Naranbhai 2011; AMSTAR 10]

WHAT IS INCLUDED IN THIS CATEGORY? Any psychoeducational intervention aimed at the child alone, or alongside their parent(s) or carer(s). Note that interventions aimed predominately at parents or carers, including training for parents or foster carers, have been categorised separately. Academic-based interventions and (pre)-school therapeutic day treatments have been categorised under 'educational'.

HOW DOES IT WORK? Psychoeducational interventions focus on information or education about psychological issues. It may contain information about resources, signposting alongside instruction on change or coping strategies to build resilience. Psychoeducation interventions are often run in groups to enable development of social skills and modelling of acceptable behaviour.

POPULATIONS: Psychoeducation interventions were aimed at a range of populations: homeless youth; children of parents with mental health problems (including depression); children exposed to domestic violence; children whose parents use drugs or alcohol; children whose parents are separated or divorced; children who have been sexually abused.

DELIVERY: Delivered in group format within school, clinic, health service, care and community settings by social workers; mental health nurses; clinical psychologists. Weekly or fortnightly one-to-two hour or day-long sessions for a duration of six weeks up to a year.

Bee et al. (2014) found that group psychoeducation for children of parents with serious mental illness did not improve mental health outcomes (1 nRCT).

Beresford et al. (2008) found that psychoeducation for children whose parents have mental health problems did not improve behaviour (1 RCT).

Broning et al. (2012) reviewed programmes for children whose parents use drugs or alcohol. The review found that school-based interventions have mixed results overall, but the results are incompletely reported.

Howarth et al. (2016) conducted a network meta-analysis of interventions for children exposed to domestic violence. Their analyses found that psychoeducation (delivered to children or parents) did not improve mental health outcomes or reduce behaviour problems overall. A further analysis indicated that group psychoeducation improved mental health outcomes, but did not impact on behaviour problems.

Loechner et al. (2017) reviewed interventions for children of parents with depression, mainly group-based psychoeducation (some also contained components of parent training and CBT). Their meta-analysis found that these interventions reduced incidence of depression (4 RCTs); reduced depressive symptoms in the short term (up to four months) but not in the medium (up to 12 months) to long term (15 -72 months post-intervention) (6 RCTs).

Macdonald et al. (2016) found that group psychoeducation interventions aimed at children who had experienced abuse or neglect (some of which also involved parents) had mixed results for PTSD (3 RCTs, 4 nRCTs) and did not reduce depression (1 RCT, 1 nRCT), externalising behaviours (2 RCTs) or internalising behaviours (2 RCTs).

Naranbhai et al. (2011) found that a group educational intervention for homeless young people had mixed results for sexual behaviour (1 RCT).

Poli et al. (2017) reviewed school-based interventions aimed at children whose parents were divorced and found that outcomes were positive in around half of cases for individual, family and school outcomes, and in around three-quarters of cases for interpersonal relations. However, the reporting of data in this review is incomplete and the authors' analyses cannot be validated.

Wilen (2014) reviewed psychosocial interventions for adults who had been sexually abused as children. This review found that psychoeducation reduced PTSD (1 RCT), and that the combination of humanistic therapy and psychoeducation improved global functioning but did not reduce PTSD (1 RCT).

4.6.4 *Treatments aimed predominately at parents*

Summary: Treatment aimed predominately at parents

Number of reviews: three reviews examine treatments aimed predominantly at parents.

Populations covered: Parental mental illness (n=2) and exposure to domestic violence (n=1).

Summary of evidence: There is limited review-level evidence on treatments aimed predominately at parents which captured child outcomes. We did not find much evidence to support this approach.

Key findings: Treatment aimed predominately at parents

- The highest quality reviews looking at treatments aimed at parents found that they did not improve mental health or behaviour outcomes for children exposed to domestic violence [Howarth 2016; AMSTAR 9.5; network meta-analysis]
- Limited evidence (less than three studies) on treatments aimed at parents suggests:they did not for improve mental health outcomes for children of parents with mental health problems [Bee 2014; AMSTAR 10].

WHAT IS INCLUDED IN THIS CATEGORY? Any intervention that is predominately aimed at addressing parents' or carers' problems. Note this category is distinct from the parent/carer training category where the primary focus is teaching parenting skills. Where there is overlap with other categories (such as CBT for parents) interventions which are targeted at parents are categorised here.

HOW DOES IT WORK? Interventions aim to address parent problems and, as a result, improve child outcomes.

INTERVENTIONS: Psychotherapy (including CBT), psychoeducation.

POPULATIONS: Parents with serious mental illness and depression, parents of children exposed to domestic violence.

DELIVERY: Delivered in home, community and clinical settings by mental health and general nurses, psychotherapists and social workers. Mostly in groups and some on an individual basis. Delivered in weekly one-to-two hour sessions for a duration of eight weeks up to a year.

Bee et al. (2014) reviewed evidence on interventions for children of parents with mental health problems. This review found that home nurse visiting (1 RCT) and conversational psychotherapy (1 nRCT) for parents with serious mental illness did not improve family outcomes. Psychotherapy for parents with depression did not improve children's mental health outcomes (1 RCT) and that education for parents did not improve family or children's social outcomes (1 RCT).

Beresford et al. (2008) looked at services for children of parents with mental health problems. They reviewed evidence on parent group CBT, but the findings were unclear (1 nRCT).

Howarth et al. (2016) conducted a network meta-analysis which found that interventions aimed at parents of children exposed to domestic violence did not improve children's mental health outcomes or reduce behaviour problems.

4.6.5 *Parent / foster carer training*

Summary: Parent / foster carer training

Number of reviews: 11 reviews examine the effectiveness of parent / foster carer training.

Populations covered: Looked-after (n=6), exposure to domestic violence (n=2), abuse and neglect (n=1), physical abuse (n=1), parental incarceration (n=1).

Summary of evidence: Evidence on parent or foster carer training was equivocal.

Key findings: Parent / foster carer training

The highest quality review on foster carer training found that:

- it improved behaviour for children exposed to domestic violence [Howarth 2016; AMSTAR 9.5; network meta-analysis]

However:

- it did not improve mental health for children exposed to domestic violence [Howarth 2016; AMSTAR 9.5; network meta-analysis]
- or mental health or behaviour for looked-after children and young people [Turner 2007; AMSTAR 8; meta-analysis]
- or behaviour for children of parents involved in the criminal justice system [Troy 2018; AMSTAR 5.5]

Limited evidence (less than three studies) suggests:

- it may not improve behaviour for children exposed to abuse or neglect [Macdonald 2016; AMSTAR 10].

WHAT IS INCLUDED IN THIS CATEGORY? Training which aims to equip parents and carers with the skills required to care for children and young people.

HOW DOES IT WORK? Interventions aim to modify parenting practices with a view to improving child wellbeing.

INTERVENTIONS: Skills-based training for carers to manage challenging behaviours and/or improve family relationships; parent-child interaction therapy (PCIT).

POPULATIONS: Foster parents and carers of children living in care; parents in families affected by domestic violence; parents of children who have been physically abused; parents involved with the criminal justice system.

DELIVERY: Delivered in home, community, clinical and prison settings by social workers, psychologists and paraprofessionals. Average total contact time around 20 hours. Primarily one-to-two hour weekly sessions over eight weeks up to six months; some sessions were longer and delivered over a shorter period of time; home visiting interventions took place over a more prolonged period of up to two years

British Columbia Centre of Excellence for Women's Health (2013) found that parent-child interaction therapy (1 nRCT) reduced behaviour problems for children exposed to domestic violence. Parent training combined with psychotherapeutic or skills-based programmes for children also reduced behaviour problems (4 RCTs) and had mixed results for mental health outcomes (2 RCTs).

Everson-Hock et al. (2012) evaluated the effectiveness of training and support for foster carers. They found that training and support did not improve looked-after children's mental health (1 RCT); results for behaviour problems were mixed (2 RCTs, 1 nRCT).

Goldman Fraser et al. (2013) found that foster parent training improved children's mental health (1 RCT) but had mixed results for behaviour problems (4 RCTs).

Howarth et al. (2016) conducted a network meta-analysis and found that parent training alongside advocacy for children exposed to domestic violence improved behaviour problems but had not effect on mental health outcomes.

Kemmis-Riggs et al. (2018) evaluated interventions to improve the wellbeing of foster children and carers. Training for foster and kinship carers showed mixed results for both behaviour problems (12 RCTs) and relationship outcomes (3 RCTs).

Kinsey and Schlosser (2013) reviewed carer training programmes for children in foster and kinship care and found mixed results for behaviour problems (3 RCTs, 2 nRCTs).

Macdonald et al. (2016) reviewed interventions for children who had experienced abuse or neglect. They conducted a meta-analysis which found that parent-child interaction therapy did not reduce externalising behaviour (2 RCTs).

Montgomery et al. (2009) reviewed interventions for children who have experienced physical abuse. They found that group parent training reduced behaviour problems (1 nRCT) and that parent-child interaction therapy had mixed results for externalising or internalising behaviours (2 RCTs).

Troy et al. (2018) evaluated parenting programmes in the criminal justice system for the parental incarceration population. They found that interventions aimed at improving parenting skills and parent-child relationships did not improve behaviour problems (4 nRCTs) and had mixed results on self-perception (2 nRCTs).

Turner et al. (2007) evaluated group cognitive-behavioural training interventions for foster carers. They conducted a meta-analysis which found that these programmes did not improve mental health outcomes (2 RCTs) or reduce behaviour problems (2 RCTs).

Ziviani et al. (2012) evaluated support services for children and young people with behavioural problems in out-of-home care. They found that parent or foster carer training did not reduce internalising and externalising behaviour (2 nRCTs) or improve social outcomes (1 nRCT).

4.6.6 *Cross-sector support*

Summary: Cross-sector support

Number of reviews: Seven reviews examine the effectiveness of cross-sector support.

Populations covered: Homeless (n=1), exposure to domestic violence (n=1), looked-after (n=3) abuse and neglect (n=1), physical abuse (n=1).

Summary of evidence: There was little substantial evidence on cross-sector support and the evidence is equivocal. There is some (limited) evidence to suggest that cross-sector interventions, such as case management and wraparound services, improve mental health outcomes for looked-after children and young people.

Key findings: Cross-sector support

The highest quality review on cross-sector support found that:

- it did not improve mental health or behaviour outcomes for children exposed to domestic violence [Howarth 2016; AMSTAR 9.5; network meta-analysis]

It had mixed results for:

- behaviour for children exposed to abuse or neglect [Macdonald 2016; AMSTAR 10].

Limited evidence (less than three studies) on cross-sector support suggests:

- it may improve mental health for looked-after children and young people [Kinsey and Schlosser 2013; AMSTAR 6]
- it may have mixed results for behaviour for looked-after children and young people [Kinsey and Schlosser 2013; AMSTAR 6]
- it may have mixed results for mental health outcomes for children exposed to abuse or neglect [Macdonald 2016; AMSTAR 10].
- it may not improve mental health outcomes for homeless young people [Altena 2010; AMSTAR 6.5]
- it may not improve homelessness for homeless young people [Altena 2010; AMSTAR 6.5]
- it may not improve access to services for looked-after children and young people [Jones 2008; AMSTAR 8.5]

WHAT IS INCLUDED IN THIS CATEGORY? Interventions relating to the co-ordination of care and support across services delivered to either the child alone, or alongside their parent(s) or carer(s). We have included treatment (or 'enhanced') foster care in this category as it involves additional support and services, often provided by multidisciplinary teams, to work alongside specially trained foster parents.

HOW DOES IT WORK? Individuals or families with complex problems require a range of practical, emotional and clinical support from across different services. Co-ordinating services may enable support to be delivered more effectively and efficiently.

INTERVENTIONS: advocacy; case management; interventions to improve access to services; multidisciplinary assessment; treatment foster care; wraparound interventions.

POPULATIONS: Interventions were aimed at: looked-after children and young people, including those in foster and kinship care and those with behaviour problems; homeless young people; children exposed to domestic violence.

DELIVERY: Interventions were delivered in community, residential and across interagency settings by a range of clinicians, multidisciplinary teams, playworkers, advocates and case managers. Information on intensity and duration of interventions was limited.

Altena et al. (2010) found that intensive case management for homeless young people did not reduce alcohol and drug use or homelessness, and did not improve mental health outcomes (1 RCT).

Howarth et al. (2016) conducted a network meta-analysis which found that advocacy alone for children exposed to domestic violence did not improve mental health outcomes or reduce behaviour problems.

Jones et al. (2008) evaluated interventions to improve access to specialist or universal services accessed by looked-after children and young people. They found that multidisciplinary assessments and case management did not improve receipt of services (3 nRCTs), and that information sharing between agencies did improve receipt of health assessments (1 nRCT).

Kinsey and Schlosser (2013) found that multi-component 'wraparound' support interventions for children in foster or kinship care improved mental health outcomes (2 RCTs, 1 nRCT); findings on behaviour problems were mixed (2 RCTs).

Macdonald et al. (2016) reviewed interventions for children who had experienced abuse or neglect. They found that treatment foster care had mixed results for mental health outcomes (2 RCTs) and behaviour problems (4 RCTs), and did not improve social outcomes (2 RCTs). Co-ordinated care did not reduce behaviour problems (1 RCT).

Montgomery et al. (2009) reviewed interventions for children who had been physically abused. They found that treatment foster care improved mental health outcomes and had mixed results for behaviour (1 RCT).

Ziviani et al. (2012) found that case management for children with behavioural issues who are in out-of-home care reduced internalising and externalising behaviour (2 RCTs) and improved social outcomes (2 RCTs), and had mixed results for criminal behaviour (2 RCTs) and school outcomes (1 RCT).

4.6.7 *Educational*

Summary: Educational

Number of reviews: four reviews examine the effectiveness of educational interventions.

Populations covered: Looked-after (n=2) abuse and neglect (n=1), physical abuse (n=1).

Summary of evidence: There was limited substantial high quality review-level evidence on this approach and results were mostly mixed.

Key findings: Educational

- The best quality reviews on educational interventions found that they had mixed results for school-related outcomes for looked-after children and young people [Evans 2017; AMSTAR 5.5].
- Limited evidence (less than three studies) on educational interventions suggests they may improve mental health outcomes for children exposed to abuse and neglect [Macdonald 2016; AMSTAR 10].

WHAT IS INCLUDED IN THIS CATEGORY? Any intervention aiming to improve educational outcomes, or through which specialist treatment is delivered through a residential or day care environment akin to a school or nursery, delivered to the child alone, or alongside their parent(s) or carer(s).

INTERVENTIONS: Educational interventions; therapeutic day care treatment (early intervention for ACE populations at risk of poor outcomes); playgroup for school readiness.

POPULATIONS: Looked-after children and young people, children exposed to abuse or neglect.

DELIVERY: Delivered in school or day care settings by teachers, counsellors and specialist therapists. Duration ranged from 40 hours up to a year.

Evans et al. (2017) reviewed interventions addressing the educational outcomes of looked-after children and young people, and found that these interventions had mixed results for academic skills (9 RCTs) and school attendance (3 RCTs).

Kinsey and Schlosser (2013) reviewed interventions for children in foster or kinship care. They found that a playgroup programme for school readiness had mixed results for behaviour problems (1 RCT).

Macdonald et al. (2016) found that therapeutic day care for children exposed to abuse or neglect reduced drug and alcohol use (1 RCT), improved developmental outcomes (1 nRCT) and self-concept (1 RCT, 1 nRCT), and had mixed results for behaviour problems (1 RCT) and criminal behaviour (1 RCT).

Montgomery et al. (2009) found that therapeutic day care for physically abused children improved developmental and social outcomes (2 nRCTs).

4.6.8 *Housing and life skills*

Summary: Housing and life skills

Number of reviews: four reviews examine the effectiveness of housing and life skills interventions.

Populations covered: Homeless (n=3), looked-after (n=1).

Summary of evidence: Evidence is equivocal and restricted to just homeless and looked-after populations. The reviews included a wide range of intervention types. There is some evidence of positive outcomes, but overall the reviews do not provide strong support for these approaches.

Key findings: Housing and life skills

The best quality review on housing and life skills interventions found mixed results for:

- social outcomes (housing, educational, employment, homelessness) for young people leaving care. [Everson-Hock 2011; AMSTAR 6.5]

Reviews on housing and life skills interventions found that:

- they did not improve mental health or behaviour (alcohol or drug use, sexual behaviour) for homeless young people [Coren 2016; AMSTAR 11; meta-analysis]

WHAT IS INCLUDED IN THIS CATEGORY? Any intervention delivered to the child alone, or alongside their family, which aims to improve their housing situation, or provide them with mentoring and practical skills to improve their future prospects.

INTERVENTIONS: Independent living programmes; supportive housing; vocational programmes; harm reduction; community reinforcement; transitional support services; group peer-led interventions.

POPULATIONS: Homeless young people; young people transitioning out of care.

DELIVERY: Delivered in homeless shelter or drop-in service settings by counsellors, therapists, clinicians, case managers, peers to families and individual children and young people. Wide range of intensity from single sessions to long-term interventions.

Altena et al. (2010) reviewed interventions for homeless young people. The review found that an independent living programme improved employment and living status, had mixed results for educational outcomes and mental health outcomes, but did not reduce delinquent behaviour (1 nRCT). Supportive housing improved general health and reduced drug use (1 nRCT). A group vocational programme improved life satisfaction, had mixed results for mental health and family/peer support, did not improve service utilisation or reduce drug/alcohol use, and had adverse effects for risky sexual behaviour (1 nRCT). A group peer-led intervention improved drug-related knowledge and intentions (1 nRCT).

Bassuk et al. (2014) reviewed housing interventions for homeless families. However, the significance of the findings was not reported.

Coren et al. (2016) evaluated the effectiveness of interventions for street-connected children and young people. Their meta-analysis synthesised data on a wide range of interventions including motivational and cognitive approaches, family therapy and case management. The meta-analysis found that overall,

interventions did not reduce alcohol- or drug-related outcomes (10 RCTs, 1 nRCT), risky sexual behaviour (3 RCTs, 2 nRCTs), or improve mental health outcomes (7 RCTs); findings on delinquent behaviour (2 RCTs) and family outcomes (2 RCTs) were mixed.

Everson-Hock et al. (2011) focused on support services for looked-after young people transitioning out of care. They found that these services improved housing and independent living outcomes (6 studies), but otherwise did not impact on other outcomes including educational outcomes (5 studies), employment (6 studies), criminal behaviour (2 studies), parenthood (3 studies), homelessness (4 studies), and mental health (3 studies).

4.6.9 *Foster care / out-of-home care*

Number of reviews: two reviews examine the effectiveness of foster care / out-of-home care interventions.

Populations covered: Maltreatment (n=1) abuse and neglect (n=1).

Summary of evidence: No conclusive findings were found in favour of either foster care or children living in out-of-home care. The studies in these reviews use observational methods and differences between groups cannot be ruled out.

WHAT IS INCLUDED IN THIS CATEGORY? Reviews comparing different types of care placements for looked-after children and young people.

INTERVENTIONS: Foster care; in-home care; kinship care.

POPULATIONS: Children assessed for care placement subsequent to abuse or neglect.

Maclean et al. (2016) reviewed cohort studies (31 studies) on children assessed for child maltreatment by child protection agencies which compared outcomes between children placed in out-of-home care and children who were cared for by their parents at home. The review assesses a wide range of outcomes including academic achievement and school-related outcomes, daily living skills, social support, behaviour problems, mental health, service utilisation, criminal behaviour and health risk behaviours. Most of the analyses show no significant difference between groups, although a few show worse outcomes for children in out-of-home care.

Winokur et al. (2014) reviewed studies (102 studies) on children removed from the home for abuse or neglect, comparing those placed in the care of relatives (kinship care) to those placed in standard foster care. They found that children in kinship care showed better outcomes for behaviour problems and mental health and wellbeing outcomes, while there were no differences for educational or family outcomes.

5 Stakeholder workshop

The methods used for our consultation with seven young people with lived experience of ACEs are described in Section 7.6.

Discussions with the young people generated the following main themes:

- Inflexibility of the school system and teachers' lack of understanding
- The impact of ACEs varies depending on various factors
- Ethnic background as a confounding factor in ACEs
- Practical skills and community recreation
- Limitations of counselling therapies
- Ways to measure progress

In order to protect the young people's anonymity we have used gender neutral pronouns below (they/them) and have avoided providing any information which may expose sufficient information to identify them.

5.1 Findings

5.1.1 *Inflexibility of school system and teachers' attitudes*

We did not directly ask the young people about school but it clearly played a large role in how the young people felt they had been largely, but not always, failed to be supported. This was the case even for those with extended school absences.

Completely confidential counselling offered in a sixth form college (confidential both within school and toward families) was cited as an example of good practice. However, there was a lot of variability in terms of experience of support. One young person with poor school attendance owing to severe anxiety had received no support for years until they moved boroughs. Their new school was able to offer one-on-one tutoring in order to try and help them to take exams.

Young people placed a lot of importance on being supported during critical junctures such as exam times and during preparation for leaving school to go on to higher education and training or work. However, some young people described receiving very little understanding of their problems or situation from their school during these periods (or at any other time). One young person who was applying for medical school was told that 'A levels weren't for them' after they had fainted during an exam. Another young person felt teachers were dismissive of the ramifications of their involvement as a witness in court proceedings during their GSCEs.

Trauma manifesting itself through mental and physical symptoms was a common theme, alongside education professionals' inability to know how, or even *if*, to support young people through these complex and not always clearly diagnosed or diagnosable problems. Training and awareness raising for teachers (to help them understand that there may not always be a 'quick fix') were repeated suggestions.

5.1.2 *ACEs impact people in different ways and at different times*

ACEs were described as affecting young people differently depending on various factors, such as stage of life, or whether or not siblings lived in the same house and if they were older or younger. Those who have lived in a household which is dysfunctional, or who are abused from a young age understandably take their experience to be 'normal' and it is only through comparison with their peers' families and relationships as they grow more independent that they may start to question what is happening in their own.

Gender and ethnicity are others factors which affect ACE experience – girls described increased likelihood of having to take on caring responsibilities, especially in ethnic minority households, and although it should be noted that males were underrepresented in the group it was suggested that boys were less likely to talk to others about being affected by ACEs.

Family structure, such as living in a single parent household, was described as both being a protective or additional risk factor depending on circumstances. In scenarios where a single parent is the sole provider in the household as well as being a perpetrator of abuse, young people faced a great deal of uncertainty about what would happen to them upon disclosure. Disability, physical or mental health problems, or reduced communication skills are likely to compound ACE-related problems such as being socially isolated. Class and financial standing also affect ACE experience – less money, either in terms of community services or on a family level, means there is less chance of receiving support.

5.1.3 *Ethnic background*

As described above, different factors affect young people's experiences of adversity. Being from an ethnic minority adds an extra layer of complexity to an already challenging homelife. Family pride and cultural expectations made ACEs particularly challenging to navigate. For example, young people described being from cultural backgrounds where mental health was regarded as taboo or was not recognised as an actual illness, or where children were expected to show reverence to parents and any opposition to parents' views in any circumstances was seen as disrespectful. Young people found that their family's values did not always translate directly to the other 'more British' community they are also part of – and that this added to their sense of isolation and fragmented identity.

5.1.4 *Recreation and practical skills*

Self-care was a recurring theme throughout discussions. This relates not only to dealing with trauma and respecting oneself and others, but also to a desire to learn practical skills (such as how to open a bank account, how to budget, learning to drive, applying for jobs or further education courses) in order to be independent and to look after oneself. This was deemed especially important in the absence of having a parental figure who will oversee the development of life skills.

Recreational activities helped enormously with improving self-esteem. Young people valued having opportunities for recreation in the community. This gave them the chance to be mentored (or, in time, to mentor) learn life skills and gain independence. Activities outside of home and school provided a much needed safe space for building identity and confidence.

5.1.5 *Counselling and talking therapies*

Lack of access to services was highlighted as a huge problem – in relation to knowing which services existed, services not being available or having year-long waiting lists.

The timeliness of counselling was described as crucial. Young people described not receiving help until a crisis point (or at all), but a preventive approach or just knowing that there is support before that stage could significantly improve the lives of young people affected by ACEs.

As with schools, support services were described as varying significantly depending on the area that the young person lived.

Some young people described counselling as distinctly stressful and invasive and felt that it looked at the symptom rather than the cause.

Services that were tailored to an individual's needs were regarded more positively, but young people warned against counselling that was too limited and standardised (for example, six weeks of CBT as standard). Young people described a pronounced gap between primary and secondary care and a lack of follow-up care.

5.1.6 *Ways to measure progress*

When asked for a suitable measure to assess the progress of someone affected by ACEs, 'connectedness' or 'reduced isolation' were suggested. Other young people suggested looking at how someone was faring at key transition points in their life to see if they were adapting positively to the next stage – if they could cope well with the transition that would be a sign that someone is doing well.

6 Discussion

6.1 Summary of findings

Our objective was to gather, assess and present evidence on what helps to mitigate the harmful impacts of ACEs, or to promote positive outcomes, for people affected by ACEs.

What helps to support young people affected by ACEs?

While the impacts of ACEs are complex and multifaceted, the views synthesis and stakeholder work presented several commonalities in terms of people's experiences and needs.

In particular, people affected by ACEs described maintaining an injured sense of trust; a compromised or fractured identity; and a lack of agency. People affected by ACEs are denied the support mechanisms to meet their basic emotional needs and, in some cases, practical needs. Trusting relationships, and control over who, and what, others know about their lives were important factors in overcoming their problems, regardless of the specific ACE population.

Views synthesis

The views synthesis highlights the kinds of problems that people affected by ACE experience; the strategies that individuals employ to mitigate the negative impacts of ACEs or to promote positive ones; the ways in which services can help to address these problems, and how services for people exposed to ACES should be delivered.

Q1: What are the negative impacts of ACEs on people's everyday lives?

We found that upheaval, rejection and betrayal - both at the interpersonal level and on a wider structural level - have a marked effect on young people's lives. ACEs negatively affect people's sense of self, their relationships, and how others perceive or treat them. Notably, young people describe being socially isolated (for example, not fitting in owing to practical and emotional differences and stigma) and having a lack of agency and power (for example, feeling that they are not heard, having limited means to self-realise).

Q2: What strategies do individuals employ to mitigate the negative impacts of ACEs?

People affected by ACEs use various strategies: including internal mechanisms, to manage or mask emotions such as anger or guilt (coping); practical solutions, such as trying to patch up precarious family relationships to deal with adversities and strive for a normal life (dealing); and reaching out through friendships and safe 'silent' spaces as ways of seeking support (sharing). These ways of coping, dealing and sharing are seen as a double-edged sword, as each can have both negative and positive consequences.

Q3: What services are needed to address the negative impacts of ACEs?

People exposed to ACEs value support from a trusted adult; they desire service providers who are empathetic, non-judgemental, and active listeners. Enabling peer support, for example through group therapy, is also valued.

Forms of practical support that services could offer include: information to help people understand and address their problems; help to manage everyday practical challenges such as engaging with the education or benefits systems; and respite from the responsibilities and problems they face.

Q4: How should services for people exposed to ACEs be delivered?

Widespread scepticism about services and service providers suggests that how services are delivered may be critical to their uptake. Continuity and dependability of service providers helps to foster trust and ensure that effective relationships can develop. Allowing service users to have flexibility and control over how and when they engage is also important for engendering trust.

Overview of intervention evidence

31 reviews met our quality threshold and were included in the synthesis. The reviews covered all ACE populations, with most evidence on looked-after children and young people, and children who have been sexually abused.

The bulk of the data focuses on individual psychological interventions and on mental health or behaviour outcomes. These data indicate that there is good evidence for the effectiveness of the following for at least some populations: cognitive behavioural therapy and other psychological therapies for mental health outcomes; psychoeducation for mental health outcomes; and parent or foster carer training for behaviour outcomes. However, there is a limited amount of evidence, and more mixed findings, on interventions which address the broader contexts of children's and young people's lives, including: interventions aimed at parents; cross-sector support; housing and life skills interventions; and educational interventions. There is also limited evidence on broader outcomes such as social functioning or life circumstances.

A map of available evidence from the overview is presented in Appendix I.

Our findings represent only a very high-level overview of the evidence. Our methodology also does not allow for a detailed consideration of how differences in, for example, the specific setting or population addressed in the studies might impact on effectiveness.

Many of the included reviews contain relatively few primary studies (median n=17), which suggests that the underlying primary evidence base for many populations is fairly small (although for some it is much larger, with Macdonald et al. 2016 finding n=198 studies on the abuse and neglect population, of which n=135 were for sexual abuse).

Stakeholder workshop

Young people described problems with forming healthy relationships or an increased likelihood of being drawn into toxic ones; low self-esteem; and uncertainty over where they could go for confidential support. They also described the need for practical and emotional support; in particular the need for learning life skills which would enhance autonomy. Also in keeping with the views synthesis, recreational activities within the community were described as a valuable way to gain confidence, build identity and relieve stress in a safe environment.

While prolonged absence from school and bullying featured in both the views synthesis and the workshop, the young people we consulted with described in more detail on how school played a central role in whether or not they felt supported to deal with their problems. They described how institutional inflexibility and teachers' lack of empathy had caused further setbacks in their lives and the need for teacher training and additional support for school staff were highlighted.

Counselling therapies tailored to young people's needs were found to be positive, but others found standard counselling invasive and stressful. Schools and support services were variable across different parts of the UK and some young people had not been able to access support when they needed it owing to long waiting lists, or a lack of appropriate services.

Discordances between the studies

Fundamental contradictions between the views synthesis and the overview of interventions make it difficult to definitively answer the question of what helps to support young people affected by ACEs.

We identified the following areas of discordance between the studies:

The overwhelming majority of interventions in the overview of interventions took a crisis point approach in that they aimed to reduce diagnosable mental health problems. While the views synthesis showed that people affected by ACEs may be susceptible to mental health problems, they also described underlying social, emotional and practical problems which psychological therapy alone would not be able to address.

Interventions were mostly brief (between six to 20 weeks) with the aim of reducing specific disorders (for example, PTSD or depression). However, the views synthesis points to the need for long-term and consistent care which provides an important counterpoint to the many inconsistencies young people affected by ACEs described, and a way to allow time to build up necessary trust.

The stakeholder work and the views synthesis showed that young people affected by ACEs emphasised the importance of support with practical and life skills to become more independent. However, the best available evidence from systematic reviews did not contain many housing or life skills-type interventions. Where they did exist they were aimed exclusively at the looked-after or homeless populations (Everson-Hock 2011, Coren 2016).

Our views synthesis found supportive relationships with peers or adults to be a key factor in overcoming problems, and stakeholders prioritised 'connectedness' as one of the most important measurements to show they were doing well. However, while interventions in the overview may address relationships and emotional developments, they were rarely measured as main outcomes.

6.2 Strengths and Limitations

Our overview of evidence was conducted according to systematic review principles, with highly sensitive search strategies and clearly defined quality assessment, data extraction, and inclusion criteria. We used a 'best evidence' approach focusing on higher-quality reviews for the overview of intervention evidence, and the most relevant and highest quality primary studies for the views synthesis. However it should be noted that AMSTAR, applied in the overview of interventions, tells us about the quality of a systematic review's methods but does not account for the quality of the primary studies contained within it.

By looking across all ACE populations, our review of evidence generates a broad overview of the best available review-level evidence on interventions, and an in-depth insight into the views and experiences of those affected by ACEs. It also allows comparison across the different kinds of evidence to identify synergies or contradictions. This inclusive approach, including a consultation with young people with lived experience of ACEs, helps to ensure that our findings are generalisable. Although it should be noted that no studies on parental incarceration or parental separation were identified for the views synthesis and these populations are also underrepresented in the overview of interventions.

One limitation of our approach to the views synthesis is that we identified primary studies from systematic reviews which were located through a search strategy intended to retrieve relevant qualitative and quantitative systematic reviews (as detailed in Section 7). One potential shortcoming is that recent primary studies published after the latest systematic reviews would not have been identified by this approach.

Using a RoR methodology for the overview of interventions has allowed us to cover a broader range of evidence than would have been practicable in a systematic review of primary studies. However, it does mean that we were unable to provide a highly detailed picture of the evidence. Where the synthesis describes results as 'mixed', it is possible that effectiveness might depend on factors (for example, the intervention content or intensity, population or setting) which we could not investigate. Furthermore, authors of the systematic reviews describe the primary study evidence base as having a number of limitations which inevitably impact on the reliability of the systematic reviews. Common limitations were: small sample sizes; a lack of information on implementation fidelity; and a lack of clarity over the precise nature of 'usual care'. All of these factors could potentially explain discrepancies and inconsistencies in the results.

Notably, aside from negative direction of effect of pre-specified outcomes there was a lack of evidence on the unintended consequences or harms of the interventions included in the overview. While it is established that social or behavioural interventions may cause unintended harms, they are not commonly studied within evaluations of public health interventions (Bonell et al. 2015). Consideration of unintended harm is particularly important to consider in relation to ACEs where the risk of potential stigmatisation or re-traumatisation is high. Coren et al. (2016) was the only review which explicitly stated consideration of unintended outcomes as a research objective. Another inherent limitation of RoRs is that primary studies may be counted more than once where they have been included in multiple reviews (Lunny et al., 2017). This is the case, for example, for the findings on CBT for sexual abuse (Goldman Fraser et al., 2013, Macdonald et al., 2016, Wethington et al., 2008, Wilen, 2014), and foster carer training (Everson-Hock et al., 2012, Goldman Fraser et al., 2013, Kemmis-Riggs et al., 2018, Kinsey and Schlosser, 2013, Turner et al., 2007). In these cases the number of reviews may be misleading as to the extent of the primary evidence base. The 'best evidence' methodology reduces this problem but does not eliminate it.

As discussed in Section 1, there are controversies regarding the epidemiological evidence on the impacts of ACEs, and not everyone who experiences ACEs will necessarily have negative outcomes as a result. Hence, the efficacy of interventions focused on ACE populations with respect to long-term health status outcomes is open to debate.

To our knowledge, this is the first evidence synthesis to cover the whole spectrum of interventions delivered to support people with one or more ACEs. As such it represents a synoptic overview of the evidence base and helps to identify gaps in the literature. In addition, the use of a mixed-methods approach helps to clarify how interventions respond (or do not respond) to the needs of people affected by ACEs.

6.3 Implications for practice and policy

The idea that people need to feel safe and have their basic needs satisfied in order to thrive is by no means new. Findings generated in our views synthesis speak to theories dating back to the 1940s. Maslow's hierarchy of needs (1943), as illustrated in Figure 6, shows how services could attempt to fill in the gaps left by ACEs through meeting practical and emotional needs. The desired attributes of professionals to support people with ACEs - non-judgemental, active listeners - evoke Carl Roger's person-centred approach to therapy (1942), which first espoused empathetically taking the lead from the client.

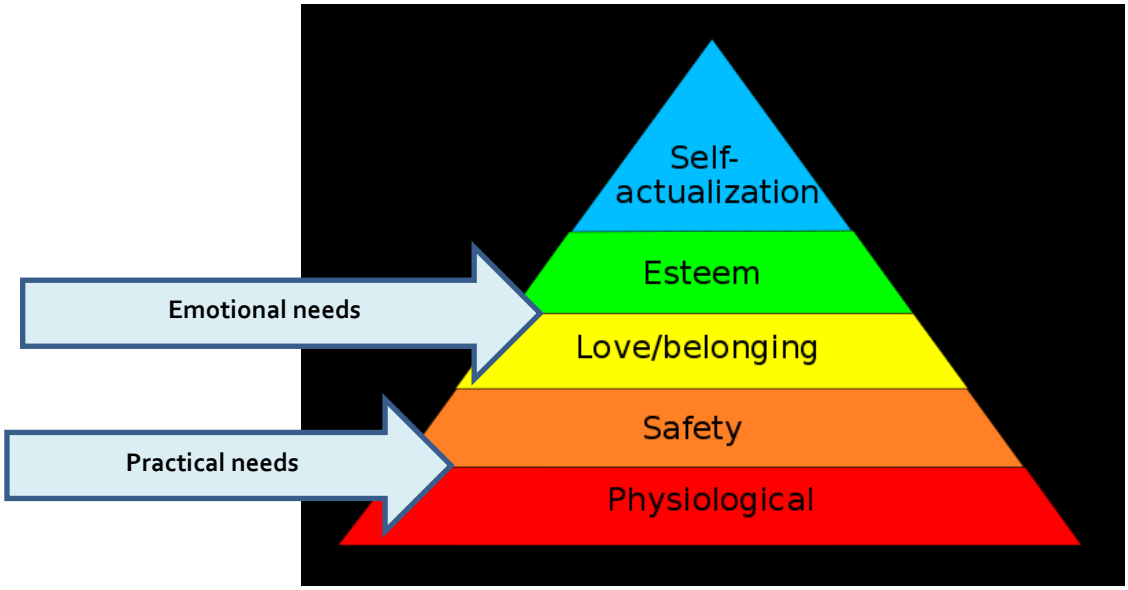

Figure 7: Maslow's Hierarchy of Basic Needs (1943)

Young people affected by ACEs describe a range of emotional, practical, social, medical and legal needs which may materialise at various stages of their life. However most systematic reviews in the overview of interventions evaluate brief interventions to reduce specific diagnosable disorders (for example, PTSD or depression). To some extent this may reflect the nature of systematic reviews. In systematic reviews individual therapies are more likely to be focused on than more structural or complex long-term interventions, as they are more easily evaluated using more robust evaluation designs such as controlled trials. In addition, the outcomes measured in psychological studies are more likely to be standardised and thus comparable in systematic reviews.

While individual psychological treatments were shown to improve mental health outcomes for certain populations in the short term, it is apparent that no one agency will be able to address the range of needs which people affected by ACEs may have. Agencies must work together - across criminal justice, education, health and social care - to ensure that ACE-related problems are addressed not just at crisis point, but across the life course. Upstream intervention and early identification could potentially reduce the need for costly, and currently severely restricted (Knapp et al. 2016), intensive psychological therapy. The highly complex and interrelated nature of the impacts of ACEs, and the prevalence of multiple ACEs (see Sections 1.2 and 1.3 above), imply that an upstream approach is likely to be more promising than the treatment of specific morbidities. Emerging policy and practice around ACEs is moving away from a crisis point approach in the direction of early intervention, prevention and integrated working. For example, practice guidelines for integrated psychological services for children and young people and their families recommend community support and early intervention as opposed to the practice of crisis management and removing children from their families (Faulconbridge et al. 2016).

In Wales, a programme to transform the way that the police and partner agencies deal with the most vulnerable people in society is currently underway through the Police Transformation Fund 2017-2020. This represents a holistic model of approaching ACEs by working collaboratively across sectors in order to facilitate early intervention and mitigate ACE-related harms.

Similarly, the Scottish Government has pledged that they will embed a focus on ACE prevention and awareness across 'all areas of public service, including education, health, justice and social work' (*A nation with ambition: the government's programme for Scotland* (2017/18)) alongside policy initiatives such as 'Getting it right for every child'. It should be noted that despite the 'lifecourse' approach of these kinds of policies very

few studies included in our review of evidence took this approach. We did not impose any restrictions on the age at which the intervention was received or the stage at which outcomes were measured, yet only one systematic review included in our overview of interventions focused on adult survivors (Wilen 2014), with one other review including evidence on young people up to the age of 25 years (Macdonald 2016).

As many ACEs have a 'hidden' or taboo nature engendering cultural shifts and teaching young people to understand their rights, and about healthy relationships and consent, is particularly important in relation to ACEs. The commitment to provide Relationship and Sex Education in schools is already enshrined in the Children and Social Work Act 2017 and it will be compulsory to do so from September 2020. In secondary schools, young people will be taught about healthy intimate relationships, the concepts and laws relating to consent, sexual exploitation, grooming and harassment. Young people will also be informed about domestic abuse, including coercive control, so they can recognise the signs of abuse.

The views synthesis and the stakeholder work in particular, highlighted that schools can play a pivotal role in supporting (or failing to support) young people affected by ACEs. Initiatives or training for teachers or professional working in schools on the potential impact of ACEs on young people's lives, alongside information on signposting to services or collaboration with relevant agencies could all be valuable avenues to explore.

It should be noted that ACEs and related impacts were shown to be durational and episodic and, as such, not necessarily conducive to being treated by brief interventions with outcomes which are evaluated at short follow up times. While this was the approach taken by many of the systematic reviews in the overview of interventions, people affected by ACEs valued stable, flexible and consistent care within which control and power dynamics are crucial - it can often take time for people to build up the necessary trust in a relationship for it to serve them well.

The guideline on promoting the quality of life for looked-after children and young people recommends that research on this population needs to be measured over the short, medium and long term and across the life course (NICE, 2010). The principles espoused by this guideline - the importance of building up a sense of identity and belonging; ensuring a stable experience of education; and engaging with young people on an ongoing rather than 'one off' basis – all resonate with many of our findings in the views synthesis. Notably, empowerment, choice, control and transparency are some of the key principles of adversity and trauma-informed approaches to mental healthcare. This applies to both services for children and young people (Young Minds, 2018) and for women and adults (Elliot 2005; Bloom 2006; Sweeney et al. 2018) affected by trauma. There is clearly potential for shared learning across different sectors for how people affected by ACEs may best be supported at different stages of their life and how principles of trauma-informed approaches may be adapted at an organisational level.

NHS England's *Strategic Direction for Sexual Assault and Abuse Services: Lifelong care for victims and survivors: 2018 – 2023*) recognises the 'devastating and lifelong consequences' that sexual abuse can have on a victim's life and espouses the need for a 'seamless approach that recognises individual needs and reduces fragmentation and gaps between services' (p.10, 2018). Again, the importance of collaborative, joined up working is highlighted, as is the need for continuity, when providing care for victims or survivors of trauma.

Another core priority in this strategy is 'involving victims and survivors in the development and improvement of services' (p.5, 2018). Involving services users in the development of services is advocated in adversity and trauma –informed care (Sweeney et al., 2018) and, in relation to people affected by ACEs, this could offer a mutually beneficial way to ensure services are appropriate while also empowering those affected by ACEs and teaching practical life skills.

Our views synthesis found supportive relationships with peers or adults to be a key factor in overcoming problems, and stakeholders prioritised 'connectedness' as one of the most important measurements to show they were doing well. The £13m Trusted Relationships Fund will support interventions that aim to strengthen the relationships between at-risk and vulnerable young people (10-17 years) and the adults who support them. Interventions will be aimed at those at risk of child sexual abuse or exploitation, criminal exploitation or relationship abuse.

6.4 Gaps in the evidence

There are several major gaps in the views synthesis and the overview of interventions relating to populations which are considered below.

6.4.1 *Populations*

Our views synthesis and overview of interventions revealed that ACE populations tend to be studied in isolation in both qualitative and quantitative research, even though prevalence data shows that ACEs often correlate (Hughes et al. 2016).

Only one study in the views synthesis (Winter, 2010) explicitly stated the concurrent ACEs that participants were exposed to, and no studies specifically aimed to explore the experience of young people exposed to multiple ACEs. However, we could infer from a few studies that participants were exposed to co-occurring ACEs. Of particular note was clustering of parental substance abuse, parental mental health problems, exposure to domestic violence, parental incarceration, and neglect.

Similarly most of the reviews in the overview of interventions focus on a single ACE population and do not explicitly address the clustering of different ACEs (although it may be assumed that many homeless and looked-after children experience clustering of ACEs in addition to the trauma of separation from their families or involvement with child protection services). It is thus difficult to draw implications about how clustering of ACEs might be addressed by policies or interventions. Given current policy thinking about the need for a holistic approach to ACEs, this represents an important gap in the literature.

We identified no studies focusing on parental incarceration or parental separation in the views synthesis and there is clearly a lack of robust research in this area. There is also a lack of high quality systematic reviews on parental incarceration, parental bereavement and parental separation.

Arguably the lack of robust research on the effects of parental separation on children could signify that the inclusion of parental separation as an ACE is outmoded. As discussed in the stakeholder consultation, being from a single parent family does not necessarily constitute an adversity and could in fact be protective.

In the overview of interventions we found limited review-level evidence on children who have experienced physical abuse, emotional abuse or neglect, compared to the very substantial body of evidence on sexual abuse. This appears to also be true of the primary evidence base, since several reviews define their population to include all forms of abuse or neglect, but locate mainly studies on sexual abuse. As findings on children who have been sexually abused may not be transferable to other forms of abuse or neglect, this represents a substantial gap in the evidence.

The overview of interventions also revealed gaps in relation to interventions and outcomes.

6.4.2 *Interventions*

Most of the evidence relates to interventions focused on individual children and young people or families rather than on community-level programmes. Most of the evidence addressing children and young people who have been abused or neglected, focuses on psychological interventions aiming to improve individuals'

mental resilience. This also applies to populations experiencing household adversity. For the looked-after and homeless populations the range of interventions is somewhat broader, and includes more service-level programmes aiming to provide support across different domains. However, for all populations, there is a gap around community-level programmes. Interventions aimed at disadvantaged communities, for example to promote economic development or increase social cohesion, may have considerable potential to promote resilience for children exposed to ACEs, but we found no evidence on this type of intervention. Early years programmes, including large-scale community-wide initiatives along the lines of Sure Start or more focused programmes such as home visiting – which are broadly effective for the prevention of ACEs such as abuse and neglect (Peacock et al., 2013, Selph et al., 2013) have not been evaluated for their impact on other outcomes in ACE populations.

More broadly, as Allen and Donkin (2015) argue, policies which act to reduce socioeconomic inequalities across the population and reduce child poverty are likely to have a positive impact on the outcomes of children experiencing ACEs, but no direct evidence on this was available in the systematic review literature identified.

Service-level interventions, as noted, have been evaluated to some extent for looked-after and homeless children but not for other populations. Interventions to co-ordinate delivery of services may be a promising way to address multiple ACEs (Marsh et al., 2011, Ungar et al., 2014), although there appears to be little robust outcome data (Newman et al., 2007). Co-operation between agencies to promote children's wellbeing is a statutory obligation under Section 10 of the Children Act 2004, and forms a core part of many current policy initiatives as discussed above.

Allen and Donkin (2015) suggest that a form of 'proportionate universalism' which includes policies at multiple levels, including both targeted programmes and national-level policies to reduce disadvantage and improve the context within which families live, may be the most promising policy response to ACEs (see also Davies 2012). However, our findings show that there is limited systematic review evidence on most interventions which could form part of such an approach.

6.4.3 *Outcomes*

For the abuse and neglect and household adversity populations, the great majority of the evidence concerns mental health outcomes such as anxiety or depression, and behaviour problems in younger children, with a smaller amount of data on family or social outcomes such as family relationships or social support. For the looked-after and homeless populations the range of outcomes is much broader and includes behaviours (for example, drug use, risky sexual behaviour, criminal behaviour) and social outcomes (for example, housing, employment, education) as well as mental health and family outcomes. These more distal measures of impact are largely lacking in the abuse and neglect and household adversity populations. Thus, there is a lack of evidence on how interventions might impact on the broader lives of people who have experienced ACEs but who are not looked-after or homeless. There is also limited evidence on physical health outcomes for any population. In addition, our overview of interventions set out to find cost-effectiveness evidence but we found just one relevant economic evaluation of CBT.

6.5 Future research recommendations

This review has highlighted the need for future research in several key areas.

ACE clustering: The lack of research focusing on young people with multiple ACEs suggests an urgent need for research which explores how ACEs cluster or co-occur and a need for interventions which target multiple ACEs.

Building life skills: The focus of evidence in the overview of interventions to address mental ill-health and the resulting lack of evidence on housing and life-skills type interventions suggests the need for evaluations of programmes that aim to empower young people affected by ACEs through offering early support and building life skills.

Fostering trusting relationships: In line with the key finding of the views synthesis on the significance of supportive relationships, evaluations are needed to understand whether and how fostering supportive relationships with a single trusted adult is beneficial for young people affected by ACEs. Understanding of how, and specifically who, support could come from would be valuable.

Cost-effectiveness studies: Given the current constraints in funding for children's services robust economic evaluations of interventions to support people affected by ACEs may be of value to service commissioners. Understanding the relative cost-effectiveness of longer-term life-skills interventions as compared to the cost of crisis-point psychological therapies may be of particular value for deciding where best to invest scarce resources.

'Lifecourse' approach: Our review of evidence revealed a lack of evidence on interventions to support adult survivors of ACEs which suggests that more research is required to understand how people affected by ACEs could be supported to thrive in adult life. In part, this could be studied by evaluating innovations in trauma-informed practice across a range of sectors.

7 Detailed Methods

This chapter provides a detailed account of the transparent and rigorous methods used to identify, appraise and synthesise the evidence. The review protocol was registered in PROSPERO (registration CRD42018092192). EPPI-Reviewer 4 software was used to manage data. The project received full ethical approval from UCL IOE Research Ethics Committee.

7.1 General methods

For the views synthesis we conducted a systematic review of qualitative evidence from the UK at the primary study level. The overview of interventions used a systematic approach to identify and bring together evidence from existing systematic reviews. We produced a systematic review of systematic reviews (RoR). This approach is often used to provide an overview of a topic covering different interventions, providers, settings and participants (Becker and Oxman, 2011, Thomson et al., 2010). RoRs are often produced to aid decision-makers and are valuable in summarising the range of policy and programme options which are available (Caird et al., 2015). They have been widely used to investigate questions of the impact of complex policy interventions (Bambra et al., 2010, Bambra et al., 2009, Cairns et al., 2015).

We focused on recent reviews (published since 2007), as these provide access to more recent primary studies as well as to older primary data. In addition, we adopted a 'best evidence' approach (see Section 7.4), prioritising the findings of higher quality reviews and the most relevant primary studies. The 'best evidence' approach reduces double-counting of primary studies within the overview of interventions (RoR), as well as ensuring that the findings of the most methodologically robust reviews are given greatest weight.

7.2 Review questions

For the **views synthesis** we sought to understand what people affected by ACEs in the UK feel are supportive and protective factors that help to mitigate the negative consequences of ACEs. We asked:

Q1) What are the impacts of ACEs on people's everyday lives?
Q2) What strategies do individuals employ to mitigate the negative impacts of ACEs?
Q3) What services are needed to address the negative impacts of ACEs?
Q4) How should services for people affected by ACEs be delivered?

For the **overview of interventions** we set out to answer the following review question:

Q5) What is known from systematic reviews about the effectiveness of interventions for children and young people (3-18 years) who have been exposed to Adverse Childhood Experiences (ACEs)?

For the **stakeholder consultations** we held open-ended discussions with young people to consider:

Q6) What are the kinds of problems they experience?
Q7) How might ACEs affect young people differently?
Q8) What types of support do they feel would help them to overcome these issues?

See Section 1.4 for our definition of ACEs.

7.3 Study identification

We conducted a systematic search for systematic reviews, as they were the source of evidence for both the views synthesis and the overview of interventions.

While the overview of interventions used the findings of reviews themselves as the source of evidence, study identification for the views synthesis involved a two-step process in which reviews were used to identify primary qualitative studies from the UK. This two-step process is described below.

7.3.1 *Searching for reviews*

The following scholarly bibliographic databases were searched, which between them cover research on healthcare, mental health, social care, social science, education, child and adolescent development, and systematic reviews:

- ASSIA (Proquest)
- British Education Index (EBSCO)
- British Nursing Index (EBSCO)
- Child development and adolescent studies (EBSCO)
- CINAHL Plus (EBSCO)
- Cochrane Database of Systematic Reviews (Cochrane Library)
- Database of Reviews of Effectiveness (DARE) (Cochrane Library)
- EMBASE (OVID)
- ERIC (EBSCO)
- Health Management Information Consortium (HMIC) (OVID)
- IBSS (Proquest)
- Medline (OVID)
- PILOTS (Published International Literature On Traumatic Stress)
- PsycINFO (OVID)
- PUBMED/Medline
- Social Policy and Practice (OVID) (this includes the NSPCC Child Protection Database)
- Sociological Abstracts (Proquest)
- Social Sciences Citation Index (Web of Science)

We searched the following online resources:

- Bielefeld Academic Search Engine
- Campbell Collaboration Library
- Epistamonikas
- NHS Evidence
- Research in Practice

We searched for references from the NICE guideline on transition from children's to adults' services for young people using health or social care services (National Institute for Health and Care Excellence, 2016) and on child abuse and neglect (National Institute for Health and Care Excellence, 2017) for relevant systematic reviews. The earlier guideline focused on social care interventions for looked-after children and young people who are transitioning from care. The guideline incorporated results from searches up until August 2015, and we had access to a search update undertaken in April 2017.

The literature search was undertaken in March 2018. The search strategy was developed and implemented by an information specialist (CS) in collaboration with two other members of the review team (SL, TL). An example full search strategy is set out in Appendix A. The search was based on three strands of concepts which were each combined with the concept of "systematic reviews": 1) the concept of children and young people with each of the following concepts: a) adversity in the home and family environment; b) divorce; c) caregiver bereavement; d) caregivers with mental health disorders, substance abuse disorders or domestic

violence; e) caregiver or sibling incarceration; f) parent; family; home; and abuse; 2) abuse of children and young people; 3) looked-after children; homeless young people; child welfare services. Synonyms and alternative words for each of these concepts were used to search titles, abstracts and controlled vocabulary fields of the databases in order to try to capture a wide range of systematic reviews. Journal fields were searched for the children and young people and abuse concepts. The search was limited to reviews published in English as we did not have the resources available to translate reviews published in other languages.

7.4 Inclusion criteria for reviews

We initially screened the titles and abstracts of identified papers using the following criteria:

1) Is the reference a systematic review?
   Include any secondary research which reports some information on the search strategy and clearly defined inclusion criteria.
2) Does the review report effectiveness, cost-effectiveness or qualitative data?
   Exclude reviews of observational quantitative data.
3) Does the review include (an) ACE population(s)?
   See Section 2.2 for the full definition of ACE populations.
   Exclude reviews whose population partly overlap with our ACE criteria, and/or which is defined with broader terms such as 'high risk' or 'trauma', *unless* ≥70% of included studies include populations in our ACE criteria, *or* there is a clearly presented subgroup analysis of a subset of the studies which meet our criteria.
4) Does the review concern interventions aimed at people who have experienced ACEs? (for reviews of effectiveness or cost-effectiveness only).
5) Does the review report outcomes for children or young people (aged 3-18 inclusive) who have experienced ACEs?
   Include any outcome relating to the child or young person, *except* outcomes relating to the (re)occurrence or incidence of ACEs themselves (abuse, parental substance use, homelessness etc.).
   Exclude reviews only reporting on parent/carer outcomes and not child outcomes.
   Include outcomes measured on people aged >18 years if they experienced ACEs at age 3-18.
6) Does the review report data from OECD member countries?
7) Is the review report available in English?
   Include reviews which include non-English-language primary studies, if the review itself is reported in English.
8) Was the review published in 2007 or later?
9) Is a full report of the review available?
   Exclude reviews for which only a protocol or an abstract is available.

The full reports of all references meeting the criteria stated in 7.4 Inclusion Criteria for Reviews, or where it is unclear whether they meet the criteria, were retrieved and re-screened using the full text of the paper. In addition, at full text stage, we included only reviews of effectiveness or cost-effectiveness data; reviews of qualitative data were marked for use in the parallel views synthesis and reviews of all other types of data were excluded. We also excluded reviews of reviews (i.e. we included only reviews of primary data). At a subsequent stage, we also excluded reviews which fell below a particular quality threshold (see Section 4.3 Best Evidence Synthesis).

An initial sample of 10% of abstracts were screened independently by two reviewers (TL, SL) and differences resolved by discussion. Overall agreement on this sample before discussion was 98.3% and interrater reliability (Cohen's kappa) κ=0.86. This was judged to be adequate agreement, and the remaining abstracts

were screened by a single reviewer. All full text references were screened by two reviewers independently and differences resolved by discussion.

7.4.1.1 Identifying relevant primary studies from within systematic reviews for the views synthesis

Identification of qualitative research from the UK involved a two-step process. Following identification of systematic reviews as described above, the second step involved identifying relevant studies from within existing systematic reviews of qualitative research relating to ACE populations.

The references of all potentially relevant studies identified in systematic reviews were imported into EPPI-Reviewer for screening. Extracted references were first screened based on the title and abstract. References that were deemed potentially relevant were then retrieved and screened using the full text. To be included studies had to meet the following criteria:

- **Population:** Participants from one or more ACE population (see definition in Section 2.2)
- **Data:** Views of ACE populations
- **Focus:** About coping and / or resilience relating to ACEs
- **Method:** Qualitative data collection and analysis
- **Country:** Conducted in the UK
- **Design:** Primary study (rather than a review of evidence)
- **Methods reporting:** Details of data collection and analysis methods reported
- **Date:** Published in 2008 or after

Title and abstract screening involved double screening of approximately ten percent of references (n=29) to check inter-rater reliability; having achieved an agreement rate of 90% we moved to single screening for the remaining titles and abstracts. All full text screening and quality appraisal was conducted by two reviewers (KS, MK) working independently. Reviewers discussed and resolved any discrepancies.

7.5 Appraising the quality and relevance of studies

Views Synthesis

Included studies were appraised using quality and relevance criteria developed and used in previous reviews conducted by the DHSC Policy Reviews Facility (Rees et al. 2009; Shepherd et al. 2010) and informed by principles of good practice for conducting social research with the public (Harden et al. 2004) (see Appendix B – Quality and Relevance Appraisal Tool). The quality of each study was considered according to:

- the rigour of sampling, data collection and data analysis;
- whether study findings were grounded in/supported by data;
- whether the breadth and depth of findings were appropriate for the review;
- whether young people's perspectives and experiences were privileged.

An assessment based on each of the above criteria was then made to consider the overall reliability of the study as either high, medium or low. Following this an assessment was made about the relevance of the study to the review question. Reviewers considered the match between study aims, sample and findings and the purpose of the synthesis; each study was rated as either high, medium or low relevance. An overarching rating of study 'usefulness' was then made based on the assessments for both reliability and relevance. Table 3 below shows the algorithm for overall 'usefulness'. Due to a large number of studies on

looked-after children populations we included only those achieving a 'gold standard' usefulness rating, for other ACE populations we included those receiving either a 'high' or 'gold standard' usefulness rating. The full appraisal tool can be found in Appendix B.

Table 3: Algorithm for overall 'usefulness' rating based on reliability and relevance

Usefulness rating	Criteria
Gold standard	A 'high' rating for both reliability and relevance.
High	One 'high' and one 'medium' reliability and relevance rating.
Medium	A 'medium' rating for both reliability and relevance.
Low	A 'low' rating for either reliability or relevance.

Overview of interventions

The AMSTAR tool was used to assess review quality (Shea et al., 2017). Quality assessment was conducted by one reviewer and checked in detail by a second.

We translated the AMSTAR results into an overall score out of 11 (see Appendix C for full details of the scoring system). We categorised reviews into ACE populations (see 2.2 for ACE definition), and then used the following procedure to include reviews in the synthesis: in a first stage, only reviews with a score of 5.5 or higher were included; in a second stage, where a population had no reviews with a score of 5.5 or higher, we included the single highest-scoring review for that population. The remaining reviews were not data-extracted or included in the synthesis.

7.6 Data extraction and synthesis

Views synthesis

We extracted the following data from the studies:

- The aims of the study;
- The numbers of ACE population participants and whether there were other participants (for example, parents/carers or service providers);
- The characteristics of ACE population participants (age, sex, ethnicity, socioeconomic status and family background);
- The key themes noted by the authors;
- The findings reported by authors including that relate specifically to ACE population views – i.e. participant quotes, author descriptions and author discussion and conclusion points (findings relating to parents/carer or service provider views were not extracted).

After data extraction, thematic synthesis (Thomas and Harden 2008) was used to inductively code and describe the papers. The process involved reading and re-reading the papers and applying line-by-line coding to capture descriptive themes. Three reviewers independently extracted data and created codes reflecting identified themes (SL, KS, MK). Frequent meetings were held to discuss and refine emerging themes and findings. Given the large number of studies focused on the looked-after / living in care populations we first synthesised findings from studies focusing on other ACE populations so as to avoid the looked-after / living in care studies dominating or skewing our interpretation of the data.

Overview of interventions

The following data were extracted:

- Search dates
- Review question / focus
- Study designs included
- Population(s)
- Outcomes
- Findings

Data extraction was conducted by one reviewer and checked in detail by a second.

A narrative synthesis was undertaken. We examined the data and grouped them according to the types of intervention found in the reviews. Where available, we focused on reviews of controlled studies (RCTs and nRCTs) as these provide more robust evidence of effectiveness. Where reviews of controlled trials were not available we included reviews of other study designs. Similarly, we focused on meta-analyses where available, but included narrative syntheses where meta-analysis was not conducted. Where results are based on a single primary study, these have been included as long as they were reported by review authors as comparing an intervention to a comparison group.

We extracted data on all outcomes except those relating to (re)occurrence or incidence of ACEs themselves. Where multiple outcomes were reported, we grouped them into the following domains to facilitate comparison between reviews:

- Mental health (for example, anxiety, depression, PTSD, internalising behaviours)
- Behaviour (for example, externalising behaviour, problem behaviour)
- Social (for example, social support, education, housing)
- Family (for example, family relationships)

7.7 Stakeholder Workshop: Methods

In May 2018 we held a three-hour stakeholder workshop to consult with young people with lived experience of ACEs about the relevance of the review evidence to their own lives.

7.7.1 *Recruitment*

We employed a participation lead with relevant expertise in the area of involving children and young people in research, Dr Louca-Mai Brady, who helped with recruitment and co-organising and co-running the workshop.

We advertised that we were recruiting young people for our event on various platforms, such as the website of the National Association for Children of Alcoholics (NACOA), through the Twitter accounts of people working in relevant networks, and through informing service leads working with young people in organisations such as the Albert Kennedy Trust and Coram's Voice. Where possible we contacted the engagement and participation leads at relevant organisations to let them know about our review and our upcoming event. We gained recruits through various sources, but most of the young people were supported to attend the workshop through Young NCB at the National Children's Bureau.

See Appendix J for the information sheet on the stakeholder workshop which we sent to organisations and mentors working with young people during the recruitment process. Appendix K contains the information sheet about the event which we gave to young people.

7.7.2 *Details of consultation*

Seven young people with lived experience of ACEs attended the workshop. They were aged between 16 to 24 years age, from a range of ethnic backgrounds and lived in a variety of places in the UK including Darlington, Lancaster, London, Kent and Hertfordshire.

We co-created ground rules with the young people and emphasised, as stated on the consent forms, that they were free to stop their involvement at any time, either to take some time out, or to halt involvement completely. We made sure that all relevant information was provided both verbally and in writing, taking time to explain that everybody should only share as much or little of their own experiences as they felt comfortable with.

Discussion was open-ended and facilitated in a way which allowed for either written, verbal, individual or group contribution, or a mixture of all of these modes. Discussion was informal and free-flowing but was structured around the following broad questions:

Q1) What kinds of problems might young people affected by ACEs experience?
Q2) How might ACEs affect young people differently?
Q3) What types of support would help to overcome these problems?

As the majority of the interventions evidence (70 out of 99 systematic reviews) related to psychological therapies we also had a discussion about counselling and talking therapies, as well as a discussion about appropriate outcome measures to monitor the progress of young people affected by ACEs. We were at a mid-stage in the review when we held the workshop. We had started mapping the characteristics of the systematic reviews but we had not yet started on any syntheses or analyses. Involving young people at this point allowed them to reflect on the nature of the existing research and its relevance to their own experience in an exploratory manner. Their reflections and input informed our analyses.

Findings from the stakeholder workshop are presented in Section 5.

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Appendix A: Example Search Strategy

The search strategy below was used in the MEDLINE database. A translated version was used in the other databases.

Databases: Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) <1946 to Present>

Date searched: 22/3/18

No. of records: 1,990

Set	Searches
1	((divorce* and (parent* or child* or family or families)) or (parent* adj2 separat*) or (marital adj2 separation*) or (family adj2 breakdown) or (family adj2 breakup) or (family adj2 separation) or (marital adj2 break*) or (marriage adj2 break*)).ti,ab
2	Divorce/
3	1 or 2
4	("parentally bereaved" or "parental bereavement" or "Parental death" or "bereaved children" or "parental loss" or "loss of a parent" or "childhood bereavement" or (children* adj grief) or (grieving adj child*) or ((parent* or mother* or father* or carer* or caregiver*) adj3 death)).ti,ab
5	(parental death/ or maternal death/) not (infant death/ or pregnancy/ or "cause of death"/ or perinatal death/ or exp "abortion, induced"/)
6	4 or 5
7	exp mental disorders/ and "Parent-Child relations"/
8	((parent* or mother* or father* or carer? or caregiver?) adj3 "mental health" adj (problem* or condition* or disorder* or illness* or difficult*)).ti,ab.
9	((parent* or mother* or father* or carer? or caregiver?) adj3 (mental* adj ill*)).ti,ab
10	((parent* or mother* or father* or carer? or caregiver?) adj3 (depressi* or anxiety) adj3 (clinical or severe or major or chronic* or illness* or condition* or disorder* or difficult*)).ti,ab.
11	((parent* or mother* or father* or carer? or caregiver?) adj3 depression).ti,ab.
12	((parent* or mother* or father* or carer? or caregiver?) adj3 (suicidal or suicide)).ti,ab.
13	((parent* or mother* or father* or carer or caregiver) adj3 (mental* adj disorder*)).ti,ab.
14	((parent* or mother* or father* or carer or caregiver) adj3 (psychiatric or psychologic*) adj3 (illness* or condition* or disorder* or difficult*)).ti,ab
15	7 or 8 or 9 or 10 or 11 or 12 or 13 or 14
16	((parent* or mother* or father* or carer* or caregiver* or sibling* or "family member" or brother* or sister*) adj3 (incarcerat* or prison* or "imprisoned" or "imprisonment" or jail* or "penitatiary" or criminal* or "detention" or "probatation" or "parole" or "young offender" or "young offenders")).ti,ab.
17	("children of" adj2 prisoners).ti,ab.

18	((parent* or mother* or father* or carer* or caregiver* or sibling* or "family member" or brother* or sister*) adj2 (criminal* adj1 convict*)).ti,ab.
19	(Parent-child relations/ or child welfare/) and (Prisoners/ or Prisons/)
20	16 or 17 or 18 or 19
21	((parent* or mother* or father* or carer? or caregiver?) adj3 (substance? or drug? or drinking or alcohol* or solvent? or medication?) adj2 ("use" or abus* or misuse* or addict* or disorder* or dependen*)).ti,ab.
22	((parent* or mother* or father* or carer? or caregiver?) adj3 (alcoholism or alcoholic* or "heavy drinking" or addicts or "heavy drinkers" or "substance related" or "substance affected" or (drinking adj1 problem*))).ti,ab.
23	exp Substance-Related Disorders/ and Parent-Child relations/
24	21 or 22 or 23
25	("Domestic violence" or "intimate partner violence" or ("IPV" not (vaccin* or ventilat*)) or "intimate partner abuse" or (battered adj3 (mother* or father* or spouse or partner)) or "domestic abuse" or "partner abuse" or (family adj2 violen*) or (families adj2 violen*)).ti,ab.
26	domestic violence/ or spouse abuse/ or intimate partner violence/
27	25 or 26
28	(((Sexual or physical* or verbal* or emotional* or psychologic*) adj2 (Abus* or assault*)) or incest* or "sexual violence" or ((rape or raped or violence) adj4 (home or family or parent* or families or homes or household?))).ti,ab.
29	Exposure to Violence/ or child abuse, sexual/ or physical abuse/
30	(abus* or assault*).ti,ab.
31	(((Ill adj treat*) or "Ill treatment" or maltreat* or mistreat* or "Neglect" or "cruelty" or "cruel" or abus* or assault*) adj3 ("offspring" or "young people" or children* or "childhood" or "child" or "boys" or "girls" or adolescen* or youth* or "young person" or teen* or preadolescen* or "early life")).ti,ab.
32	maternal deprivation/ or Paternal deprivation/
33	(victim* adj2 ("home" or "homes" or "family" or "families" or "household" or "households")).ti,ab.
34	Child Abuse/
35	"Child of Impaired Parents"/ or "Child, Foster"/ or "Child, Orphaned"/ or "Child, Adopted"/ or Homeless Youth/
36	(homeless* adj3 ("young people" or children* or childhood or child or boys or girls or adolescen* or youth* or "young person*" or teen*)).ti,ab.
37	(("Looked-after" or foster* or "adoptive" or "in care") adj1 ("young people" or children* or childhood or child or boys or girls or adolescen* or youth* or "young person*" or teen*)).ti,ab.
38	((("moving" adj1 "care") or ("leaving" adj1 "care")) and ("young people" or children* or childhood or child or boys or girls or adolescen* or youth* or "young person" or teen*)).ti,ab.
39	"Foster Home Care"/

40	("care leaver?" or "residential child*" or ("child welfare" adj2 (service* or centre or centres or center or centers)) or ("child protection" adj2 (service* or center or centers or centre or centres))).ti,ab.
41	(("living in care" or "kinship care" or "foster care" or "adoption care" or "group home" or "group homes" or "out of home placement" or "out of home care" or "child placement" or "local authority care" or "state care" or "alternative care" or "kith and kin care" or "kinship care") and ("young people" or children* or childhood or child or boys or girls or adolescen* or youth* or "young person" or teen*)).ti,ab.
42	adult survivors of child abuse/ or Adult Survivors of Child Adverse Events/
43	child/ or "child, preschool"/ or adolescent/
44	(offspring or "young people" or children* or childhood or child or boys or girls or adolescen* or youth* or "young person" or teen* or juvenile* or preadolescen* or "early life").ti,ab
45	43 or 44
46	"Caregivers"/ or parents/ or parenting/ or fathers/ or mothers/ or exp "Parent-Child Relations"/ or exp "Nuclear Family"/ or "Family"/ or exp "Family Relations"/ or exp "Grandparents"/ or exp "Single-Parent Family"/
47	("Parent" or "parents" or "mother" or "mothers" or "father" or "fathers" or "home" or "homes" or "household" or "households" or "family" or "primary carer" or "foster carer" or "guardian" or "guardians" or "grandparent" or "grandparents" or "relatives" or maternal* or paternal* or sibling* or grandfather* or grandmother* or caregiver* or carer? or "families").ti,ab.
48	46 or 47
49	((child* or "young people*" or adolesc*) and (abus* or neglect)).jw.
50	(abus* or neglect).jw.
51	("Stressful childhood experiences" or "adverse childhood events" or "adverse childhood experiences" or "traumatic childhood experiences" or "Stressful childhood experience" or "adverse childhood event" or "adverse childhood experience" or "traumatic childhood experience" or "adverse home environment" or "adverse home environments" or "adverse family environment" or "adverse family environments" or "stressful home environment" or "stressful home environments" or "stressful family environment" or "stressful family environments").ti,ab.
52	((("synthesis" or "systematic") and ("evidence" or "research" or "review")) or ("review" and (integrat* or critical* or "mapping" or "comprehensive" or "evidence" or "research" or "literature"))).ti. or ((systematic adj2 review*) or ("meta-analysis" or "Review articles" or "systematic review*" or "Overview of reviews" or "Review of Reviews") or ("data synthesis" or "evidence synthesis" or "metasynthesis" or "meta-synthesis" or "narrative synthesis" or "qualitative synthesis" or "quantitative synthesis" or "realist synthesis" or "research synthesis" or "synthesis of evidence" or "thematic synthesis" or "systematic map*" or "metaanaly*" or "meta-analy*" or "systematic overview*" or "systematic review*" or "systematically review*" or "bibliographic search" or "database search" or "electronic search" or "handsearch*" or "hand search*" or "keyword search" or "literature search" or "search term*" or "literature review" or "overview of reviews" or "review literature" or "reviewed the literature" or "reviews studies" or "scoping stud*" or "overview study" or "meta-ethnograph*" or "meta-epidemiological" or "data extraction" or "meta-regression" or "narrative review" or "art review" or "scoping review" or "iterative review" or "meta-summary")).ti,ab.
53	30 and 45 and 48

54	3 or 6 or 15 or 20 or 24 or 27 or 28 or 29 or 32 or 33 or 50
55	45 and 54
56	31 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 49 or 51 or 53
57	55 or 56
58	limit 57 to systematic reviews
59	52 and 57
60	58 or 59
61	60 not (animals/ not (animals/ and humans/))
62	limit 61 to yr="2007 -Current"
63	limit 62 to english

Appendix B: Quality and relevance appraisal tool (views synthesis)

QA1 – Were steps taken to strengthen rigour in the sampling?

Consider whether:

- *the sampling strategy was appropriate to the questions posed in the study (for example, was the strategy well reasoned and justified)*
- *attempts were made to obtain a diverse sample of the population in question (think about who might have been excluded who might have had a different perspective to offer)*
- *characteristics of the sample critical to the understanding of the study context and findings were presented (i.e. do we know who the participants were in terms of for example, basic socio-demographics, characteristics relevant to the context of the study?)*

- Yes, a fairly thorough attempt was made
- Yes, several steps were taken
- Yes, minimal few steps were taken
- Unclear
- No, not at all / Not stated / Can't tell

QA2 – Were steps taken to strengthen rigour in the data collected?

Consider whether:

- *Data collection was comprehensive, flexible and/or sensitive enough to provide a complete and/or vivid and rich description of people's perspectives and experiences (for example, did the researchers spend sufficient time at the site/ with participants? Did they keep 'following up'? Was more than one method of data collection used?*
- *Steps were taken to ensure that all participants were able and willing to contribute (for example, processes for consent see D4), language barriers, power relations between adults and children/ young people.*

- Yes, a fairly thorough attempt was made
- Yes several steps were taken
- Yes, minimal few steps were taken
- Unclear
- No, not at all / Not stated / Can't tell

QA3 – Were steps taken to strengthen rigour of the analysis of data?

Consider whether:

- *data analysis methods were systematic (for example, was a method described / can a method be discerned?*
- *diversity in perspective was explored*
- *the analysis was balanced in the extent to which it was guided by preconceptions or by the data*
- *quality analysis in terms of inter-rater reliability/agreement*
- *the analysis sought to rule out alternative explanations for findings (in qualitative research this could be done by, for example, searching for negative cases/exceptions, feeding back preliminary results to participants, asking a colleague to review the data, or reflexivity*

- Yes, a fairly thorough attempt was made
- Yes, several steps were taken
- Yes, minimal steps were taken
- Unclear
- No, not at all / Not stated / Can't tell

QA4 – Were the findings of the study grounded in/supported by the data?

Consider whether:

- *enough data are presented to show how the authors arrived at their findings*
- *the data presented fit the interpretation/ support the claims about patterns in data*
- *the data presented illuminate/illustrate the findings*
- *(for qualitative studies) quotes are numbered or otherwise identified and the reader can see they don't come from one or two people.*

- Well grounded / supported
- Fairly well grounded / supported
- Limited grounding / support

QA5 - Please rate the findings of the study in terms of breadth and depth?

Consider whether :

- *(NB it may be helpful to consider 'breadth' as the extent of description and 'depth' as the extent to which data has been transformed/analysed)*
- *A range of issues are covered*
- *The perspectives of participants are fully explored in terms of breadth (contrast of two or more perspectives) and depth (insight into a single perspective)*
- *richness and complexity has been portrayed (for example, variation explained, meanings illuminated)*
- *There has been theoretical/conceptual development*

- Good / fair breadth and depth
- Good / fair depth but very little breadth
- Good / fair breadth, but little depth
- Limited breadth and depth

QA6 – Privileges participants' perspectives/experiences?

Consider whether:

- *there was a balance between open-ended and fixed response questions*
- *whether children were involved in designing the research*
- *there was a balance between the use of an a priori coding framework and induction in the analysis*
- *the position of the researchers (did they consider it important to listen to the perspectives of children?)*
- *steps were taken to assure confidentiality and put young people at ease*

- Not at all
- A little
- Somewhat
- A lot

QA7 – Reliability

Guidance: Think (mainly) about the answers you have given to questions above

Using the ratings score 3 for top answer, 2 for middle answer, and 1 for bottom answer, 0 for no answer- 15-18=high, 11-14 = medium, 0-10 = low

- Low reliability
- Medium reliability
- High reliability

QA8 – Overall how relevant is the study for this review?

Please assess the relevance of the study checking answers to the following questions:

Aims, Actual sample, Sampling/recruitment/consent, Data collection, Findings

- High overall relevance
- Medium overall relevance
- Low overall relevance

QA9 – Usefulness

Guidance: Think (mainly) about the answers you have given to questions 4-6 above and consider:

- *the match between the study aims and findings and the aims and purpose of the synthesis*
- *its conceptual depth/explanatory power*

- Low usefulness (use for a study that gets low on either)
- Medium usefulness (use for a study that gets medium on both)
- High usefulness (use for a study that gets a high and a medium)
- Gold Standard (use if study is both highly relevant and high quality.

Appendix C: Quality appraisal tool (overview)

Our quality assessment procedure was based on the AMSTAR tool (Shea et al., 2017). This tool contains 16 items. For the purposes of this review, the questions in the full tool relating to meta-analysis (N=4) were not used in formulating a quality score, as not all reviews reported meta-analysis and so these questions were often not applicable. We also did not include question 3 ("Did the review authors explain their selection of the study designs for inclusion in the review?") as often this was implicitly stated rather than explicitly explained within the reviews. This left N=11 questions, giving each review a score between 0 and 11. The tool is shown below (further guidance can be found in Shea et al. (2017)'s paper).

1. Did the research questions and inclusion criteria for the review include the components of PICO?
    a. Yes (score 1)
    b. No (score 0)
2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?
    a. Yes (score 1)
    b. Partial Yes (score 0.5)
    c. No (score 0)
3. Did the review authors explain their selection of the study designs for inclusion in the review? [question not scored]
    a. Yes
    b. No
4. Did the review authors use a comprehensive literature search strategy?
    a. Yes (score 1)
    b. Partial Yes (score 0.5)
    c. No (score 0)
5. Did the review authors perform study selection in duplicate?
    a. Yes (score 1)
    b. No (score 0)
6. Did the review authors perform data extraction in duplicate?
    a. Yes (score 1)
    b. No (score 0)
7. Did the review authors provide a list of excluded studies and justify the exclusions?
    a. Yes (score 1)
    b. Partial Yes (score 0.5)
    c. No (score 0)
8. Did the review authors describe the included studies in adequate detail?
    a. Yes (score 1)
    b. Partial Yes (score 0.5)
    c. No (score 0)
9. Did the review authors use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that were included in the review?
    a. Yes (score 1)
    b. Partial Yes (score 0.5)
    c. No (score 0)
10. Did the review authors report on the sources of funding for the studies included in the review?
    a. Yes (score 1)
    b. No (score 0)
11. If meta-analysis was performed did the review authors use appropriate methods for statistical combination of results? [question not scored]

    a. Yes
    b. No
    c. N/A
12. If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis? [question not scored]
    a. Yes
    b. No
    c. N/A
13. Did the review authors account for RoB in individual studies when interpreting/discussing the results of the review?
    a. Yes (score 1)
    b. No (score 0)
14. Did the review authors provide a satisfactory explanation for, and discussion of, any heterogeneity observed in the results of the review? [question not scored]
    a. Yes
    b. No
    c. N/A
15. If they performed quantitative synthesis did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review? [question not scored]
    a. Yes
    b. No
    c. N/A
16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?
    a. Yes (score 1)
    b. No (score 0)

Appendix D: List of excluded studies in the views synthesis

Studies not obtained in time (n=7)

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Appendix E: Evidence tables for studies included in the views synthesis (n=21)

Study ACE population	Aims	Characteristics	Authors' themes	Study quality		
				Reliability	Relevance	Usefulness
Barn (2010) **Looked-after children**	This study explored the impact of ethnicity upon social exclusion experienced by care leavers.	**ACE population sample size:** (26) **Other participants*:** none **Age:** Not stated **Gender:** m (16) f (20) **Ethnicity:** African-Caribbean (11) African (8) Asian (3) mixed parentage (10) white (4) **SES:** Not stated **Family Background:** Not stated **Other relevant details:** None stated	• Presence of Social Capital • Absence of Social Capital	High	High	Gold

Bee (2013) **Parental mental illness**	This study used a bottom-up qualitative approach to develop a new stakeholder-led model of quality of life relevant to this population.	**ACE population sample size:** (6) **Other participants*:** parents (5) professionals (5) **Age:** 13-18 years **Gender:** m (2) f (4) **Ethnicity:** not stated **SES:** not stated **Family Background:** mothers with serious mental illness (4) (assume that means that 2 had fathers with serious mental illness) **Other relevant details:** recruited via a young carers' service in the South West of England. Primary parental mental health diagnoses, as reported by the families comprised bipolar disorder (2), major depressive disorder (2), schizophrenia (1) and borderline personality disorder (1).	• Children's emotional wellbeing • Children's social wellbeing • Children's economic wellbeing • Children's family contexts and experiences	High	Medium	High
Brewer (2011)	The purpose of our study was to explore the experiences of	**ACE population Sample size: (**13) **Other participants*:** none	• Expressing emotion • Physical activity • Positive adult relationship	High	High	Gold

Parental bereavement	young people bereaved of a parent, and investigate the factors that help them to live with their grief.	**Age:** 15 – 27 years **Gender:** not stated **Ethnicity:** white British **SES:** working class (3), middle class (10) **Family Background:** not stated **Other relevant details:** young people had been recently bereaved (4), experienced the death of a parent over ten years ago (9)	• Area of competence • Friendship/social support • Transcendence • Fun and humour			
Chouliara (2011) **Survivors of child sexual abuse**	This study aimed to elicit perceptions and experiences of talking therapy services for CSA survivors and professionals.	**ACE population Sample size:** survivors of CSA (13). **Other participants*:** professionals working in the field of CSA. (31) **Age:** 18+ years **Gender:** f (13) **Ethnicity:** not stated **SES:** not stated **Family Background:** not stated	• Benefits from talking therapy • The therapeutic relationship • Safety to disclose • Breaking isolation • Enhancing self-worth and sense of self • Contextualising the abuse • Movement' toward recovery • Challenges of using/providing service • Difficulties of trauma-focused work	High	High	Gold

		Other relevant details: Out of the 13 survivors (7) were accessing NHS services.	• Contact between appointments • Continuity and consistency • Accessibility in acute episode • Hearing and managing disclosures • Dealing with child protection issues • Resource availability and service accessibility			
Collins (2009) **Homeless Adolescents**	This qualitative study aimed to examine homeless young people's views about seeking psychological help for their problems.	**ACE population Sample size: (**16) **Age:** 17–21 **Gender:** m (9) f (9) **Ethnicity:** Black African (8), White British (2) Black British African (2), Black British Asian (2) Black British (1), Black Caribbean (1) **SES:** All homeless. **Family Background:** not stated **Other relevant details:** None was employed; (3) expressed an	• Why I need help: Domestic conflict Psychological distress Practical needs • Why I would seek help Help gets you through distressing times Help produces practical results • Why I wouldn't seek help: Asking for help is difficult and exposes you Experience of betrayal Beliefs antagonistic to seeking help	High	High	Gold

		intention to enrol in further education.	• The Kind of help I want: Effective Caring Trustworthy Understanding/ Empathic Genuine			
Driscoll (2013) **Care leavers**	This study explores the significance of supportive relationships in enabling this group of young people to make decisions about their future and encouraging them to overcome setbacks in educational attainment	**ACE population Sample size:** 7 **Age:** 16-20 **Gender:** m (4) f (3) **Ethnicity:** white British **SES:** not stated **Family Background:** foster care (4) with boyfriend (1) in own flat (1) in supported lodgings (1) **Other relevant details:** not stated	• If you knew my mum, that would be a funny question: birth families • I've got my own mentor, that's me: mistrust and self-reliance • My carer kept me going: supportive relationships • Education and 'turning points	High	High	Gold
Fraser (2009)	This study explores the views of parents/carers and children and young	**ACE population Sample size:** (8) **Other participants*:** (25) parents	• Impact on family life • Experience of support • Origins and impact on family life	High	High	Gold

Parental drug/alcohol misuse	people about the impact of parental substance use and implications for services.	**Age:** 4-14 **Gender:** m (4) f (4) **Ethnicity:** white British **SES:** not stated **Family Background:** All but one were children of (in most cases former) alcohol users. Living with parent(s) in family home (6), living in foster/residential care (2) Participants belonged to sibling groups (5) (two boys and a girl from 1 family and 2 sisters in local authority care) **Other relevant details:** Children were living with parents in (3) families, (3) of them being supervised by social services. In addition, children in a further (4) families were currently, and children in another (3) families had previously been, on the Child Protection Register. (3) children had been returned to their parents after				

		periods in foster care. Various degrees of continuing drug use.				
Gaskell (2010) **Care leavers**	This study aims to explore young care leavers' experiences of care. Through this, the extent to which feelings of care shape self-esteem and a sense of self will be explored.	**ACE population Sample size:** (10) **Age:** 16-21 **Gender:** m (3) f (7) **Ethnicity:** Black British (5) Black British (3) White British (2) **SES:** Not stated **Family Background:** Not stated **Other relevant details The** group that had experienced both residential and foster care placements and all participants had entered the care system for the first time before the age of 11 years (8). All of the young people interviewed had multiple experiences of care placements.	• Inclusion in decision-making, the trust of a consistent adult and stability of services.	High	High	Gold
Grant (2008) **Young people supporting parents with mental health problems**	In this study, we reflect on what can be done to identify, assess and support young people looking after	**ACE population Sample size:** (10) **Age:** 11-16 **Gender:** m (3) f (7) **Ethnicity:** not stated	• Family-centred work: recognising interdependencies • Multiple caregiving demands • Mediating family conflicts	Medium	High	High

	parents with mental health problems.	**SES:** not stated **Family Background:** not stated **Other relevant details:** not stated	• Help for the looked-after person • Building and valuing relations of trust • Attention to pacing • Absolute trust in project workers • One-to-one work • Dependability and consistency • Continuity of relationships • Problem-solving • Like surrogate parents • Laid back and fun • Feeling in control • Group work • Forming friendships • We're in this together • Respite • Outside recognition			
Griffiths (2012)	This study aimed to explore the experiences of	**ACE population Sample size:** (10) **Age:** 13-19	• Control and boundaries • Telling: embarrassment and pride • Do I have OCD?	High	High	Gold

Living with Parents who have OCD	young people with a parent with OCD, including the impact of parental OCD and their understanding of it.	**Gender:** m (5) f (5) **Ethnicity:** British, British-Indian, and Greek-Cypriot backgrounds. **SES:** employed (3), unemployed due to ill health (3), retired (1) **Family Background:** pairs of siblings were included in the sample (3). All the young people lived with one biological parent with OCD **Other relevant details:** mothers (6) and father (1) were aged 40–56 years, a diagnosis of OCD from a mental health professional (6), self-diagnosed and had not had contact with statutory services (1).	• Getting the right help for me			
Houmoller (2011) **Parental substance misuse**	A detailed exploration of young people's experiences of family life over time, as changing contexts can have dramatic effects on	**ACE population Sample size:** (50) **Other participants*:** (11) parents/carers; professionals (4) service providers (17) **Age:** 10-18	• Caring for family • Normalcy and social harm. • What we mean by social harms are the harms done to relationships	High	High	Gold

	young people's coping capacities.	**Gender:** m (20) f (30) **Ethnicity:** not stated **SES:** not stated **Family Background:** not stated **Other relevant details:** Almost half of the young people were affected by mother's substance misuse, (11) were affected by both parents' use and (13) of the young people were affected by father's use only. (2) young people were affected by their grandparents' (primary carer). Parents were using drugs, primarily heroin, crack and cocaine (17), alcohol (25) or both (8), parents that had died (2).	• Identity formation and experiences outside of the family			
Jobe (2012) **Young people and experiences of maltreatment**	This study explores young people's experiences of help seeking and their experiences of receiving help for maltreatment	**ACE population Sample size:** (24) **Age:** 11-14 **Gender:** m (14) f (10) **Ethnicity:** white British (18) British-Asian (1) unaccompanied asylum	• Importance of trusting, consistent relationship with social worker in making it more likely that a young person will disclose/ engage with services • Disclosure as a process, which requires feeling safe and being self-	High	High	Gold

	through statutory agencies.	seeking children originally from Afghanistan (3) and Eritrea (2). **SES:** not stated **Family Background:** not stated **Other relevant details:** Young people were recruited from different local authority areas (6).Taken into local authority care as a result of their referral (16). Others had social care intervention in their lives for short periods of time. Young people who had come into contact with Social Care Services in between the ages of 11 and 17 (18) Young people who had social care intervention from an early age (6)	confident, alongside a trusting relationship with professional			

Katz (2016) **Children living with domestic violence**	The study aims to consider how children can be harmed by, and resist, coercive controlling tactics perpetrated by their father/ father figure against their mother	**ACE population Sample size:** (15) **Other participants*:** mothers (15) **Age:** 10-20 **Gender:** m (6) f (9) **Ethnicity:** White British (10), Black British (2) British Asian (3) **SES:** not stated **Family Background:** All participants resided in the community [as opposed to refuges?] at the time of the study. All mothers and children were separated from the perpetrators and not living in danger. **Other relevant details:** Not stated	• Harmful Impacts of Living with Coercive Control • Narrowed Space for Action • Isolation from Sources of Support • Resisting Coercive Control • Resisting Control and Financial Abuse • Resisting Control of Time, Movement and Activities within the Home • Resisting Negative Emotional Impacts	High	Medium	High
Luke (2008) **Young people in foster care**	This study explores the ways in which foster parents had influenced the self-esteem of a sample of five adults with differing foster care experiences.	**ACE population Sample size:** (5) **Age:** 18-46 **Gender:** m (4) f (1) **Ethnicity:** white British **SES:** Not stated	• Self-esteem when Entering Care • General Support/Attachment • Domain-Specific Support • Normality and Inclusion.	High	High	Gold

		Family Background: Not stated **Other relevant details:** Not stated				
Madigan (2013) **Young people in foster care**	Interviews were carried out with nine 12–16-year-olds currently residing in foster care to explore their representations of 'feeling the same or feeling different'.	**ACE population Sample size:** (9) **Age:** 12-16 **Gender:** m (5) f (4) **Ethnicity:** not stated **SES:** not stated **Family Background:** **Other relevant details:** Not stated	• If they know I'm in care • What the hell can they say to me • They alienate you. • People expect you to deal with it, that you're different • Noticing differences	High	High	Gold
Matthews (2012) **Young people leaving care**	The aim of this study was to explore the health priorities of young people leaving care. Nine young people were interviewed (aged 16–21 years) from two local authorities in England using an interpretive phenomenological approach.	**ACE population Sample size:** (9) **Age:** 16-21 **Gender:** m (3) f (6) **Ethnicity:** not stated **SES:** not stated **Family Background:** young people were currently in care (3) Had left care (6) **Other relevant details:** Not stated	• How Participants Viewed the term Health • Health behaviours • Motivation • Health as the absence of disease • Health Priorities and Health Needs • Health Advice and Support • Transition Out of Care	High	High	Gold

McMurray (2011) **Looked-after children**	This study looked at analysis of semi-structured interviews with 13 young people and their social workers.	**ACE population Sample size:** (13) **Age:** 12-16 **Gender:** m (6) f (7) **Ethnicity:** not stated **SES:** not stated **Family Background:** young people lived in residential care (6), with at least one birth parent (6) in foster care (1). **Other relevant details:** Not stated	• Identity shaped by family and social relationships • Presented identity as a protective mechanism not the real them • Rejection of identity that may lead to social stigmatisation • Identity on standby	High	High	Gold
Montgomery (2015) **Women survivors of child sexual abuse**	To inform practice by exploring the impact that childhood sexual abuse has on the maternity care experiences of adult women.	**ACE population Sample size:** (9) **Age:** 28-52 **Gender:** all female **Ethnicity:** white British **SES:** ranged from those not in employment to professional women. **Family Background:** not stated **Other relevant details:** not stated	• The women's narrative of self • Women's narrative of relationship • Women's narrative of context and the childbirth journey • The concept of 'silence' linked findings from interviews with women and healthcare professionals • The review of maternity care records	High	High	Gold

Munro (2012) **Young people and foster care**	Evaluation to assess the effectiveness and impact of 'staying put' pilot. It is targeted at young people who have 'established familial relationships' with their foster carers and offers this group the opportunity to remain with their carers until they reach the age of 21.	**ACE population Sample size:** (31) **Age:** 18-21 **Gender:** m (20) f (16) **Ethnicity:** not stated **SES:** not stated **Family Background:** Young people stayed put (21) Who did not stay (11) Where young people opted out of staying put (5) Cases where foster carers were not willing or able to accommodate young people once reaching legal adulthood ('foster care opt out') (4) local authority did not allow young person to remain in foster placement post 18 (2) **Other relevant details:** Not stated	• Staying Put Models of Delivery • Staying put or leaving care? Factors influencing the decision-making process • Staying put: contributing to providing young people with a secure base and nurturing attachments? • Experiences and impact of staying put	High	High	Gold
Saha (2011) **Women recovering from child sexual abuse**	To explore how the sense of self evolves through the recovery process after intensive therapy that focuses on issues pertaining	**ACE population Sample size:**(4) **Age:** 34 to 61 **Gender:** female only **Ethnicity:** white British **SES:** educational levels ranged from leaving school at the age of 15 to	• Mental distress related to their childhood sexual trauma • Avoidance as a means to cope • Feelings of shame and guilt	High	High	Gold

	to childhood sexual abuse (CSA).	obtaining a higher degree in education. Participants were employed (3) housewife. (1) **Family Background:** divorced (2) married (1) single (1) Older participants had grandchildren (2). **Other relevant details:** not stated	• Insignificance and undeserving • Unrealistic demands on self • Positive self-understanding after the group intervention programme			
Winter (2010) **Young people in care.**	The aims of the study were to explore the perspectives of young children in care about their circumstances and implications for social work practice.	**ACE population Sample size:** (10) **Age:** 4-7 **Gender:** m (9) f (5) **Ethnicity:** not stated **SES:** not stated **Family Background:** not stated **Other relevant details:** not stated	• Removal from home and loss of connections • Unresolved feelings • Not being listened to	High	High	Gold

* Data from other participants was not included in the evidence synthesis

Appendix F: Results of Quality Appraisal (overview)

Table 4: Results of AMSTAR quality assessment (N=98).

See Appendix C for the Quality Appraisal Tool questions (note that questions 3, 11, 12 & 15 were not included in the overall score).

Reference	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Score /11
Al et al. (2012)	Y	N	Y	P	Y	Y	N	P	Y	N	Y	N	N	Y	Y	N	5
Altena et al. (2010)	Y	N	N	P	Y	N	N	Y	Y	N	X	X	Y	X	X	Y	6.5
Bassuk et al. (2014)	Y	Y	N	P	Y	Y	N	Y	Y	N	X	X	Y	X	X	N	7.5
Bee et al. (2014)	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	10
Beresford et al. (2008)	Y	P	N	Y	Y	Y	N	Y	Y	N	X	X	Y	X	X	Y	8.5
Bergman et al. (2017)	Y	N	N	P	Y	N	N	Y	P	N	X	X	N	X	X	Y	5
British Columbia Centre (2013)	Y	N	N	Y	Y	Y	Y	Y	Y	Y	X	X	Y	X	X	N	9
Broning et al. (2012)	Y	N	N	P	Y	N	N	Y	Y	N	X	X	Y	X	X	Y	6.5
Byrne (2017)	Y	N	N	P	Y	N	N	N	N	N	X	X	N	X	X	Y	3.5
Calhoun (2015)	Y	N	N	P	N	N	N	P	N	N	X	X	N	X	X	N	2
Chen and Panebianco (2018)	Y	N	N	P	Y	N	N	P	N	N	X	X	N	X	X	N	3
Chronis-Tuscano et al. (2017)	Y	N	N	P	N	N	N	P	N	N	X	X	N	X	X	N	2
Corcoran and Pillai (2008)	Y	N	N	Y	N	Y	N	P	Y	N	Y	N	N	Y	N	N	4.5
Coren et al. (2016)	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	11
Cunha (2008)	Y	N	N	P	N	Y	N	N	N	N	Y	N	N	N	N	N	2.5
Currier et al. (2007)	Y	N	Y	P	N	N	N	N	N	N	Y	N	N	Y	N	N	1.5
Davies and Allen (2017)	Y	N	N	P	N	N	N	N	P	N	X	X	N	X	X	N	2
Dawson and Jackson (2013)	Y	N	N	P	N	N	N	N	Y	N	X	X	N	X	X	N	2.5
Dorrepaal et al. (2014)	Y	N	N	N	N	N	N	P	N	N	Y	N	N	N	N	Y	2.5
Downes et al. (2016)	Y	N	N	P	Y	N	N	N	N	N	X	X	N	X	X	N	2.5
Ehring et al. (2014)	Y	N	N	P	N	Y	N	P	Y	N	Y	N	N	Y	Y	Y	5
Evans et al. (2017)	Y	N	N	Y	Y	Y	N	P	Y	N	X	X	N	X	X	N	5.5
Everson-Hock et al. (2011)	Y	N	N	Y	Y	Y	N	P	Y	N	X	X	Y	X	X	N	6.5

Everson-Hock et al. (2012)	Y	N	N	P	Y	Y	N	P	Y	N	X	X	Y	X		N	6
Forsman and Vinnerljung (2012)	Y	N	Y	Y	N	N	N	P	N	N	X	X	N	X	X	N	2.5
Furr-Roeske (2011)	Y	N	N	P	N	N	N	P	P	N	X	X	N	X	X	N	2.5
Goldman Fraser et al. (2013)	Y	N	N	Y	Y	Y	N	P	Y	N	X	X	Y	X	X	Y	7.5
Gunlicks and Weissman (2008)	Y	N	N	P	N	N	N	P	N	N	X	X	N	X	X	Y	3
Hackett (2013)	Y	N	N	P	N	N	N	N	N	N	Y	N	N	N	N	N	1.5
Hambrick et al. (2016)	Y	P	N	P	Y	Y	N	N	Y	N	X	X	N	X	X	N	5
Harvey and Taylor (2010)	Y	N	Y	P	Y	Y	Y	N	N	N	Y	N	N	Y	Y	N	4.5
Herbert and Bromfield (2016)	N	N	N	P	N	N	N	P	N	N	X	X	N	X	X	Y	2
Hetzel-Riggin et al. (2007)	Y	N	N	P	N	Y	N	N	P	N	Y	N	N	Y	Y	N	3
Holtzhausen et al. (2016)	Y	N	N	P	N	N	N	N	N	N	X	X	N	X	X	N	1.5
Hooker et al. (2016)	Y	N	N	Y	N	N	N	N	N	N	X	X	N	X	X	N	2
Howarth et al. (2016)	Y	Y	N	P	Y	Y	Y	Y	Y	N	Y	N	Y	Y	N	Y	9.5
Jensen de López et al. (2017)	Y	N	N	P	Y	N	N	P	N	N	X	X	N	X	X	Y	4
Jones et al. (2008)	Y	N	N	Y	Y	Y	P	Y	Y	Y	X	X	Y	X	X	N	8.5
Journot-Reverbel et al. (2017)	Y	N	N	P	N	N	N	P	N	N	X	X	N	X	X	Y	3
Kanine et al. (2015)	Y	N	N	P	N	Y	N	P	Y	N	X	X	Y	X	X	N	5
Kemmis-Riggs et al. (2018)	Y	Y	N	P	Y	Y	N	P	Y	N	X	X	N	X	X	N	6
Kerr and Cossar (2014)	Y	N	N	Y	N	Y	N	P	Y	N	X	X	N	X	X	N	4.5
Kim et al. (2016)	Y	N	N	P	Y	Y	N	P	Y	N	X	X	N	X	X	N	5
Kinsey and Schlosser (2013)	Y	N	N	P	N	Y	Y	P	Y	N	X	X	N	X	X	Y	6
Korotana et al. (2016)	Y	N	N	P	N	N	N	P	N	N	X	X	N	X	X	N	2
Kowalik et al. (2011)	Y	N	N	P	N	N	N	P	N	N	Y	N	N	Y	Y	N	2
Leenarts et al. (2013)	Y	N	N	P	Y	Y	N	P	Y	N	X	X	N	X	X	Y	6
Leve et al. (2012)	Y	N	N	N	N	N	N	P	N	N	X	X	N	X	X	Y	2.5
Liabo et al. (2013)	Y	N	N	Y	Y	N	N	P	N	N	X	X	N	X	X	N	3.5
Loechner et al. (2017)	Y	N	N	Y	N	Y	N	P	Y	N	Y	N	N	Y	Y	Y	5.5
Macdonald et al. (2012)	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y	N	Y	9
Macdonald et al. (2016)	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	N	Y	Y	N	Y	10
Maclean et al. (2016)	Y	N	N	P	Y	Y	N	Y	Y	N	X	X	Y	X	X	N	6.5

Mannay et al. (2015)	Y	N	N	Y	Y	N	N	P	Y	N	X	X	N	X	X	N	4.5
Marsh (2017)	Y	N	N	P	N	N	N	N	N	N	Y	N	N	Y	Y	N	1.5
McDonnell and Garbers (2017)	Y	N	N	N	Y	N	N	N	N	N	X	X	N	X	X	N	2
McMillan et al. (2008)	Y	N	N	Y	N	Y	P	P	Y	N	X	X	N	X	X	N	5
Miffitt (2014)	Y	N	N	P	N	N	N	N	N	N	X	X	N	X	X	N	1.5
Montgomery et al. (2009)	Y	N	Y	Y	N	N	N	P	N	Y	X	X	Y	X	X	N	5.5
Naranbhai et al. (2011)	Y	Y	N	Y	Y	Y	Y	Y	Y	N	X	X	Y	X	X	Y	10
Niccols et al. (2012)	Y	N	N	Y	N	Y	N	N	Y	N	X	X	N	X	X	N	4
O'Haire et al. (2015)	Y	P	N	P	N	N	N	P	N	N	X	X	N	X	X	N	2.5
Parker and Turner (2013)	Y	Y	Y	Y	Y	N	Y	N	Y	N	X	X	N	X	X	Y	7
Passarela et al. (2010)	Y	N	N	P	N	N	N	P	N	N	X	X	N	X	X	N	2
Phillips et al. (2009)	Y	N	N	P	N	N	N	N	N	N	X	X	N	X	X	N	1.5
Poli et al. (2017)	Y	N	N	P	N	Y	N	P	N	N	X	X	N	X	X	N	3
Premji et al. (2007)	Y	N	N	Y	N	N	N	P	Y	N	X	X	N	X	X	N	3.5
Reupert et al. (2013)	Y	N	N	P	N	N	N	P	N	N	X	X	N	X	X	Y	3
Rizo et al. (2011)	Y	N	N	P	N	N	N	P	N	N	X	X	N	X	X	N	2
Roberts et al. (2016)	Y	N	N	Y	N	N	N	P	Y	N	X	X	N	X	X	N	3.5
Rosner et al. (2010)	Y	N	N	Y	Y	N	N	P	N	N	Y	N	N	Y	Y	N	3.5
Rubin et al. (2017)	Y	N	Y	P	N	N	N	N	N	N	Y	N	N	N	N	Y	2.5
Ruff et al. (2010)	Y	N	N	P	N	N	N	N	N	N	X	X	Y	X	X	N	2.5
Sanchez-Meca et al. (2011)	Y	N	N	Y	N	Y	N	N	Y	N	N	N	N	Y	Y	N	4
Siegenthaler et al. (2012)	Y	N	N	Y	N	N	N	N	Y	N	Y	N	N	Y	Y	N	3
Silverman et al. (2008)	Y	N	N	P	Y	N	N	N	Y	N	Y	N	N	N	N	N	3.5
Slesnick et al. (2009)	Y	N	N	P	N	N	N	P	N	N	X	X	N	X	X	N	2
Solomon et al. (2017)	Y	N	N	P	N	N	N	P	N	N	Y	N	N	Y	N	Y	3
Stephenson et al. (2018)	Y	N	N	Y	N	N	N	P	N	N	X	X	N	X	X	Y	3.5
Stewart et al. (2013)	Y	N	N	P	N	N	N	P	Y	N	N	Y	Y	N	N	N	4
Stover et al. (2009)	Y	N	N	P	N	N	N	P	N	N	X	X	N	X	X	N	2
Taylor and Harvey (2010)	Y	N	Y	P	N	Y	Y	N	N	N	Y	N	N	Y	Y	N	3.5
Tehrani (2016)	Y	N	N	P	N	N	N	N	N	N	Y	N	N	Y	N	N	1.5

Templer et al. (2017)	Y	N	N	P	N	Y	N	N	N	N	X	X	N	X	X	N	2.5
Thanhäuser et al. (2017)	Y	N	Y	Y	N	Y	N	N	Y	N	Y	N	N	Y	Y	Y	5
Trask et al. (2011)	Y	N	N	P	N	Y	N	N	N	N	Y	N	N	Y	Y	N	2.5
Troy et al. (2018)	Y	N	Y	P	Y	Y	N	N	Y	N	X	X	N	X	X	Y	5.5
Turner et al. (2007)	Y	Y	N	Y	Y	N	Y	Y	Y	N	Y	N	N	Y	N	Y	8
Uretsky and Hoffman (2017)	Y	N	N	P	N	Y	Y	N	N	N	Y	N	Y	N	N	N	4.5
Van Andel et al. (2014)	Y	N	N	P	N	N	N	N	N	N	Y	N	N	Y	X	N	1.5
Weiner et al. (2011)	Y	N	N	P	N	N	N	N	N	N	Y	N	N	N	Y	N	1.5
Wethington et al. (2008)	Y	N	Y	Y	N	Y	N	Y	P	N	Y	Y	N	Y	N	Y	5.5
Wilen (2014)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	10
Winokur et al. (2014)	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	10
Woodgate (2017)	Y	N	N	P	Y	Y	N	P	N	N	X	X	N	X	X	Y	5
Xiang (2013)	Y	N	Y	P	N	N	N	P	Y	N	X	X	Y	X	X	Y	5
Yelick (2017)	Y	N	N	P	N	N	N	P	N	N	X	X	N	X	X	N	2
Ziviani et al. (2012)	Y	P	N	P	Y	N	N	Y	Y	N	X	X	N	X	X	Y	6

Key: Y=Yes, P=Partial Yes, N=No, X=Not applicable

Table 5: Included reviews listed by ACE population in descending order of AMSTAR score

Note that some reviews included in multiple populations appear more than once. Those included in the best evidence synthesis are shaded. References of included studies are marked * in reference list. Studies excluded from the best evidence synthesis on account of a low AMSTAR grade are listed in Appendix H.

Reference	AMSTAR score
Abuse / neglect	
Macdonald et al. (2016)	10
Wilen (2014)	10
Winokur et al. (2014)	10
Macdonald et al. (2012)	9
Goldman Fraser et al. (2013)	7.5
Parker and Turner (2013)	7
Maclean et al. (2016)	6.5
Leenarts et al. (2013)	6
Montgomery et al. (2009)	5.5
Wethington et al. (2008)	5.5
Kanine et al. (2015)	5
Ehring et al. (2014)	5
Kim et al. (2016)	5
McMillan et al. (2008)	5
Harvey and Taylor (2010)	4.5
Corcoran and Pillai (2008)	4.5
Sanchez-Meca et al. (2011)	4
Stephenson et al. (2018)	3.5
Taylor and Harvey (2010)	3.5
Silverman et al. (2008)	3.5
Hetzel-Riggin et al. (2007)	3
Rubin et al. (2017)	2.5
O'Haire et al. (2015)	2.5
Dorrepaal et al. (2014)	2.5
Trask et al. (2011)	2.5
Cunha (2008)	2.5
Herbert and Bromfield (2016)	2
McDonnell and Garbers (2017)	2
Korotana et al. (2016)	2
Kowalik et al. (2011)	2
Passarela et al. (2010)	2
Holtzhausen et al. (2016)	1.5
Hackett (2013)	1.5
Miffitt (2014)	1.5
Tehrani (2014)	1.5
Weiner (2011)	1.5
Exposed to domestic violence	
Macdonald et al. (2016)	10
Howarth et al. (2016)	9.5
British Columbia Centre of Excellence for Women's Health (2013)	9
Silverman et al. (2008)	3.5
Furr-Roeske (2011)	2.5
Rizo et al. (2011)	2

Hooker et al. (2016)	2
Stover et al. (2009)	2
Hackett (2013)	1.5
Parental incarceration	
Troy et al. (2018)	5.5
Parental mental illness	
Bee et al. (2014)	10
Beresford et al. (2008)	8.5
Loechner et al. (2017)	5.5
Thanhäuser et al. (2017)	5
Reupert et al. (2013)	3
Siegenthaler et al. (2012)	3
Gunlicks and Weissman (2008)	3
Chronis-Tuscano et al. (2017)	2
Parental alcohol / drug use	
Broning et al. (2012)	6.5
McMillan et al. (2008)	5
Niccols et al. (2012)	4
Premji et al. (2007)	3.5
Siegenthaler et al. (2012)	3
Ruff et al. (2010)	2.5
Calhoun et al. (2015)	2
Phillips et al. (2009)	1.5
Parental separation / divorce	
Poli et al. (2017)	3
Templer et al. (2017)	2.5
Parental death	
Bergman et al. (2017)	5
Jensen de López et al. (2017)	4
Chen and Panebianco (2018)	3
Journot-Reverbel et al. (2017)	3
Rosner et al. (2010)	3.5
Currier et al. (2007)	1.5
Looked-after children and young people	
Jones et al. (2008)	8.5
Turner et al. (2007)	8
Everson-Hock et al. (2011)	6.5
Ziviani et al. (2012)	6
Kinsey and Schlosser (2013)	6
Everson-Hock et al. (2012)	6
Kemmis-Riggs et al. (2018)	6
Evans et al. (2017)	5.5
Woodgate et al. (2017)	5
Hambrick et al. (2016)	5
Al et al. (2012)	5
Mannay et al. (2015)	4.5
Kerr and Cossar (2014)	4.5
Uretsky and Hoffman (2017)	4.5
Stewart et al. (2013)	4
Byrne (2017)	3.5
Roberts et al. (2016)	3.5
Liabo et al. (2013)	3.5
Solomon et al. (2017)	3

Downes et al. (2016)	2.5
Leve et al. (2012)	2.5
Forsman and Vinnerljung (2012)	2.5
Yelick (2017)	2
Marsh (2017)	1.5
Van Andel et al. (2014)	1.5
Homeless children and young people	
Coren et al. (2016)	11
Naranbhai et al. (2011)	10
Bassuk et al. (2014)	7.5
Altena et al. (2010)	6.5
Xiang (2013)	5
Dawson and Jackson (2013)	2.5
Davies and Allen (2017)	2
Slesnick et al. (2009)	2

Appendix G: Evidence Tables (overview)

Item	Altena et al. (2010)
RQ /aim	To review evidence on effective interventions for homeless young people
Databases searched	PsycINFO, ERIC, MEDLINE, Cochrane Library, EMBASE, CINAHL
Search dates	1985-2008
Other search methods	Backwards citation chasing [unclear]; Google Scholar
Inclusion criteria	Population: any homeless "youth" (age not specified), living on the street or in service accommodation Intervention: Any except family therapy, sexual health interventions, or school-based interventions Comparison: NR Outcomes: NR Study types: Any empirical, including RCTs, nRCTs, quasi-experimental studies and uncontrolled studies
N incl studies	11
Findings	Study type: n=5 RCTs, n=5 nRCTs, n=1 uncontrolled Country: n=9 USA, n=1 Canada, n=1 South Korea Interventions: intensive case management; residential independent living programme; brief motivational interviewing ; cognitive-behavioual intervention (Community Reinforcement Approach); peer-led drug prevention programme; supportive housing programme. Most (n=8) individual, n=3 group-based (short-term cognitive-behavioural group therapy; Social Enterprise Intervention (SEI) group peer-based intervention) ; most implemented within shelter or drop-in centre. Wide range of duration/intensity from 1 × 30-min session (for brief motivational interviewing) to 6-9 months; delivered by social workers, counsellors/therapists, shelter staff. Population: age 10-24; majority male; some with mental health or substance abuse problems. Findings: Intensive case management not effective for N days homeless, life satisfaction, mental health, drug/alcohol use (0 of 1 RCT). Independent living programmes effective for employment and living status (1 of 1 nRCT), mixed for

	educational outcomes and mental health outcomes (mixed in 1 of 1 nRCT), not effective for delinquent behaviour (0 of 1 nRCT). Brief motivational interviewing not effective for drug/alcohol use (0 of 2 RCTs plus 1 mixed). Cognitive-behavioural intervention effective for social stability / housing (1 of 1 RCT), mixed for mental health (mixed in 1 RCT and 1 nRCT), effective for drug/alcohol use (1 of 1 RCT). Long-term group vocational programme not effective for service utilisation (0 of 1 nRCT), effective for life satisfaction (1 of 1 nRCT), mixed for family/peer support (1 nRCT), mixed for mental health (1 nRCT), not effective for drug/alcohol use (1 nRCT), adverse effects for sexual behaviour (1 nRCT). Group peer-led intervention effective for drug-related knowledge and intentions (1 nRCT). Supportive housing effective for general health (1 nRCT) and drug use (1 nRCT).
Review limitations (author)	Non-English-language sources not searched; descriptive studies not included.
Primary evidence limitations (author)	Limitations in reporting of intervention content, fidelity, randomisation, attrition, intention-to-treat analysis. Many interventions were multi-component and it is hard to identify effectiveness of components. Most focus on drug/alcohol use rather than broader outcomes.
Limitations (reviewer)	Search strategy probably limited sensitivity. Note substantial overlap with Coren et al. (2016).
Evidence gaps (author)	Not clearly reported

Reference	Bassuk et al. (2014)
RQ /aim	"to identify, appraise, and summarise the relevant evidence on effectiveness of housing interventions and housing and services for ending family homelessness in the United States."
Databases searched	Web of Science, Academic Search Premier, Medline, PsycINFO, CINAHL, Econlit, ASSIA, Social Services Abstracts, Sociology Abstracts
Search dates	2007-2013
Other search methods	Contact with experts; Google; Google Scholar; web searches

Inclusion criteria	Population: homeless families, defined as a parent or caretaker with child(ren) under 18 (or pregnant mothers) (Excluded formerly homeless families, single people and unaccompanied young people, and residents of domestic violence shelters.) Intervention: any housing or housing and service intervention, including rehousing, subsidies, emergency shelter, transitional housing, case management, motivational interviewing, parenting training, vocational training, "and any other intervention designed to address the basic needs (other than housing) of homeless families". Comparison: NR Outcomes: housing status; employment; developmental and behavioural problems; school attendance [also housing status, employment, parental outcomes and family reunification, not in scope of this review] Study design: RCTs, nRCTs, before-and-after, interrupted time series, cohort studies; excluded cross-sectional studies
N incl studies	6 (n=5 with effectiveness data)
Findings	Study designs: all uncontrolled Country: all USA Interventions: most combine assistance with housing (re-housing support, transitional housing, subsidies, priority for public housing) with a case management component; some also include other services (employment, mental health, activities for children) Population: most younger children (under 6 in n=4); high rates of IPV, child abuse/neglect, alcohol/drug use Findings: Unclear findings for child wellbeing (positive changes in some studies, but significance not reported)
Limitations (author)	NR
Limitations (reviewer)	Significance of findings mostly NR, which makes it impossible to interpret the effectiveness findings.
Evidence gaps (author)	More robust effectiveness data; screening and assessment; comparison of subsidies and different housing options; subgroup outcomes; type, duration and dosage of services; contextual influences on implementation; longer-term outcomes; factors that increase the likelihood of family reunification; cost-effectiveness data.

Item	Bee et al. (2014)

RQ /aim	To systematically review evidence for community-based interventions for improving the quality of life of children and adolescents of parents with serious mental illness
Databases searched	MEDLINE, CINAHL, PsycINFO, EMBASE, CENTRAL, CDSR, DARE, Web of Science, HSRProj, HMIC, ASSIA, SCOPUS, IBSS, Social Services Abstracts, Social Care Online, ChildData, ERIC, AUEI, BRIE, Dissertation Abstracts, NCJRS, EPPI parental mental health database, EED, PEDE, IDEAS
Search dates	-2012
Other search methods	Journal handsearching; backwards and forwards citation chasing; targeted author searches; contact with experts, advisory group and stakeholders; meta-Register of Controlled Trials; search engines; website searching
Inclusion criteria	Population: Children (0 to <18 years) or parents, one or more parents with serious mental illness with or without substance misuse/other mental health comorbidity (>50% of sample) Intervention: Any health, social-care or educational intervention aimed at the young person, parent or family, delivered alone or in combination with pharmacology. Inpatient interventions excluded. Comparator: active control, no treatment, waitlist, delayed treatment, usual care Outcomes: mental health, physical wellbeing, social wellbeing, family functioning, self-esteem and –actualisation Study type: RCTs, quasi-randomised trials, controlled observational studies, uncontrolled studies [synthesis prioritises controlled studies]
N incl studies	57 (between n=17 and n=21 in scope of this review on age)
Findings	(Separate analyses for parents with serious mental illness (SMI) / with depression. Note uncontrolled studies only briefly considered in synthesis and not extracted here.) Parents with SMI Study type n=3 RCTs, n=4 nRCTs, n=4 uncontrolled Country: n=5 USA, n=4 Australia, n=1 UK, n=1 Canada Population: parental diagnoses including psychosis, schizophrenia, bipolar disorder, personality disorder; child age 0-5 in n=4, 6-12 in n=8, 13-16 in n=4 Interventions: psychoeducation (n=6), psychotherapy (n=5), extended care (n=4); parent-focused (n=6 studies (3 RCTs, 2nRCTs, 1 uncontrolled), child-focused (n=7 studies (2 RCTs, 3nRCTs, 2 uncontrolled); or parent-child /family-focused (n=2 (1nRCT, 1 uncontrolled)); home, community and clinic settings; predominant duration 9-16 weeks (n=6). Group delivery in n=11 studies (4 RCTs, 4nRCTs, 3 uncontrolled) and n=6 were individual (1 RCT, 3nRCT, 2 uncontrolled) (not

	mutually exclusive). Findings: Group psychoeducation not effective for QoL (1 nRCT); not effective for depression (1 nRCT). Child-oriented cognitive-behavioural problem-solving training not effective for internalising and externalising behaviours (1 RCT). Group psychoeducation not effective for prosocial behaviour (1 nRCT); not effective for social relationships (1 nRCT). Psychoeducation holiday programme versus after-school delivery, no difference for social relationships (1 nRCT). Home visiting not effective for family functioning (1 RCT). Child-oriented cognitive-behavioural problem-solving training, parent counselling and parent education unclear results for family functioning (incompletely reported for 1 RCT). Parent-centred conversational psychotherapy not effective for family functioning (1 nRCT). Psychoeducation holiday programme versus after-school delivery, no difference for family functioning (1 nRCT). Child-oriented cognitive-behavioural problem-solving training not effective or adverse effects for cognitive function (1 RCT). Home visiting versus extended care, no difference for cognitive function (1 nRCT). Child-oriented cognitive-behavioural problem-solving training mixed findings for problem-based coping skills (1 RCT). Group psychoeducation not effective for problem-based coping skills (1 nRCT). Psychoeducation holiday programme versus after-school delivery, no difference for coping skills (1 nRCT). Psychoeducation holiday programme versus after-school delivery, no difference for self-esteem (1 nRCT). Parents with severe depression Study type: n=26 RCTs, n=4 nRCTs, n=11 uncontrolled, n=1 economic evaluation (note that 69% of RCTs (n=18), and all nRCTs and economic evaluation, are out of scope of this review on child age; only outcomes clearly reported for 3-18 age group extracted here) Country (for all RCTs): USA (n=11), Australia (n=4), UK (n=4), Canada (n=3), France (n=1), Pakistan (n=1), Chile (n=1), Sweden (n=1) Population: child age 0-2 years in n=18 [NB outside scope of this review], 3-4 years in n=2, 5-12 years in n=7, 13-17 years in n=5. Parents mainly mothers (mothers only in n=21). Target of intervention (for all RCTs) Parent only n=31; child only n=1; parent-child or family focused n=6. Delivery (for all RCTs) individual n=25; group n=13 Interventions (for all RCTs): mainly individual psychotherapy, primarily CBT or interpersonal therapy, some psychoeducation; mainly parent-focused; n=14 had some parenting or family function focus; home, community and clinic settings; mean total time 11.5 hours. Findings: Brief interpersonal psychotherapy (for parents) effective for socio-emotional function at 9 mo (1 RCT); effective for depression at 9 mo (1 RCT). Education for parents not effective for peer relationship quality, recreational engagement or family functioning (1 RCT). Education for parents effective for

	mental health literacy at 6 w (1 RCT). CBT for children not effective for self-esteem at 6 w (1 RCT).
Review limitations (author)	Poorer-quality trials included; inconsistencies in reporting of mental illness measures may lead to loss of relevant evidence.
Primary evidence limitations (author)	Most evidence focused on mothers to the exclusion of fathers; poor reporting of sample demographics, particularly ethnicity; lack of child-centred interventions; lack of studies measuring validated quality of life/wellbeing outcomes, esp. in older adolescents; safety outcomes; child-rated family functioning outcomes; studies mainly focus on high-risk, socioeconomically deprived families; methodological limitations with respect to randomisation, allocation concealment; limited reporting of family context; lack of long-term follow-up.
Review limitations (reviewer)	No methodological limitations. Note that almost half the studies in the severe depression category were for parents of young (0-2 years) children and not in scope of our review.
Evidence gaps (author)	RCTs on parental serious mental illness; UK evidence; user-centred outcomes such as quality of life; family- or child-focused interventions; interventions informed by stakeholder perspectives; nested qualitative studies within outcome studies; cost-effectiveness data

Reference	Beresford et al. (2008)
RQ /aim	"To identify, extract and synthesise research evidence on the outcomes of services/interventions (on children, parents, families, parenting or couple relationships) used in children's services, adults' services and family services in the UK and elsewhere, that support children, families, parenting or couple relationships when a parent has a mental health problem."
Databases searched	PsycINFO, MEDLINE, EMBASE, CINAHL, HMIC, Cochrane Library, NRR, ASSIA, NCJRS, ERIC, C2 SPECTR, C2 RIPE, Social Services Abstracts, Social Work Abstracts, Social Care Online, Childata, CommunityWISE
Search dates	-2007
Other search methods	Web searches; contact with experts and SCIE networks; handsearching of conference proceedings and research registers; forward and backward citation chasing

Inclusion criteria	Population: Parents with mental health problem [not further defined] Intervention: Any non-clinical intervention Comparison: Any Study type: Any 'comparative' [includes uncontrolled pre-post]
N incl studies	37 for effectiveness component (of which n=19 report child outcomes)
Findings	Study type: n=12 RCTs, n=1 nRCT, n=24 uncontrolled (of which n=8 RCTs, n=11 other designs report child/family outcomes and are in scope of this review). Country: n=24 USA, n=6 UK, n=7 other Interventions: parent training, individual or group psychoeducation or problem-solving training, CBT, family therapy, psychiatric treatment; mainly delivered by MH professionals, some by social workers; intensity NR. Combined results: interventions aimed at parents only n=15; aimed at parent-child or family n=16; aimed at child only n=5 Populations: some mothers only, some mothers and fathers; predominantly depression diagnosis. Some with additional problems such as homelessness. Limited information on child participants (age not consistently reported, but appears to be mainly within scope of this review). Findings: CBT mixed results for depression (1 of 2 RCTs). Problem-solving training effective for depression (1 uncontrolled). Interpersonal psychotherapy mixed results for depression (1 uncontrolled). Psychoeducation and problem-solving effective for self-esteem / self-concept (2 of 3 uncontrolled). CBT and family intervention not effective for behaviour (0 of 1 RCT). CBT and psychoeducation not effective for behaviour (0 of 1 RCT). CBT not effective for behaviour (0 of 2 RCTs, unclear in 1 nRCT). Psychoeducation for children not effective for behaviour (0 of 1 RCT). Family therapy effective for behaviour (1 uncontrolled). Psychoeducation for children and parents effective for behaviour (1 uncontrolled). Psychoeducation for children effective for children's understanding of parental MH (1 of 1 RCT, 1 of 1 uncontrolled). CBT and family intervention not effective for social functioning (0 of 1 RCT). Interpersonal psychotherapy for mothers not effective for social functioning (0 of 1 uncontrolled). Parent group CBT and psychotherapy unclear findings on mother-child relationship (unclear in 1 nRCT and 1 uncontrolled). Psychoeducation effective for life skills (1 of 1 uncontrolled). Psychoeducation and problem-solving training for parents mixed results for family functioning (1 of 2 uncontrolled). Psychoeducation mixed results for family functioning (1 uncontrolled). Family therapy effective for family functioning (1 uncontrolled).
Review limitations (author)	Meta-analysis not possible

Primary evidence limitations (author)	Poor reporting of methodology; small sample sizes; inadequate control groups; lack of interrupted time series designs for uncontrolled evaluations
Review limitations (reviewer)	Limited information on child participants
Evidence gaps (author)	NR

Item	Bergman et al. (2017)
RQ /aim	To systematically review studies about effective support interventions for parentally bereaved children and to identify gaps in the research.
Databases searched	PubMed, PsycINFO, Cinahl, PILOTS, Sociological Abstracts, Social Services Abstracts
Search dates	-2015
Other search methods	Backwards citation chasing
Inclusion criteria	Population: ≤18, parentally bereaved Intervention: any bereavement interventions aimed at child or family Outcomes: any Study type: RCT, quasi-experimental or pre-post [uncontrolled
N incl studies	17 (n=12 effectiveness)
Findings	Study type (effectiveness studies only): n=12 RCTs, n=1 nRCT, n=1 uncontrolled Country: n=10 USA, n=1 UK, n=1 multiple countries Interventions: Mostly group interventions. Interventions aimed at children (n=2); interventions aimed at child-parent or family (n=13); most directed at children in an early stage of their grief process, with exceptions being one starting while parent was terminally ill, and one aimed at refugees dealing with traumatic grief (see below). Some interventions focused more on children's trauma experience, expressing grief and painful feelings; others more on parent-child relationships

	and supporting the surviving parent. Duration 6-14 sessions total. Comparisons: no intervention n=3, delayed treatment n=1, telephone support n=1, and self-study program n=10 Population: one study was aimed a refugee children from Afghanistan with high symptom of table and for some of whom many years had passed since their parents' death through war. Most were aimed at school aged-children up until 18 years with exception of 2 studies where younger children (0-16) were involved in family therapy. Cause of death of parent across studies: parent died because of an illness (65–82%), thereafter due to an accident (15–20%) or suicide/homicide (10–14%). Findings: Effective for traumatic/intrusive grief (1 of 2 RCTs plus 1 mixed, 1 of 1 nRCT). Not effective for mental health (depression, anxiety, PTSD etc.) (0 of 5 RCTs plus 2 mixed, 0 of 1 nRCT, 0 of 1 uncontrolled). Not effective for internalising/externalising behaviour (0 of 5 RCTs plus 2 mixed). Mixed results for school-related outcomes [unclear what these are exactly] (1 of 2 RCTs). Effective for health (1 of 1 RCT).
Review limitations (author)	NR
Primary evidence limitations (author)	Small sample sizes
Review limitations (reviewer)	Limited and incompletely reported quality assessment. Non-standard analysis of effect sizes, which arguably overestimates effectiveness, and reporting of findings in text and discussion emphasises findings of effectiveness.
Evidence gaps (author)	Longer follow-up; larger sample sizes to enable power for subgroup analyses; interventions for pre-school-age children; evaluation studies incorporating child involvement; children living with single parent

Reference	British Columbia Centre (2013)
RQ /aim	What types of interventions and approaches are effective in identifying and responding to children who are exposed to domestic violence in healthcare, social care and specialised domestic violence service settings? [Other questions not in scope of this review]
Databases searched	AMED, British Nursing Index, Campbell Library, CINAHL, Central, Cochrane Database of Systematic Reviews, DARE, EMBASE, EPPI Centre Database, ERIC,

	HMIC, MEDLINE, UK Clinical Research Network, PsycINFO, Social Policy and Practice, Social Science Citation Index, Contemporary Women's Issues, Family & Society Studies Worldwide, LGBTLife, Social Work Abstracts, Studies on Women & Gender Abstracts, Violence and Abuse Abstracts, Women's Studies International, OpenGrey Repository
Search dates	2000-2012
Other search methods	Websites; backwards citation chasing; contact with experts; NICE call for evidence
Inclusion criteria	Population: Children who are exposed to domestic violence (i.e. the violence is not perpetrated on them directly, but they witness or experience it). [Other populations not in scope of this review] Intervention: Any intervention to reduce or respond to domestic violence between adults and young people who are, or have been, intimate partners. [Some interventions not in scope of this review] Setting: Health-care, social care and specialized domestic violence service settings. (Interventions involving the activities of the police, criminal justice, education, early years excluded.) Study Type: RCTs, case-control, cohort, cross-sectional, observational, systematic review
N incl studies	38
Findings	N=13 individual studies (n=3 RCT, n=1 nRCT, n=7 uncontrolled, n=2 qualitative [not extracted here]) plus N=25 studies from a previous systematic review Country: new studies: n=2 Australia, n=2 UK, n=1 Sweden, n=8 USA; From SR: n=20 US, n=1 UK, n=4 Canada Populations: ages 0-17 years; exposed to IPV; some report other ACEs (physical abuse, sexual abuse, parent mental illness); limited further information. Interventions: (review authors' categorisation) Single component therapeutic interventions delivered to mother and child; Single component psycho-education interventions delivered to mother and child; Single component therapeutic interventions delivered to child only; Single component psycho-education interventions delivered to child-only; Multi-component interventions focused on advocacy; Multi-component interventions focused on advocacy and therapy; Multi-component interventions focused on therapy and parenting. Therapeutic and psychoeducational interventions aimed at mother + child n=10; therapeutic and psychoeducational interventions aimed at child only n=9 [for first section] Findings: 1) Single component therapeutic interventions delivered to mother and

	child: mother-child psychotherapy, parent training; 10-50 weeks duration. Mother-child psychotherapy effective for behaviour problems (2 of 2 RCTs); effective for mental health (2 of 2 RCTs). Parent-child interaction therapy effective for behaviour problems (1 of 1 nRCT). Group parent training effective for unclear outcomes (1 time series). 2) Single component psycho-education interventions delivered to mother and child: psychoeducational and support groups, group and individual parent training; 12-30 weeks duration. Group parent-child psychoeducation and support effective for behaviour problems (1 mixed uncontrolled). Group parent training effective for behaviour problems and externalising/internalising behaviour (1 of 1 RCT, but only within-group findings reported). 3) Single component therapeutic interventions delivered to child only. Individual play therapy in a shelter setting and sibling group play therapy equally effective for behaviour problems and mental health (but significance unclear) (1 time series). Expressive writing therapy not effective for mental health (1 uncontrolled). Equine-assisted psychotherapy effective for overall functioning (but significance unclear) (1 uncontrolled). 4) Single component psycho-education interventions delivered to child-only: educational programmes focusing on problem-solving, coping and relationship skills, delivered in school, shelter or community settings (some also report parent components); 5-15 weeks duration; one delivered by mental health and school-based professionals, unclear for others. Effective for behavioural problems (2 of 2 uncontrolled), mental health (2 of 2 uncontrolled), skills/knowledge (2 of 2 uncontrolled). 5) Multi-component interventions focused on advocacy: crisis-response and wraparound services involving care planning and co-ordination, liaison with or referral to services, assessment, individual treatment, plus one study on Head Start children's services. Service interventions effective for behaviour problems (2 of 2 uncontrolled [including 1 RCT reported as one-group]), mental health (1 of 1 uncontrolled). Head Start services mixed results for behaviour problems (1 RCT). 6) Multi-component interventions focused on advocacy and therapy: individual psychoeducation or skills training, service co-ordination or case management, advocacy training for parents in 1 study. Effective for knowledge (1 of 1 uncontrolled), effective for self-confidence (but significance unclear) (1 of 1 RCT); unclear in 1 nRCT. 7) Multi-component interventions focused on therapy and parenting: parent training combined with psychotherapeutic or skills-based programmes for children; 9-10 weeks duration (where stated). Effective for behaviour problems (4 of 4 RCTs, 1 of 1 uncontrolled (but significance unclear)); mixed results for mental health (1 of 2 RCTs, 1 of 1 time series, 1 of 1 uncontrolled). Effective for knowledge/skills (1 of 1 uncontrolled, but significance unclear).
Review limitations (author)	Quality of the systematic review studies is reliant on the judgements made by the authors of the previous systematic review (as individual studies were not re-appraised by the authors of this review).

Primary evidence limitations (author)	Lack of long-term follow-up, esp. for uncontrolled studies; lack of gender-based analysis for child outcomes
Review limitations (reviewer)	Some unclarity in reporting of findings, and not clear that negative findings have been consistently reported. Review categorisation of intervention types is not very perspicuous. Some settings (for example, schools) excluded. Some studies had mixed populations with children who may not have been exposed to DV and the results are not always stratified in order to report outcomes for each group relating to the pre-intervention DV exposure or levels of severity.
Evidence gaps (author)	Controlled studies; reporting of benefits specific to sub-components of multi-component interventions, which makes it difficult to compare and discuss the benefits of modalities; gender-based analysis or discussion of sex or gender issues; preventive or broader population-level interventions which may have wider reach.

Reference	Broning et al. (2012)
RQ /aim	To review the effectiveness of selective preventive programmes to reduce the risk of substance disorders or mental health problems in children from substance-affected families
Databases searched	Cochrane Database of Systematic Reviews, Ovid [sic], MEDLINE, EMBASE, PsycINFO, PSYNDEXplus
Search dates	1994-2009
Other search methods	NR
Inclusion criteria	Population: 0-17 years, with one parent/guardian who "uses alcohol and/or other psychotropic substances (legal or illegal) in a risky or problematic way, or is dependent on at least one substance" Intervention: Any preventive intervention (excluding indicated interventions for children with substance use problems (already showing harmful substance use) and therapeutic interventions (for example, for children with mental problems diagnosed according to the child and psychiatric standards)) Outcomes: NR Study design: Any

N incl studies	13 (n=9 effectiveness)
Findings	Study design: n=7 RCT, n=2 nRCT [plus n=2 cross-sectional and n=2 qualitative, not extracted here] Country: NR Populations: most around 8-11 years old; limited further information Interventions: school-based n=4, family-based n=5; all delivered in a group format (group size 8-12). Mostly educational with focusing on coping skills and family relationships, and parent training in the family interventions; some included other components (peer mentoring, academic assistance, leisure activities, family crisis intervention, family case management); duration 8-14 weeks, around 90 minutes per session. Findings (note incomplete reporting; authors report overall effect sizes, but it is unclear how these were arrived at and no significance tests or confidence intervals are reported). School-based intervention unclear results for substance use (1 RCT). Community intervention adverse effects (1 RCT) for substance use. School-based interventions unclear for coping skills (effective in 1 RCT, mixed in 1 RCT, but unclear how many studies had negative findings). School-based interventions unclear for social behaviour (effective in 1 RCT, mixed in 2 RCTs, but unclear how many studies had negative findings; text suggests none). School-based interventions not effective for self-esteem (0 of 2 RCTs plus 1 mixed). School- and family-based interventions effective for programme knowledge (2 of 2 RCTs, 1 of 1 nRCT).
Review limitations (author)	NR
Primary evidence limitations (author)	Adverse effects not mentioned or not explored; implementation fidelity not reported; substance use outcomes not validated; short follow-up; no evidence on effectiveness of intervention components.
Review limitations (reviewer)	Some unclarity in criteria. Limited search. Reporting of findings (particularly findings of ineffectiveness) incomplete and inconsistent; overall analysis combines cross-sectional and qualitative data with effectiveness data; unclear how overall effect sizes were derived (not extracted here) and which were significant (discussion suggests that cross-sectional results may have been interpreted in terms of effectiveness).
Evidence gaps (author)	Studies from countries other than USA; sufficiently powered studies; validated outcome measures; reporting of adverse events; longer follow-up.

Reference	Coren et al. (2016)
RQ /aim	"To evaluate and summarise the effectiveness of interventions for street-connected children and young people that aim to: promote inclusion and reintegration; increase literacy and numeracy; facilitate access to education and employment; promote mental health, including self-esteem; and reduce harms associated with early sexual activity and substance misuse." Secondary research objective: to consider adverse or unintended outcomes.
Databases searched	CENTRAL, MEDLINE, EMBASE, CINAHL, PsycINFO, ERIC, Sociological Abstracts, Social Services Abstracts, HealthSTAR, LILACS, OpenGrey, ProQuest Dissertations and Theses, EconLit, IDEAS, JOLIS, BLDS, Google, Google Scholar
Search dates	-2015
Other search methods	Contact with experts; advisory group; backward and forward citation chasing; contact with authors; website searching; author searching
Inclusion criteria	Population: 0-24, "street-connected" Intervention: "any interventions that: involved harm-reduction, inclusion or reintegration programmes for street-connected children and young people, were intended to reduce harms associated with risky sexual activity and substance misuse and promoted inclusion and reintegration; increased literacy, numeracy and self-esteem; increased participation in education and skills-based employment; and provided shelter, housing and drop-in support." Outcomes: inclusion and reintegration, defined as "the children and young people entering a residential and/or educational environment that has the potential to provide them with elements of physical safety, medical care, nutrition, counselling, education, inclusion in social and economic opportunities and room for recreation and personal and spiritual growth that may impact positively on longer-term life chances"; range of secondary outcomes Comparison: Any (no treatment, TAU, other intervention) Study types: RCTs, controlled trials, controlled before-and-after studies, quasi-randomised trials
N incl studies	13
Findings	Study types: N=11 RCTs, n=2 nRCTs Country: N=12 USA, N=1 Korea Interventions: included individual (child-oriented (n=10)), family (n=6) and group-based (n=5) approaches; range of treatment intensity from 1 session to 'ongoing';

	frameworks including motivational, community reinforcement, CBT, case management including individual therapy; family therapy. Findings: no findings on inclusion or reintegration outcomes. Not effective for N times had sex: combined mean difference -0.04 (-0.25 to 0.17) at 3 months (n=2 studies), -0.04 (-0.22 to 0.13) at 6 months (n=2). Not effective for N sexual partners: combined mean difference -0.56 (-1.13 to 0.01) at 3 months (n=2), 0.73 (-2.97 to 4.43) at 6 months (n=2). Effective for unprotected sex for women, not effective for men (n=1). Effective for intentions / self-efficacy for condom use (n=1). Not effective for sexual abstinence (n=1). Not effective for other sexual behaviour outcomes (knowledge, risk behaviour etc.) (n=3). Not effective for N days of alcohol use: combined mean difference -0.3 (-2.25 to 1.59) at 1 months (n=2), 1.10 (-0.67 to 2.88) at 3 months (n=2). Not effective for % days of alcohol use: combined mean difference 0.03 (-1.86 to 1.93) at 3 months (n=5), 1.05 (-1.76 to 3.86) at 6 months (n=3), 0.63 (-2.23 to 3.48) at 12 months (n=3). Effective for N drinks: combined mean difference -2.87 (-5.68 to -0.07) at 3 months (n=2). Not effective for adolescent drinking index score: combined mean difference 1.08 (-4.42 to 6.57) at 3 months (n=2). Not effective for % days drug/alcohol use: combined mean difference -0.70 (-9.09 to 7.70) at 3 months (n=4), -2.15 (-9.82 to 5.53) at 6 months (n=3), 5.87 (=5.06 to 16.79) at 12 months (n=2). Not effective for % days drug use: combined mean difference 0.67 (-6.82 to 8.15) at 3 months (n=5), -2.28 (-11.53 to 6.96) at 6 months (n=3), -5.28 (-13.79 to 3.23) at 12 months (n=3). Not effective for N days marijuana use: combined mean difference -0.52 (-3.65 to 2.62) at 1 month (n=2), 0.37 (-2.73 to 3.47) at 3 months (n=2). Not effective for N days other drug use: combined mean difference 1.21 (-0.68 to 3.10) at 1 months (n=2), 0.22 (-1.84 to 2.28) at 3 months (n=2). Mixed results for problem consequences: combined mean difference 1.51 (0.56 to 2.47) at 3 months (n=3), 0.34 (-0.67 to 1.34) at 6 months (n=2. Effective for N substance use diagnoses: combined mean difference -0.70 (-1.27, -0.14) at 3 months (n=2). Not effective for N categories drug use: combined mean difference 0.14 (-0.33 to 0.61) at 6 months (n=2). Not effective for self-esteem: standardised mean difference 0.11 (-0.22 to 0.44) (n=2). Not effective for depression: combined mean difference -0.03 (-0.22 to 0.17) at 3 months (n=9), 0.83 (-0.88 to 2.55) at 6 months (n=6), 1.28 (-0.36 to 2.92) at 12 months (n=5). Not effective for verbal aggression: combined mean difference -0.00 (-0.07 to 0.06) at 3 months (n=3). Not effective for family violence: combined mean difference -0.00 (-0.02 to 0.02) at 3 months (n=3). Not effective for % days living at home: combined mean difference -9.46 (-27.96 to 9.03) at 3 months (n=2). Mixed results for delinquent behaviours: combined mean difference -0.29 (-0.54 to -0.03) at 3 months (n=5), -0.07 (-0.52 to 0.37) at 6 months (n=3), -0.16 (-1.05 to 0.72) at 12 months (n=2). Not effective for internalising behaviours: combined mean difference 0.73 (-0.87 to 2.34) at 3 months (n=8), 0.30 (-1.36 to 1.97) at 6 months (n=6), 0.31 (-1.58 to 2.20) at 12 months (n=5). Not effective for externalising behaviours: combined mean difference 0.09 (-0.10 to 0.28) at 3 months (n=8), 0.83 (-0.74 to 2.41) at 6 months (n=6), 0.04 (-2.89 to 2.97) at 12

	months (n=5). Effective for family cohesion: combined mean difference 0.88 (0.23 to 1.54) at 3 months (n=3). Not effective for family conflict: combined mean difference -0.05 (-0.91 to 0.81) at 3 months (n=3). [Also parenting outcomes, not in scope of this review.]
Review limitations (author)	Review included studies without no treatment / usual service control group (i.e. comparing two active interventions)
Primary evidence limitations (author)	No evaluations of drop-in shelter services (most commonly provided service) or long-term residential settings, and studies focus on atypical and intensive psychological interventions; participants mainly recruited from drop-in shelters rather than from the street; exclusion criteria (for example, family contact) may limit generalisability of findings; lack of information on participants' reasons for leaving home, for example, abuse or substance use; limited reporting of socioeconomic status; limited attention to harms specific to women; limited data on relationship outcomes.
Review limitations (reviewer)	No methodological limitations. Synthesis groups together heterogeneous interventions.
Evidence gaps (author)	No-treatment control groups; street-recruited rather than agency-recruited populations; interventions building on participation or consultation with service users; further analysis of confounders and process factors; clarification of conceptual frameworks; evaluations in low- and middle-income countries.

Reference	Evans et al. (2017)
RQ /aim	The effectiveness of interventions addressing the educational outcomes of looked-after children and young people, as evaluated by use of an RCT.
Databases searched	ASSIA, British Education Index, CINAHL, ERIC, Embase, Medline, Medline in Process, Social Care Online, Social Science Citation Index, Social Services Abstracts, Scopus, PsycINFO
Search dates	-2014
Other search methods	Contact with experts; backwards citation chasing; suggestions from peer reviewers

Inclusion criteria	Population: Children and young people ≤18 years, currently looked-after or previous care experience. Intervention: Any Comparison: Any Outcomes: academic skills; academic achievement and grade completion; special education status; homework completion; school attendance, suspension and drop-out; number of school placements; teacher-student relationships; school behaviour; and academic attitudes. Study type: RCTs only
N incl studies	12
Findings	Country: n=7 USA, n=3 Canada, n=2 UK Interventions: Fostering Individualized Assistance Program (FIAP); Early Start to Emancipation Preparation (ESTEP); Teach Your Children Well (TYCW) at both individual and group level; Multidimensional Treatment Foster Care (MTFC-A), Kids in Transition to School; On the Way Home (OTWH); Education Specialist; Head Start. Most commonly delivered by carers within care setting (n=5); n=1 delivered by student tutors in care setting; n=1 delivered by teachers to children and facilitators to carers in school setting; n=3 broader programmes including wraparound services (for example, Head Start) and holistic family interventions; n=1 case management and parent training programme for young people leaving residential care. Durations around 4 months to 1 year; total 40-138 hours. Populations: Most ages around 6-15; foster or kinship care; a few studies also included juvenile justice system, secure units, emergency shelters, group homes. Some aimed at younger children (Head Start 3-4 years; Kids in Transition to school ≤6 years). Findings: Mixed results for academic skills (reading, mathematics etc.) (1 of 9 RCTs plus 3 mixed). Mixed results for school attendance (1 of 3 RCTs plus 1 mixed; 1 adverse effect). Effective for school suspension (1 of 1 RCT). Mixed results for school drop-out (1 of 2 RCTs). Effective for teacher-student relationship (1 of 1 RCT). Unclear findings for homework completion (1 RCT). Not effective for N of school placements (0 of 2 RCTs). Not effective for academic achievement and grade completion (0 of 2 RCTs); school behaviour (0 of 1 RCTs); academic attitudes (0 of 1 RCTs).
Review limitations (author)	No meta-analysis (due to heterogeneity of studies); lack of external validity / generalisability to UK context; may not include unpublished evaluation reports; excluded study types other than RCTs.
Primary evidence	Variable conduct and reporting; lack of trial protocols; small sample sizes; "usual care" control groups not well characterised

limitations (author)	
Review limitations (reviewer)	Heterogeneous interventions and limited analysis of differences (possibly due to limitations in evidence base).
Evidence gaps (author)	Economic evaluations; description of context of intervention (for example, child welfare and educational system); system perspectives on interventions; logic models; evidence on harms

Reference	Everson-Hock et al. (2011)
RQ /aim	"to identify and synthesise evidence on the effectiveness of support services for transition to adulthood/leaving care (TSSs) delivered towards the end of care for LAYP on their adult outcomes, compared with no intervention/usual care."
Databases searched	ASSIA, Australian Family and Society Abstracts, BEI, C2 Library, CERUK Plus, ChildData, Cochrane Library, CINAHL Plus, EMBASE, HMIC, IBSS, JSTOR, Medline, PsycInfo, Social Care Online, Social Services Abstracts, Social Work Abstracts, Zetoc
Search dates	1990-2008
Other search methods	Backwards and forwards citation chasing; consultation with experts
Inclusion criteria	Population: looked-after young people (currently or previously); no age limit at time of intervention Intervention: "Support services designed to assist and prepare LAYP for the transition from foster/residential care to independent living or some form of community care, delivered or commenced during the LAYP's time in care. After-care services were not included." Comparison: usual care, no intervention Outcomes: Any, including educational attainment, employment, substance misuse, offending behaviour, young parenthood, housing, health outcomes Study types: RCTs, nRCTs, case control studies, cohort studies; uncontrolled studies excluded
N incl studies	7

Findings	Study design: all cohort studies (5 retrospective and 2 prospective) Interventions: multi-component transition support including life skills training, employment advice or placements, access to services, liaison with other agencies for example, housing, general advice or assistance; most delivered by local authorities or agencies working for local authorities Populations: most 16-18 years; mix of urban and rural; limited further information Findings: Mixed results for educational outcomes (2 of 5 studies, plus mixed in 1, adverse effects in 1). Mixed results / not effective for employment (2 of 6 studies, adverse effects in 1). Not effective for crime (0 of 2 studies plus 1 mixed). Mixed results for parenthood (1 of 3 studies). Effective for housing / independent living outcomes (3 of 6 studies). Not effective for homelessness (0 of 4 studies). Not effective for mental health (0 of 3 studies plus 1 mixed).
Review limitations (author)	NR
Primary evidence limitations (author)	Generally poor methodological quality; few subgroup analyses for example, by gender; variation in length of follow-up.
Review limitations (reviewer)	Non-significant findings are reported as positive in text.
Evidence gaps (author)	Studies on LAYP from ethnic minorities, asylum seekers, gay and lesbian LAYP or LAYP with complex needs or disabilities, and LAYP in residential care homes.

Reference	Everson-Hock et al. (2012)
RQ /aim	"to identify and synthesize evidence that evaluates the effectiveness of additional training and support provided to approved carers (for example, foster carers, residential child care workers, birth family members), professionals (for example, teachers, social workers) and volunteers (for example, independent visitors) involved in the care of or working directly or indirectly with LACYP on the physical and emotional health and wellbeing of LACYP"
Databases searched	ASSIA, Australian Family and Society Abstracts, BEI, Campbell C2 Library, CERUK Plus, ChildData, Cochrane Library, CINAHL, EMBASE, HMIC, IBSS, JSTOR, Medline, PsycInfo, Social Care Online, Social Services Abstracts, Social Work Abstracts, Zetoc

Search dates	1990-2008
Other search methods	Backwards and forwards citation chasing
Inclusion criteria	Population: people caring for / working with children looked-after by local authorities, including foster carers, family members, teachers, social workers, volunteers etc. No restrictions on age at time of study. Intervention: Any training or support intervention Comparison: TAU, no treatment Outcomes: Any ("physical and emotional health and well-being … longer-term outcomes in adult life and intermediate outcomes (including behavioural problems and placement stability)" Study designs: RCTs, nRCTs, case-control studies, cohort studies, uncontrolled studies
N incl studies	6
Findings	Findings (note n=1 study out of scope of this review on age, data not extracted) Study designs: n=5 RCTs, n=1 controlled cohort (nRCT) Country: n=3 USA, n=3 UK Population: ages 0-18 years; limited further information Interventions: All aimed at foster parents. Intensity around 15-30 hours total; group training (n=4) or individual training in foster parent homes (n=2); delivered by social workers, psychologists, trained facilitators; appear to mainly focus on management of challenging behaviour Findings: mixed results for behaviour problems (1 of 2 RCTs, 0 of 1 nRCT); not effective for mental health (0 of 1 RCTs).
Review limitations (author)	NR
Primary evidence limitations (author)	Limited information on usual training control groups. Differences between US and UK studies may limit generalisability to the UK context.
Review limitations (reviewer)	No major limitations. Note overlap with Kinsey (2013).

Evidence gaps (author)	Longer follow-up; studies of higher-intensity interventions in UK; training and support for professionals and volunteers working with LACYP

Reference	Goldman Fraser et al. (2013)
RQ /aim	To systematically review the comparative effectiveness evidence for interventions to ameliorate the negative sequelae of maltreatment exposure in children ages birth to 14 years.
Databases searched	PubMed, SSCI, PsycInfo, Cochrane Library
Search dates	1990-2012
Other search methods	Specialist and general registries; backwards citation chasing
Inclusion criteria	Population: Children 0-14 years exposed to child maltreatment, or whose families were involved with child protective services, including children who remained in the care of their biological parent and those placed in out-of-home care. Intervention: Clinical interventions including psychotherapy, psychosocial interventions (individual, caregiver or family level); pharmacotherapy. (Service- or organisational-level interventions, for example, intensive family preservation or routine preservice foster parent training programs, excluded.) Comparison: Any Outcomes: mental and behavioural health; caregiver-child relationship; development (cognitive, language, physical); school-based functioning; safety; treatment engagement / adherence / readiness [also placement stability and permanency, not in scope of this review] Study type: Systematic reviews, RCTs, nRCTs, cohort studies (prospective and retrospective), case-control. Studies rated as being at high risk of bias were excluded.
N incl studies	25
Findings	Study type: n=23 RCTs, n=1 nRCT, n=1 cohort study Country: n=19 USA, n=2 Canada, n=1 UK, n=1 Iran, n=1 Romania Populations: limited information Interventions: (1) Trauma-focused treatments including trauma-focused CBT, eye

	movement desensitisation and reprocessing, group psychotherapy; 12-26 sessions; most focus on 6-13 age group; n=5 of 7 trauma-focused care interventions included a caregiver-directed component in the form of sessions delivered either separately or together with the child (EMDR and group treatment for sexually abused girls did not). Some delivered in groups; limited information on setting or delivery. (2) Parent training interventions focused on improving caregiver-child relationships and promote problem-solving strategies; 8-50 sessions; most delivered to parent-child pairs, some to parents only in groups; some focus on younger children (0-5), some on 3-12 age group; limited information on setting or delivery. [Note: findings separately reported for foster and biological parents: the latter are mostly out of scope of this review due to child age and data are not extracted here, but intervention description includes both.] Findings: (1) CBT / EMDR mixed results for mental health (0 of 5 RCTs plus 3 mixed) and behaviour problems (0 of 5 RCTs plus 2 mixed). Group psychotherapy mixed results for mental health (mixed in 1 RCT), effective for behaviour problems (1 of 1 nRCT). (2) Foster parent interventions effective for mental health (1 of 1 RCT), mixed results for behaviour problems (2 of 4 RCTs).
Review limitations (author)	Excluded data on widely used interventions due to study design. Excluded children exposed to domestic violence. Excluded over-14 age group. Excluded system-level interventions and preventive intervention.
Primary evidence limitations (author)	Unclear reporting of sample size determination, attrition, blinding of outcome assessment. Power calculations not reported. Several studies report per-protocol rather than intention-to-treat analysis and do not account for multiple comparisons.
Review limitations (reviewer)	Many controlled studies used active controls so harder to summarise in terms of effectiveness. Limited information on populations. Analysis focuses on identifying effective interventions rather than providing complete overview of available evidence, and not all findings are reported in the text of the review.
Evidence gaps (author)	Head-to-head trials of representative treatment options; adapted interventions; contextual factors which may affect efficacy (therapeutic relationship, engagement etc.); validated assessment and screening tools; comparison of age subgroups; data on fidelity, implementation, engagement, retention; Bayesian analysis to deal with heterogeneity.

Reference	Howarth et al. (2016)

RQ /aim	To synthesise evidence on the clinical effectiveness, cost effectiveness [and acceptability] of interventions for children exposed to domestic violence and abuse.
Databases searched	MEDLINE, CINAHL, PsycINFO, EMBASE, Cochrane Central, Science Citation Index, Applied Social Science and Abstracts Index, International Bibliography of the Social Sciences, Social Services Abstracts, Social CareOnline, Sociological Abstracts, Social Science Citation Index.
Search dates	-2015
Other search methods	Trial registries; backwards citation chasing [other methods used for acceptability review]
Inclusion criteria	Population: children and adolescents <18 years exposed to DVA Intervention: Any, including interventions delivered to parents, children or both Comparison: Any Outcomes: behaviour, behaviour symptoms, mental health (for example, depression, anxiety, self-harm, PTSD), school attainment, school attendance or school functioning, self-esteem, self-competence or self-efficacy, happiness/social relationships, quality of life, intervention of social services (children taken into care, child protection services, care conferences, etc.). Study types: RCTs, nRCTs.
N incl studies	13
Findings	Study types: n=9 RCTs, n=4 nRCTs Country: n=10 USA, n=1 Canada, n=1 Israel, n=1 Netherlands. Interventions: Advocacy, emotional support, group activity, parenting skills training, play therapy, psychoeducation and psychotherapy (note most use active controls which are also incorporated in the network meta-analysis). Most interventions delivered to parents and children (n=9), others to children only (n=3) or parents only (n=1). Delivered by social workers, psychologists, therapists; settings including home, community settings, shelters; modal duration 5-10 weeks, most with weekly sessions. Delivery took an individual format in n=7 interventions, group delivery in n=5 and one intervention used a mixture of both. Populations: Just over half female; most 4-12 years with n=4 aimed at younger children (under 6 years, with only one study included children <4 years) and n=2 aimed at 7-14 year olds. The participants lived in: domestic violence shelters n=3; the community n=3; a shelter but moving out to a home n=2; either a shelter or a home n=2; not stated n=3. Findings: From network meta-analysis (SMDs and credible intervals). (Data

	extracted here for main analysis which excludes nRCTs and is more conservative with respect to outcomes; various sensitivity analyses are also presented, not extracted here.) Psychotherapy + psychoeducation not effective for mental health (SMD –0.15 (–0.97 to 0.79)). CBT not effective for mental health (SMD –0.43 (–1.24 to 0.50)). Psychotherapy alone not effective for mental health (SMD –0.51 (–1.13 to 0.10)). Advocacy + parent training not effective for mental health (SMD –0.31 (–1.04 to 0.46)), effective for behaviour problems (SMD –0.46 (–0.85 to 0.06)) [appears this should be (–0.85 to –0.06), although is reported in text as credible interval (CrI) crossing 0]. Advocacy alone not effective for mental health (SMD 0.07 (–0.23 to 0.38)) or behaviour problems (SMD 0.18 (–0.11 to 0.47)). Psychoeducation delivered to child and parent separately not effective for mental health (SMD 0.05 (–0.43 to 0.50)) or behaviour problems (SMD –0.18 (–0.57 to 0.23)). Psychoeducation delivered to child not effective for mental health (SMD –0.39 (–0.80 to 0.02)) or behaviour problems (SMD 0.27 (–0.21 to 0.77)). Target of intervention. Interventions aimed at child effective for mental health (SMD –0.44 (–0.87 to –0.01)), not effective for behaviour problems (SMD 0.19 (–0.28 to 0.67)) Interventions aimed at both parent and child in parallel not effective for mental health (SMD –0.07 (–0.48 to 0.34)), not effective for behaviour problems (SMD –0.30 (–0.62 to 0.02)). Interventions aimed at parent not effective for mental health (SMD 0.11 (–0.21 to 0.43)), not effective for behaviour problems (SMD 0.27 (–0.02 to 0.55)) (Note: "It should be noted that all of the interventions aimed exclusively at the child were delivered in groups and contained some psychoeducational component. It is, therefore, not possible to ascertain if the impact on child mental health outcomes was attributable to the psychoeducational component or to the fact that the child was the target of the intervention. We can say, however, that the most effective interventions for improving mental health outcomes seem to be those with a psychoeducational component, delivered to children in groups." p. 107)
Review limitations (author)	Network meta-analysis reflects several assumptions including comparability of populations, when in fact they differ by age and on whether or not studies restricted inclusion to children with health or behavioural problems. There were insufficient studies to be able to conduct sensitivity analysis on these sub-groups. Heterogeneous range of outcome measures. Uncontrolled studies excluded.
Primary evidence limitations (author)	Unclarity in reporting of randomisation and allocation concealment; small sample sizes; limited information on context of intervention delivery; lack of process evaluation; lack of evidence on harms.
Limitations (reviewer)	No assessment for publication bias. Quality of studies was only considered inasmuch as RCTs were grouped in analyses separately from nRCTs.

Evidence gaps (author)	Comparisons of child- and parent-oriented interventions; interventions aimed at abusive party; lower-intensity interventions for families not ready to engage fully with therapy, for example, computer-based interventions; different types of violence/abuse; interventions designed for specific symptoms or adapted for specific groups; research on infants and older adolescents; interventions in community-based mental health clinics, schools and primary care; interventions delivered by non-mental health specialist staff; cost-effectiveness analyses; non-health outcomes for example, school attainment, wellbeing; interventions incorporating consultation with intended recipients.

Reference	Jones et al. (2008)
RQ /aim	"What is the effectiveness of interventions to improve access to specialist or universal services accessed by looked-after children and young people and delivered during ongoing care on access to services and/or the physical and emotional health and wellbeing of looked-after children and young people, compared with usual care/access?"
Databases searched	ASSIA, Australian Family and Society Abstracts, BEI, C2 Library, CERUK Plus, ChildData, Cochrane Library, CINAHL, EMBASE, HMIC, IBSS, JSTOR, Medline, PsycInfo, Social Care Online, Social Services Abstracts, Social Work Abstracts, Zetoc
Search dates	1990-2008
Other search methods	Consultation with advisory group
Inclusion criteria	Inclusion criteria Population: looked-after children and young people [not further defined], or adults who were LA Intervention: Any intervention intended to improve access to any specialist or universal health service accessed by LACYP during their time in care (excluding treatment foster care) Comparison: usual treatment, no treatment (incl pre-intervention) Outcomes: Service access, health and wellbeing "and longer-term outcomes in adult life and intermediate outcomes" Study type: randomised controlled trials, non-randomised controlled trials, case control studies, prospective cohort studies, retrospective cohort studies, non-comparative studies

N incl studies	5
Findings	Study designs: n=4 prospective cohort studies (nRCTs), n=1 uncontrolled Country: USA n=4, UK n=1 Population: ages 0-18 years [limited further information] Interventions: placing MH clinicians within foster care agencies; multidisciplinary clinics and case management programme; information sharing between health and social services Findings: Mixed results for multidisciplinary assessments for children entering the care system on receipt of services (mixed in 1 nRCT). Multidisciplinary assessments and case management not effective for receipt of mental health services (0 of 2 nRCTs plus 1 unclear). Multidisciplinary assessment and case management mixed results for referral to medical services (1 of 2 nRCTs). Information sharing effective for health assessments (1 of 1 nRCT), not effective for immunisation uptake (0 of 1 uncontrolled). Multidisciplinary assessments and case management not effective for receipt of educational services (0 of 1 nRCT).
Review limitations (author)	NR
Primary evidence limitations (author)	Poor reporting of baseline characteristics, statistical methods. No studies addressed more than one or two points on the care pathway.
Limitations (reviewer)	Fairly limited information on populations and interventions
Evidence gaps (author)	Gaps for several population groups (LACYP from ethnic minorities, asylum seekers esp. unaccompanied asylum seekers, with disabilities); studies on different types of placement (for example, local authority versus foster care); interventions spanning care pathway; interventions at service level. Long-term follow-ups.

Reference	Kemmis-Riggs et al. (2018)
RQ /aim	To synthesise data from randomised trials on interventions to improve the wellbeing of foster children and carers
Databases searched	PsycINFO, MEDLINE, Web of Science, CENTRAL, Scopus

Search dates	1990-2016
Other search methods	NR
Inclusion criteria	Population: 0-18 and carers, history of maltreatment or child protection services involvement and placed in foster or kinship care. Excluded children in residential/group care or interventions for biological / adoptive parents, or referred to foster care from institutional care / juvenile justice. Interventions around exit from care or family reunification excluded. Intervention: Any psychosocial intervention involving foster/kinship carers that aimed at improving child and parent wellbeing; excluded wraparound services and interventions for professionals Comparison: active control, wait-list, TAU Outcomes: behaviour problems, mental health, interpersonal skills, biomarkers, placement stability, carer-child relationships, parent stress / mental health, parenting skills Study design: RCTs, quasi-randomised trials (sample size > 20)
N incl studies	17
Findings	Study design: all RCTs Country: n=11 USA, n=3 UK, n=3 other Europe Population: mean ages 4-11 years in most studies; history of abuse/neglect and behaviour problems reported for some studies Intervention (of n=14 distinct interventions): Half delivered to carers only (n=7), half to carers and children (n=7); delivered to foster and kinship carers. Most (n=9) group-based, n=4 delivered to carer-child dyads, others to sibling pairs or pairs of foster and biological parents. Most based on cognitive-behavioural or social learning framework to help carers manage behaviour and improve family relationships. No information on intensity / delivery. Findings (of n=17 studies): Mixed results for behaviour problems (6 of 12 RCTs). Mixed results for attachment and carer-child relationships (0 of 3 RCTs with 2 mixed).
Review limitations (author)	Excluded wraparound services.
Primary evidence	Limited information on sample demographics and intervention components. Wide range of outcome measures. Short follow-up.

limitations (author)	
Review limitations (reviewer)	Limited information on interventions or populations.
Evidence gaps (author)	Longer-term follow-up; consistency in outcome measures; clearer rationale for outcome measures with respect to intervention aim; clearer reporting of intervention components

Reference	Kinsey and Schlosser (2013)
RQ /aim	To establish what interventions are effective for children in foster and kinship care
Databases searched	PsycInfo, Medline, Web of Knowledge, Cochrane Library
Search dates	1995-2009
Other search methods	"bibliographic review" [?]
Inclusion criteria	Population: foster parents or foster children (excluding institutional care and children remanded from the justice system receiving therapeutic foster care) Intervention: any apart from interventions aimed at biological parents or short term respite foster care Outcome: NR Study design: Any quantitative evaluation design
N incl studies	N of incl studies 22
Findings	Study design (of n=30 study reports): n=17 RCTs, n=7 nRCTs, n=6 uncontrolled (note n=4 reports (n=2 studies) out of scope on age, data not extracted; partial reporting of age in some studies) Country: USA n=25; UK n=5 Population: ages 0-12; limited further information Interventions (of n=20 distinct interventions): categories include wraparound services, relational interventions, non-relational interventions for carer and child, carer training programmes and interventions for the foster child. Most aimed at carers or families, n=2 mainly at children. Most (n=12) group interventions (group

	sizes 3-15), others individual child sessions or individual carer-child dyads (n=2); 4-16 sessions; delivered by social workers, psychologists, multidisciplinary teams. Half (n=10) focused on helping carers to manage child's behaviour problems, others mainly on improving child outcomes (developmental, mental health, educational) or carer-child relationships. Findings. Wraparound interventions (comprehensive family support services including carer training and support (individual or group), home visiting, mental health services, liaison with services) (n=10 study reports) mixed results for behaviour problems (0 of 2 RCTs plus 1 mixed, 1 mixed uncontrolled); effective for mental health (1 of 2 RCTs, 1 of 1 nRCTs) [other outcomes out of scope of this review]. Carer training programmes (n=10 study reports) mixed results for behaviour problems (1 of 3 RCTs, 0 of 2 nRCTs plus 1 mixed, 1 mixed uncontrolled). Relational interventions focused on carer-child relationships (carer training, play therapy; mostly individual carer-child dyads, some with group component) (n=5 study reports) not effective / mixed results for behaviour problems (1 of 2 RCTs, 2 of 2 uncontrolled). Group support for carers and children (n=1 study report) effective for self-esteem (1 of 1 uncontrolled). Child only directed interventions: Playgroup for school readiness (n=1 study report) mixed results for behaviour problems (1 RCT). Group psychotherapy for foster children (n=1 study report) mixed results for unclear outcome (1 uncontrolled).
Review limitations (author)	Excluded studies before 1995, non-English-language, qualitative studies
Primary evidence limitations (author)	Few interventions directly aimed at children.
Review limitations (reviewer)	Search strategy probably limited sensitivity (and not fully reported). Reporting of findings data not clear or complete. Some studies out of scope of this review on age.
Evidence gaps (author)	Studies in UK, particularly of wraparound services; interventions for older children (10-15 years); interventions shown to be effective in non-foster-care populations for problems common in foster care population.

Reference	Leenarts et al. (2013)
RQ /aim	To systematically evaluate psychotherapeutic treatments for children exposed to childhood maltreatment

Databases searched	PsycINFO, PubMed, EMBASE, CENTRAL, PILOTS
Search dates	-2012
Other search methods	NR
Inclusion criteria	Population: 6-18 years, exposed to childhood maltreatment (not war-related violence or traumatic grief) Intervention: Psychotherapeutic treatments using cognitive-behavioural techniques Comparison: wait list, delayed treatment, treatment as usual, other active psychotherapeutic treatments or no treatment. Pharmaceutical comparisons were excluded. Outcome: PTSD, PTSD symptoms [stated in criteria, but several other outcomes are mentioned in findings and elsewhere, for example, anxiety, aggressive behaviour] Study types: RCTs, nRCTs.
N incl studies	33
Findings	Study type: n=27 RCTs, n=6 nRCTs Country: n=23 USA, n=2 Canada, n=2 UK, n=1 Sweden, n=3 Netherlands, n=1 Iran, n=1 South Africa Populations: Varied (note n=5 wholly and n=7 partially outside scope of this review). Sexual abuse most common (n=11 whole sample, n=6 partial), also 'maltreatment', physical abuse, parental IPV; range of ages. Interventions: Various including CBT, various psychotherapy, eye movement desensitization and reprocessing; limited information on content, setting or delivery; most unclear whether parent- or child-targeted, and whether individual or group. Findings. EMDR effective for PTSD and unclear outcomes (2 of 2 RCTS). CBT unclear effectiveness for unclear outcomes (6 RCTs, 1 nRCT). TF-CBT with a child and non-offending parent unclear effectiveness for unclear outcomes (stated to be effective, but full data NR (4 RCTs, 1 nRCT)). Multi-systemic therapy more effective than enhanced outpatient treatment for mental health (1 RCT). Youth Relationships Project effective for mental health (1 RCT). Imagery Rehearsal Therapy effective for mental health (1 nRCT). Individual vs group psychotherapy + caregiver support in both arms, no difference (1 RCT).

Review limitations (author)	Limited inclusion criteria: controlled studies, cognitive-behavioural therapies only, PTSD outcomes only. No comparison possible between older and younger age groups. Non-English-language databases not searched.
Primary evidence limitations (author)	High attrition; small sample size; lack of blinded outcome assessment; lack of power calculations; no information about fidelity; no studies on harms
Limitations (reviewer)	Search strategy not fully reported. Some inconsistencies between criteria and findings: maltreatment is not reported for all populations; and outcomes other than PTSD are reported. Very heterogeneous populations. Limited information on intervention content or populations. Very unclear and incomplete reporting of outcomes data.
Evidence gaps (author)	Factors related to treatment non-completion; comparison of parent-involved and non-parent-involved interventions; gender differences in outcome; children with comorbid aggressive or violent behaviour.

Reference	Loechner et al. (2017)
RQ /aim	To assess the effectiveness of preventive interventions for children of parents with depression
Databases searched	Pubmed, Medline, Embase, PsycINFO, Cochrane Library, Web of Science
Search dates	-2017
Other search methods	Contact with experts; trial registries; backwards citation chasing
Inclusion criteria	Population: Non-depressed children aged 18 or younger of at least one parent with depression (children with previous history of depression included) Intervention: Any aiming to reduce risk of depression Comparison: placebo, no treatment, alternative treatment Outcomes: depression, internalising symptoms Study design: RCTs only
N incl studies	7

Findings	Country: USA n=5, Canada n=1, Finland n=1 Population: ages 6-18 (mean 12.8); most studies included some children with history of depression (11%-88%) Interventions: All group-based interventions aiming to improve knowledge of depression and resilience to stress; content including psychoeducation, family communication, cognitive-behavioural techniques, parenting training. Some focused mainly on children (n=2), some on families (n=4), n=1 only on parents. Intensity 6-15 sessions total. Findings: Effective for depressive symptoms at immediate post-intervention (0-4 months) (6 RCTs, SMD -0.20 (-0.34 to -0.06)); not effective at short-term follow-up (5-12 months) (5 RCTs, SMD -0.11 (-0.25 to 0.03)); not effective at long-term follow-up (15-72 months) (5 RCTs, SMD -0.05 (-0.18 to 0.08). Effective for incidence of depression at 6-15 months (4 RCTs, relative risk 0.56 (0.40 to 0.77)). No significant difference between trials with active controls vs TAU or wait-list controls. No significant difference between intervention types found for depression at earliest available time point.
Review limitations (author)	Limited N of studies; meta-analysis pools distinct outcome measures
Primary evidence limitations (author)	Few studies outside USA; limited ethnic diversity in study samples.
Review limitations (reviewer)	No major limitations.
Evidence gaps (author)	Replication studies by researchers not involved in developing interventions; longer follow-up; active care control groups; subgroup analysis; cost-effectiveness analysis

Reference	Macdonald et al. (2012)
RQ /aim	To assess the efficacy of cognitive-behavioural approaches (CBT) in addressing the immediate and longer-term sequelae of sexual abuse on children and young people up to 18 years of age.
Databases searched	CENTRAL, MEDLINE, EMBASE, CINAHL, PsycINFO, LILACS, OpenGrey

Search dates	-2011
Other search methods	Trial registries; backwards citation chasing; contact with authors; contact with experts
Inclusion criteria	Population: ≤18 years, sexual abuse Intervention: Any behavioural or cognitive-behavioural delivered to children (with parents included or not) Comparison: TAU, placebo, active control Outcomes: depression, PTSD, anxiety, sexualised behaviour, externalising behaviour, offending behaviour [also parent outcomes, not in scope of this review] Study types: RCTs (including quasi-randomised studies)
N incl studies	10
Findings	Country: n=9 USA, n=1 Australia Interventions: All CBT. Content mainly focused on mitigating consequences of abuse, for example, self-esteem, coping/relaxation techniques, reducing self-blame; also responding to / disclosing abuse, dealing with unwanted touching, etc. Most aimed at individual parents and children (n=2 compare therapy aimed at child only vs aimed at both parent and child); group therapy for children only in n=2; group therapy for parents and children separately in n=1. Duration 6-10 sessions for group interventions, 8-20 for individual. Setting and personnel mostly NR. Populations: ages most commonly around 7-14; independently substantiated contact sexual abuse; last abuse 6 months – 3 years before intervention; all studies majority female, n=2 girls only. Findings: Not effective for depression (Child Depression Inventory) immediately after intervention (5 RCTs) (MD -1.92 (-4.0 to 0.4); effective at 3-6 months (4 RCTs) (MD -1.84 (-3.41 to -0.27); not effective at ≥1 year (4 RCTs) (MD -1.19 (-2.70 to 0.32). Effective for PTSD immediately after intervention (6 RCTs) (SMD -0.44 (-0.73 to -0.16)); effective at 3-6 months (4 RCTs) (SMD -0.39 (-0.74 to -0.04)); effective at ≥1 year (3 RCTs) (SMD -0.38 (-0.65 to -0.11)). Effective for anxiety immediately after intervention (5 RCTs) (SMD -0.23 (-0.42 to -0.03); effective at 3-6 months (4 RCTs) (SMD -0.38 (-0.61 to -0.14)); effective at ≥1 year (4 RCTs) (SMD -0.28 (-0.52 to -0.04)). Not effective for child sexualised behaviour immediately after intervention (5 RCTs) (MD -0.65 (-3.53 to 2.24); not effective at 3-6 months (3 RCTs) (MD -0.46 (-5.68 to 4.76)); not effective at ≥1 y (3 RCTs) (MD -1.61 (-5.72 to 2.49)). Not effective for externalising behaviour immediately after intervention (7

	RCTs) (SMD -0.12 (-0.40 to 0.17)); not effective at 3-6 months (4 RCTs) (SMD -0.11 (-0.42 to 0.21); not effective at ≥1 y (SMD 0.05 (-0.16 to 0.27).
Review limitations (author)	NR
Primary evidence limitations (author)	Lack of allocation concealment and blinding; small sample sizes; short follow-up; several studies included asymptomatic children (which may limit ability to detect effect of intervention); not all studies report intention-to-treat analyses.
Limitations (reviewer)	No methodological limitations. Note almost all included studies also in Macdonald (2016).
Evidence gaps (author)	Observational studies in real-world settings; studies focussing on children with mental health symptoms; evidence on different modes of intervention delivery, for example, group vs. individual; evidence on harms

Reference	Macdonald et al. (2016)
RQ /aim	To synthesise evidence of the effectiveness, cost-effectiveness [and acceptability] of interventions addressing the adverse consequences of child maltreatment
Databases searched	CENTRAL, MEDLINE, EMBASE, CINAHL Plus, PsycINFO, Science Citation Index Expanded, Social Sciences Citation Index, Social Care Online, Social Services Abstracts, ERIC, British Education Index, Australian Education Index, HTA database, HMIC, TRoPHI, EconLit, NHS EED, HEED, Paediatric Economic Database Evaluation, IDEAS, Campbell Library, DoPHER, DARE, Cochrane Database of Systematic Reviews, OpenGrey
Search dates	-2014
Other search methods	Website searching; Google; author searches; backwards citation chasing
Inclusion criteria	Population: Maltreated population, including physical abuse, emotional and psychological abuse, sexual abuse and neglect; ≤25 years at time of study, <18 at time of maltreatment Interventions: Any psychosocial intervention aiming to address the consequences of maltreatment (studies that were aimed at the prevention, identification and cessation of maltreatment were excluded).

	Comparisons: No treatment, wait list, TAU, active control Outcomes: psychological distress/mental health (particularly PTSD, depression and anxiety and self-harm); behaviour (particularly internalising and externalising behaviours); social functioning, including attachment and relationships with family and others; cognitive/academic attainment; quality of life; substance misuse; delinquency; resilience; acceptability. [Also carer outcomes and placement stability, not in scope of this review] Study types: Any controlled (RCTs, quasi-randomised trials, quasi-experimental controlled, controlled observational)
N incl studies	204
Findings	N=198 effectiveness studies, n=6 cost-effectiveness studies Country: (effectiveness studies) n=130 USA, n=22 Canada, n=17 UK, n=11 other Europe, n=6 Australia, n=12 other; (cost-effectiveness studies) n=3 USA, n=2 UK, n=1 Australia. Populations: median age approx. 10 years (approx. 13 for CBT interventions, approx. 8 for systemic interventions); majority female (61%, 80% in sexual abuse studies); sexual abuse n=135, physical abuse n=85, neglect n=50, emotional abuse n=31, multiple forms n=37, other n=49; note many studies include children in foster care, although these studies are not analysed separately. Interventions: (effectiveness) CBT, relationship-based interventions, systemic interventions, psychoeducation, group work with children, psychotherapy, peer mentoring, intensive service models, activity-based therapies [Also attachment-based interventions: these are mostly out of scope of this review on age (n=6 of 10 mean age <3 years) and data are not extracted here.] (cost-effectiveness) CBT, psychotherapy, treatment foster care, collaborative care. Settings mainly health service for CBT, community or health service for parenting interventions, mix of settings for other interventions; generally between 8-20 sessions; limited information on personnel. Findings [Meta-analyses were only conducted for CBT for sexual abuse and relationship-based interventions.] CBT for sexual abuse (group children n=1; separate groups children and mothers n=1; individual child n=9, some with parallel treatment for non-offending parent, of which n=2 compared individual child-only with parent-only and/or child+parent therapy) effective for PTSD immediately after treatment (6 RCTs) (SMD -0.44 (-4.43 to -1.53)); effective at 3-6 months (5 RCTs) (SMD -0.39 (-0.74 to -0.04)); effective at ≥1 year (3 RCTs) [SMD -0.38 (-0.65 to -0.11)]. CBT for sexual abuse effective for depression (CDI) immediately after treatment (5 RCTs) (MD -2.83 (-4.53 to -1.13)) [note discrepancy between this result and Macdonald 2012; different data are reported in this review for one of the included studies and the authors do not explain why]; effective at 3-6 months (4 RCTs) (MD -1.76 (-3.33 to -0.20)); not effective at ≥1 year (4 RCTs) (MD -1.42 (-2.91 to 0.06)). CBT for sexual abuse effective for anxiety immediately after

	treatment (5 RCTs) (SMD -0.23 (–0.42 to -0.03)); effective at 3-6 months (4 RCTs) (SMD -0.38 (95% CI -0.61 to -0.14)); effective at ≥1 y (4 RCTs) (SMD -0.28 (0.52 to -0.04)). CBT for sexual abuse not effective for sexualised behaviour immediately after intervention (5 RCTs) (MD -0.65 (-3.53 to 2.24); not effective at 3-6 months (3 RCTs) (SMD -0.46 (-5.68 to 4.76)); not effective at ≥1 year (3 RCTs) (SMD -1.61 (-5.72 to 2.49)). CBT for sexual abuse not effective for externalising behaviour immediately after treatment (7 RCTs) (SMD -0.12 (95% CI, -0.40 to 0.17)); not effective at 3-6 months (4 RCTs) (SMD -0.11 (-0.42 to 0.21)); not effective at ≥1year (5 RCTs) (SMD 0.05 (-0.16 to 0.27)). [Parent outcomes out of scope of this review.] CBT for sexual abuse not effective for self-efficacy (1 RCT), effective for behaviour problems (1 RCT). No difference between CBT and EMDR for mental health (1 RCT). Economic evidence for CBT for sexual abuse: CBT, CBT plus pharmaceutical treatment and non-directive counselling all cost-effective compared to no treatment (all ICERs <Aus$7000 per QALY); CBT plus pharmaceutical treatment most cost-effective, followed by CBT alone, then non-directive counselling. CBT for physical abuse (n=1 family therapy vs parents and children separately (unclear if individual); n=1 children+parents vs parents only (unclear if individual); n=1 groups of 2-3, unclear if parents or children) effective for PTSD symptoms (1 RCT, but only pre-post findings); not effective for depression (1 RCT); effective for behaviour problems (3 RCTs, but only pre-post findings). CBT for multiple forms of maltreatment (n=5 appear to be individual and aimed mainly at children, although not fully described; n=4 included component for foster carers): effective for PTSD (4 of 4 RCTs); effective for depression (2 of 3 RCTs); mixed results for anxiety (1 of 2 RCTs); mixed results for behaviour (2 of 5 RCTs); effective for STIs (1 RCT). [Cost-effectiveness for CBT for adoptive parents out of scope of this review as not based on child outcomes.] [Attachment interventions out of scope of this review on age.] Parent-child interaction therapy (appears to be individual parent-child dyads) not effective for externalising behaviour (2 RCTs) (SMD 0.03 (-0.38 to 0.43)). Family therapy not effective for depression (0 of 1 RCT); effective for behaviour problems (1 of 1 RCT). Multi-systemic family therapy effective for PTSD (2 of 2 RCTs, 0 of 1 nRCT); mixed results for depression (1 of 1 RCT, 0 of 1 nRCT); effective for internalising behaviour (2 of 2 RCTs); not effective for risky sexual behaviour (0 of 1 RCT). Family-based systemic interventions (n=2 group family (groups of 3-4 families), n=1 both child-only (individual sibling pairs) and separate foster carers, n=1 both individual child-mother dyads and child groups) effective for depression (1 of 1 nRCT); mixed results for behaviour (0 of 2 RCTs plus 1 mixed, 1 of 1 nRCT). Group psychoeducation aimed at children (some with parent components) mixed results for PTSD (0 of 3 RCTs plus 1 unclear and 1 mixed, effective 3 of 4 nRCTs); not effective for depression (0 of 1 RCT, 0 of 1 nRCT); not effective for externalising behaviours (2 RCTs) (SMD -0.19 (-0.45 to 0.06)); not effective for internalising behaviours (2 RCTs) (SMD 0.00 (-0.25 to 0.25)). Cost-effectiveness of psychoeducation: one study finds individual psychotherapy to have similar

	outcomes and higher costs than psychoeducation. Group therapy ('group work') for children: not effective for depression when added to family treatment (1 RCT); effective for self-esteem (1 RCT); mixed results for behaviour problems (0 of 1 RCT, 2 of 2 nRCTs); not effective for sexual behaviour (1 nRCT); effective for self-esteem (1 nRCT). Psychotherapy/counselling for children (n=4 individual, n=2 group, n=2 compared individual vs group) mixed results for PTSD (mixed in 1 RCT and 1 nRCT); mixed effects for behaviour problems (mixed in 1 RCT and 2 of 3 nRCTs). 'Peer mentoring' (individual pair play therapy for pre-school children): effective for social interaction / social skills (2 of 2 RCTs); effective for behaviour problems (2 of 2 RCTs); not effective for academic progress (0 of 1 RCT). Treatment foster care (most have both child and carer/family components, and both individual and group components): not effective for PTSD (0 of 1 RCT); mixed results for mental health (1 RCT); mixed results for behaviour problems (2 of 4 RCTs); not effective for social functioning (0 of 2 RCTs). Cost-effectiveness of intensive service interventions: one study shows intervention dominates usual care; one study finds higher placement rates and lower costs for Multidimensional Treatment Foster Care as against standard foster care. Therapeutic day care (children, group): mixed results for behaviour problems (1 RCT); effective for drug/alcohol use (1 RCT); mixed results for criminal behaviour (1 RCT); effective for developmental outcomes (1 nRCT); effective for self-concept (1 RCT, 1 nRCT). Co-ordinated care not effective for behaviour problems (1 RCT). Group activity-based therapies for children (arts therapy, play therapy, animal therapy) mixed results for PTSD (1 of 3 nRCTs plus 1 mixed); mixed results for depression (1 of 3 nRCTs plus 1 mixed); mixed results for anxiety (1 nRCT).
Review limitations (author)	Unable to conduct meta-analysis in many cases. No analysis of effectiveness of intervention components or modes (for example, involvement of parents, group interventions, psychoeducation).
Primary evidence limitations (author)	Mostly non-UK studies; narrow focus on clinical outcomes and specific consequences of maltreatment; lack of no-treatment or wait-list controls; heterogeneous (and not always relevant) outcome measures
Limitations (reviewer)	No major limitations.
Evidence gaps (author)	Studies of widely used interventions including CBT, music and other activity-based therapies, group interventions; looked-after children and residential care; interventions addressing broader consequences of maltreatment rather than narrow clinical outcomes; schools and day-care settings; populations representative of those presenting to UK CAMHS; broader range of cost-effectiveness analyses.

Reference	Maclean et al. (2016)
RQ /aim	To examine the associations between out-of-home-care (OoHC) versus in-home care and developmental health and wellbeing outcomes for children who have been maltreated.
Databases searched	ACP Journal Club, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, DARE, HTA, NHS EED, Embase, MEDLINE, PsycINFO, CINAHL Plus, SocIndex
Search dates	-2015
Other search methods	Backwards citation chasing; contact with experts
Inclusion criteria	Population: 0–18 years assessed by a child protection agency for child maltreatment prior to a decision about placement in out-of-home (OoHC) or in-home care. Intervention: Any form of out-of-home care (OoHC) (including foster, kinship, group homes), for at least 1 month on average Comparison: any form of in-home care, for at least 1 month on average Outcomes: any child health or wellbeing outcome, including child or adult functioning (for example, cognition, educational achievement, behaviour and mental health assessments), risky behaviour (for example, delinquency, running away and suicide attempts) and health (for example, physical development and health problems); service use. Study type: RCTs, quasi-randomised trials, cohort studies with controls for several variables at baseline and sample size >100
N incl studies	31
Findings	Study types: all cohort studies (n=31 studies from n=11 distinct cohorts; findings are reported by study) Country: n=27 USA, n=3 Sweden, n=1 Portugal Interventions: Out-of-home care and in-home care Findings. Cognitive outcomes: no significant differences between groups (0 of 1 low RoB, 0 of 2 high RoB). Academic achievement: mixed results (1 of 3 high RoB shows lower achievement for in-home care group, 2 no significant difference). Truancy / school attendance: mixed (0 of 1 low RoB, 1 of 1 high RoB shows OOHC better outcomes than in-home care). School engagement: no significant differences (0 of 1 high RoB). Employment: unclear (1 high RoB). Daily living skills: no significant difference (0 of 1 high RoB). Social support: smaller social network

	for foster care than in-home care (1 high RoB). Internalising/ externalising behaviour: no significant differences between groups (0 of 1 low RoB, 0 of 1 high RoB). Other mental health outcomes: no significant differences (0 of 4 high RoB). Emergency health care: significantly increased for children with caseworkers 'more likely' OoHC compared to in home care (1 low RoB). Physical health: no significant differences (0 of 1 high RoB). Criminal behaviour: mixed results (1 of 2 high RoB shows worse outcomes for foster care, other no significant difference; 2 of 5 high RoB show worse outcomes for OOHC, mixed in 1). Drug/alcohol use: worse outcomes for OOHC (4 of 5 high RoB). Suicide attempts: mixed results (1 of 2 high RoB shows worse outcomes for OOHC, other no significant difference). Risky sexual behaviours: better outcomes for OOHC (1 of 1 high RoB). Early sexual initiation: better outcomes for OOHC (1 of 1 high RoB). Teenage pregnancy: no significant difference (0 of 1 Low RoB, 0 of 1 high RoB). Health risk behaviours: no significant difference (0 of 1 high RoB). Running away: worse outcomes for those receiving OOHC only (1 high RoB). Mental health service use: worse outcomes for OOHC (6 of 6 high RoB).
Review limitations (author)	Wide inclusion criteria; subgroup analysis on age, duration of care etc. not possible.
Primary evidence limitations (author)	Generally high risk of bias. Almost all conducted in USA. Heterogeneity in design, analysis, outcome measures. No RCTs.
Limitations (reviewer)	Very broad inclusion with respect to outcomes, and some variation with respect to comparison groups which is not systematically explored. Summary Risk of Bias score arguably does not give a good sense of reliability of findings and there are serious limitations in this respect which are not reflected in the reporting of findings (although they are in the discussion).
Evidence gaps (author)	Randomised trials; cohort studies minimising selection bias; matching of comparison cohorts

Reference	Montgomery et al. (2009)
RQ /aim	To review the efficacy of interventions for improving outcomes for children who have experienced physical abuse and for preventing the recurrence of abuse.
Databases searched	Cochrane Controlled Trials Register, MEDLINE, EMBASE, CINAHL, PsycINFO, Sociological Abstracts, ERIC, Social Science Citation Index, Dissertation Abstracts

Search dates	-2007
Other search methods	Trial registries; journal handsearching; backwards citation chasing; contact with experts
Inclusion criteria	Population: 0-18 years, physical abuse Intervention: Child, parent, or family-focused interventions, for example,: CBT, behavioural social skills training, play therapy, art therapy, individual psychotherapy, etc. Outcomes: Any Study type: RCTs, quasi-randomised trials, nRCTs, cohort studies.
N incl studies	45
Findings	(Note: findings are reported separately in three groups: child-focused, parent-focused and family-focused. Most of the parent-focused interventions, and all of the family-focused interventions, are out of scope of this review due to outcome. Descriptive figures below refer to child-focused interventions only; relevant outcomes from parent-focused studies are briefly added at end of findings. Note that interventions including parent sessions included in this category if ≥50% of sessions with the child) Study type: n=8 RCTs, n=5 nRCTs, n=4 uncontrolled Country: n=13 USA, n=1 New Zealand (partially NR) Interventions: Child CBT, Treatment foster care, peer-led social skills training, individual child psychotherapy, psychodrama, art therapy, residential treatment, play therapy Populations: limited information. Findings: Treatment Foster Care (Early intervention foster care (EIFC) = Therapeutic foster care programme + parent training and consultation for foster parents + parent training for birth parents + weekly therapeutic playgroups + behavioural day treatment) effective for mental health, mixed results for behaviour (1 RCT). Individual child+parent CBT vs family therapy, no difference for mental health or behaviour (1 RCT). CBT-based skills group for young men in group home effective for improving compliance to house rules, ineffective for aggression (1 RCT). Residential treatment for children (cognitive-behavioural 'sanctuary model' delivered in residential unit by trained staff over 4 months; appears to be group format) not effective compared to usual residential care for internalising or externalising behaviours (1 RCT). Group psychodrama for children (discussion and re-enactment of traumatic events; 20 sessions; led by trained clinical social worker) mixed results for internalising behaviours, not effective for externalising behaviours (1 RCT). Therapeutic day treatment (individual / group child programme + individual / group parent training and counselling; preschool

	educational services with 1:4 teacher-child ratio and additional services delivered by play therapy, speech therapy, and physical therapy delivered by specialists) effective for developmental/cognitive outcomes and peer and maternal acceptance (2 nRCTs). Individual play therapy mixed results for child development outcomes (1 nRCT). Dyadic Developmental Therapy (appears to be individual; involves both child+parent sessions and child-only observed by parent) effective for behaviour problems (1 nRCT). Trauma-focused CBT (children received 16 sessions + 3 sessions for parent/ carer) unclear findings (1 uncontrolled). Art therapy for children (17 sessions, appears to be individual) effective for behaviour problems (1 uncontrolled). Parent-child interaction therapy (14-20 sessions delivered to parents or families, mostly court-mandated) mixed results for externalising or internalising behaviours (1 of 2 RCTs). Group parent training effective for behaviour problems (1 nRCT).
Review limitations (author)	NR
Primary evidence limitations (author)	Generally limited evidence. Few studies investigated child wellbeing outcomes. Few UK studies. High attrition rates. Limited information on study samples and subgroup outcomes / moderators of effectiveness. Several studies excluded families with multiple problems for example, mental illness, drug use.
Review limitations (reviewer)	Limited synthesis of individual findings. No quality assessment. Inconsistently reported information on implementation / content of interventions. Search strategy limited sensitivity with respect to intervention type.
Evidence gaps (author)	Randomised trials; 'objective' outcome measures; manualised, replicable interventions; cost-effectiveness analyses

Reference	Naranbhai et al. (2011)
RQ /aim	"To evaluate and summarise the effectiveness of interventions for modifying sexual risk behaviours and preventing transmission of HIV/AIDS among homeless youth" (p4)
Databases searched	MEDLINE, EMBASE, AIDSearch, PsycInfo, LILACS, CENTRAL
Search dates	1981-2010

Other search methods	Conference abstract handsearching; website searching; citation chasing; contact with experts; contact with authors; trial registries
Inclusion criteria	Population: 12-24, homeless (including living in shelter or temporary residence) Intervention: Any aimed at reducing sexual risk behaviour Comparison: NR Outcomes: HIV or STI infection, pregnancy, abstinence, condom use, unprotected sex, frequency of sex, N partners, visits to STI clinics, STI tests Study type: RCTs only
N incl studies	3
Findings	Country: All USA Intervention: Two mainly behavioural programmes aimed at YP with a focus on education / counselling (n=1 individual, n=1 small groups); one family therapy delivered to YP and parents/guardians. N of sessions 9 to 16. Delivered by therapists or shelter staff. Findings: Family intervention not effective for sexual behaviour (0 of 1 RCT); group intervention mixed results for sexual behaviour (mixed results in 1 RCT: some positive findings for female participants, not for male) [note findings for one study are not reported].
Review limitations (author)	NR
Primary evidence limitations (author)	Poor methodological quality generally; only urban US populations; only self-reported behaviour outcomes
Review limitations (reviewer)	No methodological limitations. Note that all the studies included in this review are also in Coren (2016).
Evidence gaps (author)	Novel interventions for example, cash transfers, social security interventions; standardised outcome measures; biological markers for example, HIV status.

Reference	Parker and Turner (2013)

RQ /aim	To assess the effectiveness of psychoanalytic/psychodynamic psychotherapy for children and adolescents who have been sexually abused
Databases searched	CENTRAL, Ovid MEDLINE, Embase, PsycINFO, CINAHL, Sociological Abstracts, Social Science Citation Index, Conference Proceedings Citation Index - Social Science and Humanities, LILACS, World Cat.
Search dates	-2013
Other search methods	Trial registries; backwards citation chasing; contact with authors; contact with experts
Inclusion criteria	Population: ≤18 years, sexual abuse; symptomatic at the time of entry into the study. Intervention: Any predominantly psychoanalytic/psychodynamic interventions, including as an adjunctive treatment, aimed at children or families Comparison: TAU, no treatment, waiting list (active controls excluded) Outcomes: Post-traumatic stress disorder, depression, sexualised behaviour, aggression, conduct problems, self-harm, adverse outcomes, suicide, symptoms / psychiatric diagnosis, psychosocial functioning, service use, satisfaction / acceptability Study types: RCTs, quasi-randomised trials
N incl studies	0
Findings	None
Review limitations (author)	Overly restrictive in terms of study type, esp. exclusion of active control groups (since no-treatment control groups may raise ethical concerns).
Primary evidence limitations (author)	N/A
Limitations (reviewer)	No methodological limitations
Evidence gaps (author)	Randomised trials with clinical populations; standardised outcomes reflecting broad aims of intervention, rather than narrowly symptom-focused measures; evidence on harms; long-term follow-up; comparison of individual and group

	therapy; effect of different types of treatment (for example, intensity) or participants (for example, severity of abuse).

Reference	Poli et al. (2017)
RQ /aim	To conduct a systematic review of the existent research on group interventions for children with separated or divorced parents.
Databases searched	PsychINFO, MEDLINE, PubMed, Periodicals Archive Online, Scopus
Search dates	1980-2014
Other search methods	Reference harvesting; contact with authors
Inclusion criteria	Population: children and adolescents with separated or divorced parents Intervention: Group interventions (group size ≥3) designed specifically for children with separated or divorced parents; semi-structured or structured group sessions conducted by adult trained professional. Outcomes: any
N incl studies	29 (n=27 effectiveness)
Findings	Study type: n=11 RCTs, n=10 nRCTs, n=6 uncontrolled [n=2 process data only] Country: n=26 USA, n=1 Australia, n=1 Italy, n=1 South Africa Interventions: appear to be most or all child-only; most school settings (n=15 of 19 with information). Duration 4-18 sessions (modal 8). Group sizes around 4-11, most with 1-2 leaders. Limited information on intervention content; n=10 categorised as preventive, n=6 supportive, n=5 psychoeducational, n=3 counselling-based. Comparison groups included some no treatment and some with children from intact families. Population: Most around 5-12 years, mixed ethnicity, mixed or 'middle class' SES Findings: (Findings are incompletely reported and do not provide information on individual studies or study types; this summary depends on reviewer's own rather than on details of the studies (stated that 'positive' means significantly positive, but supporting data NR)). Self-individual outcomes (for example, self-esteem, self-concept, anxiety): 38/70 showed positive effect, 29/70 showed neutral (no significant) effect and 3/70 showed negative/adverse effect. Family relations: positive effect in 26/45; neutral effect in 16/45; negative in 3/45. Interpersonal

	relations: positive effect in 16/21; neutral in 4/21; negative in 1/21 School: positive in 7/12; neutral in 5/12; negative in 0/12 Behaviour: positive in 22/42; neutral in 18/42; negative in 2/42. Counselling-based and preventive interventions were more effective (in 71.42% and 65.79% of cases, respectively) as compared with the other types of interventions (no data reported to support this).
Review limitations (author)	Categorisation of interventions ad hoc. Review focused only on main effects, not moderators.
Primary evidence limitations (author)	Inconsistent outcome measures.
Review limitations (reviewer)	Search strategy probably limited sensitivity. No quality assessment. Limited information on intervention delivery. Reporting of outcomes data is extremely partial and lacks transparency, and cannot be regarded as reliable.
Evidence gaps (author)	Long-term effects; moderator analysis on time since divorce; information on attrition.

Reference	Troy et al. (2018)
RQ /aim	To synthesise evidence on the feasibility, appropriateness, meaningfulness, and effectiveness of parenting programmes in the criminal justice system
Databases searched	PsycInfo, Medline, NCJRS, CINAHL, ScienceDirect
Search dates	-2016
Other search methods	Handsearching "of work known to the authors"; citation chasing from reviews
Inclusion criteria	Population: Parents of 3-18-year-olds involved in the criminal justice system. Parents who volunteered as well as those who were mandated to take part in the intervention were included Interventions: Any parenting programme where parent in CJS was main recipient (excluded if children of parents in CJS were main recipient, or if program delivered to parent on account of child's offending behaviour)

	Comparison: NR Outcomes: social, emotional and behavioural development, family cohesion and stability [also parent outcomes, not in scope of this review] Study designs: any
N incl studies	29 (n=5 report child outcomes)
Findings	(Data extracted only from the n=5 studies with child outcomes.) Study designs: n=4 nRCT, n=1 uncontrolled Country: n=3 USA, n=1 Netherlands, n=1 Australia Populations: (only reported for whole sample) mean age 5-11 years; limited further information Intervention: n=3 aimed at mothers, n=2 at fathers. Mainly training programmes to improve parenting skills and parent-child relationships; unclear if individual or group-based (n=1 included group component and individual home visits). Intensity between 7h-120h total (for whole sample). Topics (for whole sample) including disciplining children, communication, positive parenting, child development, emotion regulation; some included other topics for example, life skills. Findings: Not effective for behaviour problems (0 of 4 nRCT plus 1 mixed, 0 of 1 uncontrolled). Mixed findings on self-perceptions (1 of 2 nRCTs).
Review limitations (author)	NR
Primary evidence limitations (author)	Generally low quality; small sample sizes; limitations in reporting of sample, intervention, and findings, particularly parent participants' crimes and length of sentence, and whether programmes were mandatory. Many studies did not report group × time analyses. Heterogeneity in intervention content and outcome measures.
Review limitations (reviewer)	Search strategy probably limited sensitivity (and not fully reported). Only a subset of studies within scope of our review (as most do not report child outcomes). Incomplete reporting of findings data.
Evidence gaps (author)	NR

Reference	Turner et al. (2007)

RQ /aim	To assess the effectiveness of cognitive-behavioural training interventions in improving looked-after children's behavioural/relationship problems and outcomes for foster carers / families
Databases searched	CENTRAL, MEDLINE, EMBASE, CINAHL, PsycINFO, ASSIA, LILACS, ERIC, Sociological Abstracts, National Research Register
Search dates	-2006
Other search methods	Backwards citation chasing; contact with experts; contact with authors
Inclusion criteria	Population: Foster carers of children/YP ≤18 years Interventions: Any behavioural or cognitive-behavioural intervention Comparison: no-treatment or waitlist Outcomes: Psychological outcomes (for example, depression, PTSD, anxiety), behaviour problems, interpersonal functioning, family functioning [also parent outcomes, not in scope of this review] Study types: RCTs or quasi-randomised studies.
N incl studies	6
Findings	Country: n=4 UK, n=2 USA Populations: Foster care; mean ages around 9-10; abuse/neglect in several studies Interventions: group foster carer training on cognitive-behavioural principles; approx. 20-25 hours total (NR for several); delivered by former foster carers, social workers (NR for several); plus increased payment in n=1 study. Findings: Not effective for child psychopathology (Reactive Attachment Disorder Scale or Strengths & Difficulties Questionnaire) at end of intervention (2 RCTs, SMD 0.13 (-0.71 to 0.96)). Not effective for child psychopathology (Child Behaviour Checklist) at 6 to 9 months (2 RCTs, SMD 0.23 (-0.06 to 0.52)). Not effective for self-esteem (0 of 1 RCTs). Unclear findings on inappropriate sexual behaviour (1 RCT). Unclear findings on child problem behaviours (3 RCTs). Not effective for behaviour problems (Eyberg Child Behaviour Inventory) (0 of 1 RCTs). Unclear findings on interpersonal functioning (1 RCT). No data on family functioning outcomes.
Review limitations (author)	Limitations identified by author NR
Primary evidence	Many studies underpowered

limitations (author)	
Review limitations (reviewer)	None
Evidence gaps (author)	Evidence gaps identified by author More sensitive outcome measures; longer follow-up; adequately powered studies; studies which group participants according to type of challenging behaviour

Reference	Wethington et al. (2008)
RQ /aim	To evaluate interventions commonly used to reduce psychological harm among children and adolescents exposed to traumatic events.
Databases searched	MEDLINE, EMBASE, ERIC, National Technical Information Service, PsycINFO, Social Sciences Abstracts, NCJRS
Search dates	-2007
Other search methods	Backwards citation chasing; contact with experts
Inclusion criteria	Population: ≤21, exposed to traumatic event(s) [not precisely defined] Intervention: Any aiming to reduce psychological harm following trauma Comparison: No intervention, delayed or lower dose, or period without exposure for uncontrolled studies Outcomes: PTSD symptoms, PTSD, anxiety, depression, suicidal ideation / behaviour, substance abuse, externalising and internalising disorders / symptoms Study types: Any
N incl studies	30 (sexual abuse subgroup n=9)
Findings	(Note n=19 (63%) studies are in scope of this review with respect to population: data extracted only for the sexual abuse group (n=9) which is reported separately.) Country: US n=7, Australia n=1, unspecified n=1 Population: Sexual abuse; limited further information. Interventions: Individual CBT, group CBT; mainly aimed at children, some also with parental involvement; limited further information Findings: Individual CBT not effective for mental health outcomes (4 studies):

	anxiety SMD -0.23 (-0.48 to 0.01) (random effects); depression SMD -0.03 (-0.28 to 0.21) (random effects); PTSD SMD -0.29 (-0.69 to 0.11) (random effects) Group CBT compared to supportive therapy (1 study): not effective for mental health outcomes: depression SMD -0.14 (-0.69 to 0.41) (fixed effects); PTSD SMD 0.04 (-0.55 to 0.63) (fixed effects).
Review limitations (author)	Categorisation of interventions is partly arbitrary.
Primary evidence limitations (author)	Several studies excluded children with severe disruptive behaviour or at risk of suicide.
Review limitations (reviewer)	Limited details on quality assessment process. Limited information on intervention content and delivery. Only sexual abuse subgroup is in scope of this review.
Evidence gaps (author)	Predictors of symptoms; optimal timing of intervention with respect to exposure; subgroup analysis relating to severity of trauma; long-term follow-up; cost-effectiveness data; studies on 'minority populations'; interventions delivered by non-professionals; interventions in low-income countries

Reference	Wilen (2014)
RQ /aim	To synthesise the literature on the effects of psychosocial interventions for CSA survivors through pair-wise meta-analysis; to determine which interventions are relatively more effective than others overall and for specific sub-groups of survivors through moderator analysis; to assess and compare the effectiveness of different therapeutic interventions in treating adult survivors of child sexual abuse through the use of network meta-analysis.
Databases searched	CENTRAL, PsycINFO, MEDLINE, Sociological Abstracts, NIH RePORTER, PsychExtras, PILOTS, EMBASE, CINAHL, PAIS
Search dates	-2012
Other search methods	Trial registries, website searching, conference proceedings handsearching, contact with authors, contact with experts, backwards citation chasing

Inclusion criteria	Participants: ≥18 at time of study; sexually abused as children (excluded: developmentally disabled, active psychosis, victims of human sex trafficking) Intervention: Any psychosocial intervention Comparison: Active treatment, no treatment, minimal attention control, or a different dose of treatment Outcomes: PTSD, depression, anxiety, mental health functioning / distress, perpetration of abuse / neglect, substance use, self-harm, disordered eating, dissociation Study types: RCTs only
N incl studies	18
Findings	Country: NR Intervention: humanistic therapy (n=8), various combinations of treatments (n=7), CBT (n=6), dynamic (n=3), psychoeducation (n=2), EMDR (n=1), and forgiveness therapy (n=1). N=18 group therapy with approx. 10-25 sessions, n=7 individual, n=1 both, n=2 'residential' [?]; limited further information on implementation or delivery. Population: 97.4% women, mean age at time of study 35.9 years. Mean age at time of first offense 6.5 years. 87% of sample experienced incest with over half (56.5%) experiencing penetration. Findings (note only treatment vs attention/waitlist controls extracted here, not head-to-head comparisons). PTSD: Psychoeducation effective for PTSD (1 RCT, SMD -0.83 (-1.55 to -0.12)). EMDR effective for PTSD (1 RCT, SMD 1.07 (-1.75 to -0.40)). Combination of CBT, humanistic, psychodynamic, and psychoeducation therapies effective for PTSD (1 RCT, SMD -1.21 (-1.90 to -0.52)). Humanistic therapy not effective for PTSD (3 RCTs, SMD -0.14 (-0.53 to 0.26)). CBT not effective for PTSD (2 RCTs, SMD -0.06 (-0.49 to 0.37)). Humanistic and psychoeducation together not effective for PTSD (1 RCT, SMD -1.42 (-3.00 to 0.16)). Dynamic therapy not effective for PTSD (1 RCT, SMD -0.11 (-0.77 to 0.55)). Aggregate of all treatments effective for PTSD (6 RCTs, SMD -0.50 (-0.95 to -0.05)). Depression: CBT effective for depression (1 RCT, SMD -2.59 (-3.45 to -1.73)). Humanistic therapy effective for depression (1 RCT, SMD -0.57 (-1.12 to -0.02)). EMDR effective for depression (1 RCT, SMD -0.72 (-1.37 to -0.07)). Combinations of CBT, humanistic, and psychoeducation not effective for depression (1 RCT, SMD -0.49 (-1.22 to 0.23)). Combination of CBT, humanistic, dynamic, and psychoeducation not effective for depression (1 RCT, SMD -0.43 (1.07 to 0.21)). Aggregate of all treatments effective for depression (SMD -1.01 (-1.83 to -0.19)). Anxiety: CBT effective for anxiety (1 RCT, SMD -1.99 (-2.77 to -1.21)). EMDR effective for anxiety (1 RCT, SMD -1.32 (-2.03 to -0.61)). Combination of CBT, humanistic, dynamic, and psychoeducation effective for anxiety (1 RCT, SMD=-0.89 (-1.56 to -0.76)). Aggregate of all treatments effective for anxiety (2 RCTs, SMD -1.53 (-2.39 to -0.67)). Global functioning: Combination

	of humanistic and psychoeducation effective for global functioning (1 RCT, SMD -2.00 (-3.81 to -0.20). Humanistic therapy not effective for global functioning (1 RCT, SMD -0.20 (-0.74 to 0.34)). Aggregate of all treatments not effective for global functioning (2 RCTs, SMD -0.89 (-2.61 to 0.83)). Network meta-analysis (summary findings only extracted): CBT, dynamic therapies, EMDR, humanistic therapies, and psychoeducation not effective for PTSD compared to waitlist, but all effective compared to minimal attention control; no sig diff between any treatment. [Network not constructed for anxiety or depression outcomes.] Cumulative ranking analysis indicates EMDR most effective for PTSD, CBT most effective for depression.
Review limitations (author)	Network analysis conducted post hoc. Publication bias may affect findings. Network meta-analysis may be confounded by intervention definition and implementation, impact of cultural variables, etc. Small N of studies in most analyses and limited power. Categorisation of intervention types partly arbitrary.
Primary evidence limitations (author)	Limitations with respect to allocation concealment, randomisation, differential attrition, selective outcome reporting. High levels of (statistical) heterogeneity. Small sample sizes. Limited reporting of sample demographics, trauma experiences, treatment characteristics.
Review limitations (reviewer)	Limited information on intervention content, setting or delivery.
Evidence gaps (author)	RCTs of head-to-head treatment comparisons; studies including sexual abuse survivors in larger populations; studies of intervention components and common factors to inform 'eclectic' practice; studies of male sexual abuse survivors, incarcerated people and people who experienced polyvictimization; moderator analyses relating to population characteristics, trauma exposure etc.

Reference	Winokur et al. (2014)
RQ /aim	To evaluate the effect of kinship care placement compared to foster care placement on the safety, permanency, and wellbeing of children removed from the home for maltreatment.
Databases searched	CENTRAL, MEDLINE, C2-SPECTR, Sociological Abstracts, Social Work Abstracts, SSCI, ISI Proceedings, Family and Society Studies Worldwide, ERIC, PsycINFO, CINAHL, ASSIA, Dissertation Abstracts International.
Search dates	-2011

Other search methods	Handsearching of journals; citation chasing from reviews; contact with authors.
Inclusion criteria	Population: <18, removed from the home for abuse, neglect, or other maltreatment, and placed in kinship care Intervention: Formal kinship care placements (paid or unpaid) Comparison: Foster care Outcomes: behavioural development, mental health, placement stability, permanency, educational attainment, family relations, service utilisation, and re-abuse, or other outcomes relating to wellbeing or safety Study types: Controlled experimental or quasi-experimental studies
N incl studies	102
Findings	Country: n=89 USA, n=1 UK, n=12 other Findings: Kinship care better outcomes than foster care for internalising and externalising behaviour (15 studies, SMD -0.33 (-0.49 to -0.17); 6 studies with dichotomous data, OR 0.62 (0.41 to 0.93)). Kinship care better outcomes than foster care for adaptive behaviours: (6 studies, SMD -0.42 (-0.61 to -0.22)). Kinship care better outcomes than foster care for psychiatric disorders (6 studies, OR 0.51 (0.42 to 0.62)). Kinship care better outcomes than foster care for wellbeing (OR 0.50 (0.38 to 0.64)). [Placement stability outcomes not in scope of this review.] No significant difference for educational attainment (6 studies, OR 0.73 (0.50 to 1.07)). No significant difference for family relations (5 studies, SMD -0.01 (0.30 to 0.28); 4 studies with dichotomous data, OR 1.21 (0.56 to 2.59)). Kinship care better outcomes than foster care for mental health service utilisation (13 studies, OR 1.79 (1.35 to 2.37)). No significant difference for developmental services utilisation (3 studies, OR 0.94 (0.38 to 2.32)). No significant difference for physician service utilisation (7 studies, OR 1.37 (0.48 to 3.93)).
Review limitations (author)	High degree of statistical heterogeneity in outcomes. Synthesis includes studies with wide range of sample sizes.
Primary evidence limitations (author)	Limitations with regards to comparability of groups, attrition and other methodological domains. Kinship care varies widely in practice, which may make it harder to detect an effect.
Review limitations (reviewer)	Limited information on participants or differences between groups (selection bias was assessed but is not reported in the findings of the review), which makes it hard to assess the reliability of findings. Interpretation of service utilisation outcomes is unclear.

Evidence gaps (author)	Statistical methods to mitigate selection bias; survival analysis to explore impact of length of stay; educational outcomes; informal and voluntary kinship care; non-US studies.

Reference	Ziviani et al. (2012)
RQ /aim	To assess the effectiveness of support services for children and young people with behavioural issues related to or secondary to disability, who are in out-of-home care
Databases searched	PsycINFO, ERIC, MEDLINE, CINAHL, CENTRAL, Social Services Abstracts, PAIS international, PsycARTICLES, Sociological Abstracts
Search dates	1990-2010
Other search methods	Author name searches; journal handsearching; backwards citation chasing
Inclusion criteria	Population: 0-18 years, out-of-home (including kinship and foster care) with "complex psychological and/or behavioural issues, and/or a disability" Intervention: any Comparison: placebo, usual care or different intervention type Outcome: NR Study design: RCTs, quasi-RCTs, nRCTs, cohort studies
N incl studies	4
Findings	Study designs: 2 RCTs, 2 nRCTs Country: NR Populations: ages 2-17; participants with / at risk of emotional disorders or challenging behaviour (rather than developmental or sensory disabilities) Interventions: behavioural parent / foster parent training (n=1 small parent-only group, n=1 individual with both parent-only and parent-child sessions) with focus on family relationships and caregiver stress in n=2, intensive individual family case management (including caregiver training and support, therapy and counselling for children/YP and/or families, and liaison with other services) with focus on improving family relationships and improving placement stability in n=2; duration 3 days / 16 sessions for parent training interventions, 2-3 years for case management; delivered by clinical psychologists, therapists, 'family specialists' [appears similar to social worker] Findings: Case management effective for internalising and externalising behaviour

	(2 of 2 RCTs), mixed results for criminal behaviour (2 RCTs), mixed results for school outcomes (1 RCT), effective for social problems / social participation (2 of 2 RCTs). Parent training not effective for internalising and externalising behaviour (0 of 2 nRCTs) or social problems/social participation (0 of 1 nRCT). [Also findings on placement stability and foster parent outcomes, not in scope of this review].
Review limitations (author)	Limited scope so few studies. Heterogeneous interventions. Grey literature not searched.
Primary evidence limitations (author)	Limited number of RCTs; unrepresentative sampling; small sample sizes and few studies report power calculations; inadequate follow-up.
Review limitations (reviewer)	Search terms probably limited sensitivity. Analysis appears to take $p<0.10$ as significant for one study.
Evidence gaps (author)	Studies of children with disabilities; higher-quality and longitudinal studies; research comparing components or features of interventions; subgroup outcomes

Appendix H: Lists of Excluded Studies (overview)

Studies excluded from the best-evidence synthesis on account of low AMSTAR rating (n=67)

Al CMW, Stams GJJM, Bek MS, Damen EM, Asscher JJ, van der Laan PH (2012) A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning. *Children and Youth Services Review* 34: 1472-1479.

Byrne N (2017) Systematic review of speech and language therapy outcomes for children who are in Out of Home Care (OOHC). *Speech Language and Hearing* 20: 57-61.

Calhoun S, Conner E, Miller M, Messina N (2015) Improving the outcomes of children affected by parental substance abuse: a review of randomized controlled trials. *Substance Abuse and Rehabilitation* 6: 15-24.

Chen CY-C, Panebianco A (2018) Interventions for young bereaved children: A systematic review and implications for school mental health providers. *Child and Youth Care Forum* 47: 151-171.

Chronis-Tuscano A, Wang CH, Woods KE, Strickland J, Stein MA (2017) Parent ADHD and evidence-based treatment for their children: Review and directions for future research. *Journal of Abnormal Child Psychology* 45: 501-517.

Corcoran J, Pillai V (2008) A meta-analysis of parent-involved treatment for child sexual abuse. *Research on Social Work Practice* 18: 453-464.

Cunha LM (2008) *The efficacy of therapeutic interventions for adolescent maltreatment victims: A meta-analysis.* Alliant International University, Fresno. U.S

Currier JM, Holland JM, Neimeyer RA (2007) The effectiveness of bereavement interventions with children: A meta-analytic review of controlled outcome research. *Journal of Clinical Child and Adolescent Psychology* 36: 253-259.

Davies BR, Allen NB (2017) Trauma and homelessness in youth: Psychopathology and intervention. *Clinical Psychology Review* 54: 17-28.

Dawson A, Jackson D (2013) The primary health care service experiences and needs of homeless youth: A narrative synthesis of current evidence. *Contemporary Nurse* 44: 62-75.

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Campo M, Kaspiew R, Moore S, Tayton S (2014) *Children affected by domestic and family violence: a review of domestic and family violence prevention, early intervention and response services.* Melbourne: Australian Institute of Family Studies. http://apo.org.au/node/42151	Not child outcome
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Curnow ES (2017) *Foster youth, aging out, and early parenting.* University of Texas.	Not systematic review
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Dawe S, Harnett P, Frye S (2008) Improving outcomes for children living in families with parental substance misuse: what do we know and what should we do. *Child abuse prevention issues* 29: 1-14.	Not systematic review
De Arellano M, Lyman R, Jobe-Shields L, George P, Dougherty RH, Daniels AS, Ghose SS, Huang L, Delphin-Rittmon ME (2014) Trauma-focused cognitive-behavioral therapy for children and adolescents: assessing the evidence. *Psychiatric Services* 65: 591-602	Not ACE population (< 70% identifiably ACE)
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De Swart JJ, Van den Broek H, Stams GJ, Asscher JJ, Van der Laan, Holsbrink-Engels GA, Van der Helm, GH (2012) The effectiveness of institutional youth care over the past three decades: A meta-analysis. *Children and Youth Services Review* 34: 1818-1824.	Not ACE population (youth offender)
de Valk S, van der Helm GHP, Beld M, Schaftenaar P, Kuiper C, Stams GJJM (2015) Does punishment in secure residential youth care work? An overview of the evidence. *Journal of Children's Services* 10: 3-16.	Not ACE population (secure psychiatric units or youth correctional facilities)
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del Pozo de Bolger A, Dunstan D, Kaltner M (2018) A conceptual model of psychosocial adjustment of foster care adoptees based on a scoping review of contributing factors. *Clinical Psychologist* 22: 3-15.	Not effectiveness/ comparative/ qualitative study
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Dinehart LH, Katz LF, Manfra L, Ullery MA (2013) Providing quality early care and education to young children who experience maltreatment: a review of the literature. *Early Childhood Education Journal* 41: 283-290.	Not systematic review
Dodd M (2011) *Health professionals' experiences with older adults affected by the trauma of their childhood sexual abuse: a systematic review of text and expert opinion.* University of Adelaide.	Not child outcome
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Dubach SL (2011) *Providing long-term psychotherapy to children in foster care by psychology graduate students: Growth through a secure attachment.* Wright Institute	Not systematic review
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Fisher MH (2009) Literature analysis to determine the inclusion of children with disabilities in abuse interventions. *Child abuse and neglect* 33: 326-327.	Not systematic review
Flores AT (2013) *Children, incarcerated mothers and the child welfare system: a systematic review of the literature.* California State University.	Not effectiveness/ comparative/qualitative study
Foley KP (2011) *A comparison of parent-child interaction therapy and treatment as usual with families with a history of child abuse and neglect and intimate partner violence.* West Virginia University.	Not systematic review
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Forrester D, Goodman K, Cocker C, Binnie C, Jensch G (2009) What is the impact of public care on children's welfare? A review of research findings from England and Wales and their policy implications. *Journal of Social Policy* 38: 439-456.	Not effectiveness/ comparative/qualitative study
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Gekoski A, Horvath MAH, Davidson JC (2016b) The effectiveness and impact of the child protection and criminal justice systems in cases of intrafamilial child sexual abuse. *Journal of Criminological Research Policy and Practice* 2: 54-66.	Not effectiveness/ comparative/qualitative study
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Appendix I: Evidence Map (overview)

	= positive effect		= mixed effects (evidence of both positive effects and no positive effects)		= no positive effect
	= limited evidence of positive effect (< 3 primary studies)		= limited evidence of mixed effects		= limited evidence no positive effect (< 3 primary studies)
	= no evidence (gap)				

Table 6: Available evidence on effectiveness of interventions to support people exposed to ACEs

Intervention type	**Abused / neglected**	**Sexually abused**	**Parent with mental health problems**	**Exposed to domestic violence**	**Looked-after / in care**	**Home-less**	**Parent in prison**	**Parent has died**	**Parents divorced**
Mental Health (for example, anxiety, depression, PTSD, internalising behaviours)									
CBT									
Other psych therapies									
Psychoeducation									
Parental interventions									
Parent and foster care training									
Cross sector support									
Educational interventions									
Housing and life-skills									
Out of home and foster care*									
Intervention type	**Abused / neglected**	**Sexually abused**	**Parent with mental**	**Exposed to domestic violence**	**Looked-after / in care**	**Home-less**	**Parent in prison**	**Parent has died**	**Parents divorced**

			health problems						
Behaviour (for example, externalising behaviour, risk behaviours)									
CBT									
Other psych therapies									
Psychoeducation									
Parental interventions									
Parent and foster care training									
Cross sector support									
Educational interventions									
Housing and life-skills									
Out of home and foster care*									

Social outcomes (for example, social support, access to services, educational attainment, homelessness)									
CBT									
Other psych therapies									
Psychoeducation									
Parental interventions									
Parent and foster care training									
Cross sector support									
Educational interventions									
Housing and life-skills									
Out of home and foster care*									

*The primary studies within the reviews on out of home and foster care did not present findings that were interpretable in terms of effectiveness

Appendix J: Information on the stakeholder workshop for organisations or mentors working with young people

What helps young people affected by Adverse Childhood Experiences (ACEs)?

A review of the evidence 2018

A research team from the EPPI-Centre at UCL Institute of Education are looking for young people, and young people's groups, to get involved in a review of the evidence on what helps young people affected by Adverse Childhood Experiences (ACEs). As this project is about looking at the evidence on young people's views and experiences we want to involve young people in looking at this evidence, and to hear their thoughts on what we find and what is missing.

What are ACEs?

Adverse Childhood Experiences (ACEs) are stressful experiences which may harm a child or affect the environment in which they live. This can include things like physical and sexual abuse, and emotional and physical neglect; or growing up in a house where there is domestic violence, a parent or carer in prison, substance abuse or family breakdown.

We know quite a lot from research about when and where ACEs happen and how this may affect children as they grow and in their adult lives. But we know less about what helps to promote positive changes and reduce the negative impact of ACEs, or the views and experiences of the children and young people affected.

The Research Project

We have been asked by the government to look at all the research that has been done in this area to find out what is known about the effectiveness of interventions (services or other support) for children and young people (aged 3-18 years) who have experienced one or more ACE, and about their views and experiences. This work is being funded by the Department of Health and will help us to provide the government with evidence on the options available to help children affected by ACEs.

Involving young people

The research team are particularly keen to work with individuals or groups of young people who have had personal experience of ACEs (see appendix). They do not need to have previous experience of involvement in research, as we will provide any necessary training and support. We hope that this will be an opportunity for young people to develop new knowledge and skills and add something to their CV. It's also a great chance for them to help improve future services and interventions for children and young people who have also experienced ACEs.

Young people involved will be given a gift voucher as a thank you for their time and offered payment for travel or other expenses. Young people who agree to be involved will be free to stop their involvement in the project at any point and any information they give will be anonymised and treated with complete confidentiality.

How could young people be involved?

We'd like to involve young people either:

- as young advisors, who work with the research team on different elements of the project and help us produce materials for young people, or
- by meeting groups of young people and talking to them about what we're learning from the review

In both cases we think it's important to get young people's input to find out:

 whether we're asking the right questions when we're looking at the evidence

 whether what we're finding makes sense to young people affected by ACEs - do the findings seem believable? Do you agree with them? What might be missing?

 what, of the things we learn from the review, do you think are most important?
 what do you think the implications of the review might be? Who might be affected?

Next steps

We are currently identifying abstracts (summaries) of research we think might be relevant to this review. When we have done this we would like to talk to young people **in late April/early May 2018** about what we're finding and what we should look at next. Depending on who is interested we will then discuss with those involved how young people could be involved in the later stages of the project.

Want to be involved? Any questions?

If you're interested in being involved on the project, or if you simply want to find out more, please contact:

Sarah Lester, Research Officer, UCL Institute of Education

sarah.lester@ucl.ac.uk, Tel: 0207 612 6606, Mob: 07xxxxxxxxx

Appendix K: Stakeholder workshop information sheet for young people

What helps people who have had Adverse Childhood Experiences (ACEs)?

Information for Young People

Please will you help us with our research?
This sheet contains information on the work we are doing and how you can help us. We would be happy to answer any questions that you have. Ask Sarah or Louca-Mai during the workshop or, after today, use the contact details at the end of this sheet.

Why is the research being done?
A research team from the EPPI-Centre at UCL Institute of Education have been asked by the government to do a **systematic review*** of all the research on what helps young people affected by **Adverse Childhood Experiences (ACEs)**. This work is being funded by the Department of Health and will help us to provide evidence to the government on the best way to help children affected by ACEs.

As part of this project looks at the evidence on young people's views we want to involve young people who have experience of ACEs during their childhood. This will help us make sure that we're asking the right questions, finding information about the things that are important to young people and if there are any gaps.

***Systematic reviews** follow a series of steps to find as much as possible of the research relevant to a particular research question, in this case what helps young people who have experienced ACEs. The results help to inform decisions about policy or practice.

ACEs are defined as exposure to stressful experiences or harmful environments in the home, or living in care. We are looking at those who have personal experience of: physical, verbal, emotional or sexual abuse, or neglect - living in care, or being homeless - growing up with domestic violence, a parent/carer in prison, parental mental health, drug or alcohol problems, or where a parent is absent through separation or death.

What are the benefits of being involved?
We hope that this will be a chance for you to develop new knowledge and skills and add something to your CV, as well as giving us a chance to learn from your experience**.** You will get lunch and a £20 gift voucher as a thank you for coming and payment of travel expenses. If you want to stay in touch we will let you know how the project develops.

Could there be problems for me if you take part? Can I pull out?
You don't need to tell us anything about your personal experiences or share anything unless you want to do so. We have provided a support sheet with organisations that you may find useful to contact after the workshop. If you feel upset you can pull out of the workshop at any point and ask for the information that you have given to be removed. Talk to Sarah or Louca-Mai during the workshop if you want to stop your involvement. If you wish for your information to be removed after the workshop has ended contact Sarah (Sarah.Lester@ucl.ac.uk) to tell her you no longer want to be part of it. You will still receive your gift voucher and expenses whatever you decide to do.

What happens with the information I give today?
We will treat everything that you say as private and we will not speak to anyone outside of the project about it. We cannot guarantee that the other young people you talk to will not speak to others about what you have said, but we will try to make sure everybody respects each other's need for trust and privacy. We would only let anyone else know about what you have said if you ask us to. If we were really worried about your, or other young peoples', safety, or if you were being hurt by someone in a position of trust we might have to tell someone or do something about it, but not without talking to you about it first.

How will you record today's session?
Together we will be writing notes on flipcharts and post-its and, if you agree to it, we will audio record the session. We will use notes and audio files to write up what happened and to check the discussion rather than doing it from memory.

What will you do with the information after the workshop?
Only people in the project team will have access to your personal information. When we record or write up our discussions we will not use people's names or anything else that could identify them. Recordings of group discussions and any personal information will be kept in a locked filing cabinet or a password-

protected computer.

Who can I contact about the project?
Sarah Lester, sarah.lester@ucl.ac.uk, Tel: 0207 612 6606, Mob: 07*********

The Department of Health & Social Care Reviews Facility aims to put the evidence into development and implementation of health policy through:

- Undertaking policy-relevant systematic reviews of health and social care research
- Developing capacity for undertaking and using reviews
- Producing new and improved methods for undertaking reviews
- Promoting global awareness and use of systematic reviews in decision-making

The Reviews Facility is a collaboration between three centres of excellence: EPPI-Centre (Evidence for Policy and Practice Information and Co-ordinating Centre), UCL Institute of Education, University College London; CRD (Centre for Reviews and Dissemination), University of York; and the London School of Hygiene and Tropical Medicine.

The Department of Health & Social Care Reviews Facility collaboration has grown out of a previous 'reviews facility' in Health Promotion and Public Health based at the EPPI-Centre, and has been funded by the Department since 1995.

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