Protocol: Accommodation-based interventions for individuals experiencing, or at risk of experiencing, homelessness: A network meta-analysis

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Background

The problem, condition or issue

Homelessness is a pervasive and intractable issue which may require a radical solution. The UK government has been radical with a pledge to eradicate rough sleeping in England by 2027 (Ministry of Housing, Communities and Local Government, 2018), but with a failing housing market and a lack of social housing many experts have questioned how this is possible in the timeframe.

Key stakeholders responsible for the allocation and implementation of available resources have a responsibility to assess and understand the body of evidence on existing programmes. However, the Housing First (HF) intervention, which falls under the umbrella of an accommodation-based approach, seems to have already won the approval of the Secretary of

accommodation-based approach, seems to have already won the approval of the Secretary of State for Housing, Communities and Local Government with a ringfenced £28 million towards the programme.

The main forms of current housing intervention can be traced to the large-scale deinstitutionalisation programme of the 1980s and 90s, in particular to the running down of the large mental hospitals. Cohen's (1964) study of English mental health hospitals reported there were over 30 hospitals accommodating more than 2000 patients each. HF originated in 1992 in New York and is an increasingly well-known evidenced based housing intervention utilised in 15 countries. Worryingly, the effectiveness of the housing first is disputed across three randomised control trials for outcomes related to health (O'Campo et al., 2016), income (Poremski et al., 2016) and substance abuse (Kirst, Zerger, Misir, Hwang & Stergiopoulos, 2015); while results from randomised control trials on the effectiveness of other types of accommodation-based approaches are conflicting and vulnerable to biases associated with small sample sizes and poor study quality (Munthe-Kaas et al., 2018).

Globally homelessness is rising and there is a significant need to identify and combine all relevant interventions which aim to reduce homelessness. To ensure that policymakers avail of the most robust and rigorous evidence to date a Systematic Review and network meta-analysis of the literature around accommodation-based interventions is required.

The intervention

Interventions aimed at reducing homelessness can be traced as far back as 1824, where the UK government's response to the congregation of people in urban areas was the Vagrancy Act (1824). This history, coupled with the complexity of homelessness, has led to a diverse range of accommodation-based interventions. Due to the anticipated range and diversity of these interventions an extensive list of all possible types will not be listed here. Indeed, most commentators acknowledge the challenges of lack of clear definition of the many terms used to describe the various types of accommodation interventions. A clear example of the confusion which exists in the literature is that the term 'supported housing' was used in the 1980s by Carling (1993, 1995) in the US to describe an alternative to the mental health managed accommodation. Meanwhile in the UK 'supported accommodation' was used more widely and included the growing number of mental health managed accommodations. One study (Gustafsson et al 2009 cited in McPherson, Krotofil and Killaspy 2018a), identified 307 unique terms for supported accommodation across 400 articles. There is broad implementation of supported housing, with over 60,000 individuals receiving support in the UK in mental health supported accommodation settings (Sandhu et al 2016). A recent review of classification in the literature (McPherson, Krotofil and Killaspy 2018a), found that there were no agreed methods for reporting supported accommodation in the literature. The authors developed a simple taxonomy for supported accommodation (STAX-SA) consisting of five accommodation types across four domains.

The review team will attempt to categorise the intervention into one of the following major classifications:

Housing First models

Housing First (HF) interventions offer housing to homeless individuals with minimal obligation or preconditions being placed upon the participant. HF provides safe and stable housing to all individuals, regardless of criminal background, mental instability, substance abuse, or income. HF programmes share some common themes: (i) the participant is provided housing immediately, without conditions, (ii) decisions around the location of the home and the services received are made by the client, (iii) support and services to aid the individual recovery are provided after stabilisation, (iv) social integration with local community and meaningful engagement with positive activities is encouraged.

HF is based on the principle that housing should be made available in the first instance and preconditions such as sobriety and involvement in treatment programmes are unnecessary barriers placed upon homeless individuals. Through the removal of these common obstacles, it is believed that the individual has a better chance of achieving stabilisation in appropriate housing and feel more willing or able to accept treatment. If this is achieved, services aimed to address their more complex needs can be introduced, usually through community-based support.

Hostels

Hostels provide homelessness accommodation for both short-term and long-term housing needs. They are open 24 hours per day. Hostels are most often funded by housing benefit. Individuals usually need to be referred by their local council or other agency. Many hostels charge additional fees directly to the individual for services such as laundry, food, or heat. Homeless people do not always sleep in homeless hostels and in times of emergency or adverse weather conditions, will self-fund a stay in a private hostel aimed towards backpackers or students.

Homeless hostels have rules about the individuals who stay there, but they may include homeless individuals, homeless families, homeless couples, and homeless individuals with pets. While most hostels will offer beds to either gender, some are specifically for homeless males and others for homeless females. Individuals who do not conform to binary classification of gender may find it difficult to be housed in hostels that are gender-specific in their intake. Some hostels will accommodate young people exclusively. Sleeping arrangements are variable with some offering dormitory style sleeping alongside communal kitchen, living, and shower areas while others have bedsit flats.

The type of support offered by a homeless hostel varies, often being determined by the needs of the individuals who stay there. For example, in hostel accommodation females who have suffered domestic abuse require different services and support than males who have specific mental illness. However, some common types of support offered in homeless hostels include a support plan to move to more stable accommodation, practical help with form filling and obtaining necessary governmental documents, or treatment for substance abuse issues.

Shelters
Homeless shelters are a basic form of temporary accommodation where a bed is provided in a shared space overnight. One of the key features of a homeless shelter is that it is transitional and an option for those homeless who are not yet eligible for more stable accommodation. Shelters are not usually seen as stable forms of accommodation as the individual must vacate the space during daytime hours with their belongings. Homeless shelters often place additional requirements on potential users including night time curfews. Additional services that may or may not be provided by the homeless shelter are warm meals for dinner and breakfast or support from volunteers who help individuals make connections to other services.

Day shelters for homeless individuals act as a drop-in centre, often aimed towards those homeless with additional needs such as substance abuse, or mental illness. Services may include access to case workers, meals, access to laundry facilities, or support groups. The obvious difference between night and day shelters is that a day shelter will not offer a bed to the individuals who use the services. Some criticisms of homeless shelters relate to overcrowding, physical altercations, theft, substance abuse, and unhygienic sleeping conditions.

Supported housing
Supported housing is an extremely complex intervention type. To be categorised as supported housing, the intervention will combine housing with additional supportive service/s as an integrated package. The housing offered can be permanent or temporary; non-abstinent contingent or abstinent-contingent; staffed group homes, community based or in a private unit; and the subsidies towards rent also vary.

Supportive services will be offered directly to the individual or through referrals to the relevant body. Supportive services might include those to help with mental health issues, substance misuse, those interventions which increase access to health services, support to continue education or find employment, help with accessing benefits, or those services which focus on social aspects of the individual's life such as positive interactions with society, or community engagement.

Examples of interventions which use supported housing are the Pathways to Housing supported housing programme (Tsemberis & Eisenberg, 2000) and the US Department of Housing and Urban Development (HUD) and the US Department of Veterans Affairs (VA) Supported Housing (O'connell, Kasprow & Rosenheck, 2008) programme.

Rapid rehousing

Rapid rehousing is like the housing first approach in that it seeks to provide accommodation to individuals experiencing homelessness as quickly as possible. Generally rapid rehousing interventions will identify available accommodation, aid with application, rent and moving in and the provision of case managemeupported housingnt to support access to other services.

Rapid rehousing always provides the service user with a short-term subsidy to assist with rent and will generally target those persons experiencing homelessness who are lower risk and less likely to require substantial access to services. The amount of support provided through rapid rehousing programmes is usually time limited, ranging from three to six months of support.

How the intervention might work

The primary objective of all supported housing interventions is to provide people with the stability of housing (even if only for the short-term) alongside the service and support they require to continue life independently without the risk of future homelessness.

Why it is important to do the review

The aim of this systematic review and network meta-analysis is to establish the effectiveness of all accommodation-based approaches though a robust and rigorous synthesis of the available literature. Through this understanding of what works, for whom, and why, some of the detrimental effects of experiencing a life of homelessness may be alleviated.

This systematic review will be based on evidence already identified in two existing evidence and gap maps (EGMs) commissioned by the Centre for Homelessness Impact (CHI) and built by White, Saran, Teixeira, Fitzpatrick and Portas (2018). The EGMs present studies on the effectiveness and implementation of interventions aimed at people experiencing, or at risk of experiencing, homelessness.

The EGMs identified various systematic reviews which assess the effectiveness of interventions like housing first (Beaudoin, 2016; Woodhall-Melnik & Dunn, 2016) and supported housing (Burgoyne, 2014; Nelson, Aubry & Lafrance, 2007; Richter & Hoffmann, 2017), and interventions which were conducted in hostel and shelter settings (Haskett, Loehman & Burkhart, 2016; Hudson, Flemming, Shulman & Candy, 2016). However, a network meta-analysis of accommodation-based interventions for a homeless population does not exist.

Various systematic reviews which synthesise accommodation-based interventions more generally, differ from the proposed review in several ways:

Differences in population

Bassuk, DeCandia, Tsertsvadze, and Richard (2014) systematically reviewed and narratively reported the findings of six studies which looked at the effectiveness of housing interventions and housing combined with service interventions. The interventions included Housing First, rapid rehousing, vouchers, subsidies, emergency shelter, transitional housing, and permanent supportive housing. However, authors limited the population to families who were experiencing homelessness and so any final conclusions on the efficacy of accommodation-based interventions on the wider population of individuals experiencing homelessness are impossible to reach.

Differences in outcomes of interest

Fitzpatrick-Lewis and colleagues (2011) conducted a rapid systematic review on the effectiveness of interventions to improve the health and housing status of individuals experiencing homeless. Of the 84 included studies, interventions included everything from housing first to the Healthy Living Program. Only those studies published between January 2004 and December 2009 were included in this review and so the current review will be more current and much broader in scope. Additionally, the primary purpose of the review was to identify literature which improved health outcomes for those experiencing homelessness and so other important outcomes were not included.

A title registration form has been submitted to the Campbell Collaboration by Mathew and colleagues (2018) which looks at how various interventions impact the physical and mental health of homeless individuals alongside other social outcomes. One objective listed in the title registration form is similar to the scope of the current review. Authors will assess “What are the effects of housing models (i.e. Housing First) on the health outcomes of homeless and vulnerably housed adults compared to usual or no housing?”. However, the current review will have a wider scope by including additional outcomes across a wider population.

A recent Campbell Collaboration review by Munthe-Kaas, Berg and Blaasvær (2018) assessed the effectiveness of both housing and case management programmes for people experiencing, or at risk of experiencing homelessness. The main outcomes of interest to the authors were reduction in homelessness and housing stability. Authors searched the literature until January 2016 and uncovered 43 randomised controlled trials meeting the predetermined inclusion criteria. Authors did not include qualitative research or extract data related to the cost of the interventions, which are outcomes of interest to this proposed review.

Differences in analytic methods

Finally, a recent review by the what works centre for wellbeing (Chambers et al., 2018) included 90 studies which included clusters of housing first (n=47), supported housing (n=12), recovery housing (n=10), housing interventions for ex-prisoners (n=7), housing interventions for vulnerable youth (n=3) and ‘other’ complex interventions targeted at those with poor mental health (n=11). Authors presented a comprehensive search strategy of both commercial and grey literature, however, due to resource constraints were unable to conduct independent screening of the potential studies and therefore risk selection bias in the review. Additionally, only studies published after 2005 were included in this review and so the current review will be broader in scope. Finally, the authors objective was to create a conceptual pathway and evidence map between housing and wellbeing and so the results were not meta-analysed but described narratively instead.

Objectives

1. What is the relative effect of accommodation-based interventions on outcomes for individuals experiencing or at risk of experiencing homelessness? i.e. which intervention (Housing First, hostels, shelters, supported housing, and rapid rehousing) is most/least effective compared to other interventions and compared to business as usual (passive control)?
2. Who do accommodation-based interventions work best for?
    a. Young people/older adults?
    b. Males/Females?
    c. Other sub groups or populations?
3. What implementation and process factors act as barriers or facilitators to intervention delivery?
4. Is implementation fidelity related to the effectiveness of the intervention?

Methodology

Criteria for including and excluding studies

Types of study designs

Only studies which use a control group design will be eligible for inclusion. These groups (intervention and control) can be assigned randomly or non-randomly. If non-random, only a rigorous matched-comparison group design will be accepted for inclusion in the analysis. A matched group design consists of a treatment and control group that share similar baseline characteristics. This design allows greater confidence that observed group differences are due to the intervention rather than baseline differences. In a matched-comparison design, the interventionists ensure equivalence between the two groups by collecting data on potential confounding variables at pre-test. Non-random studies will be judged in relation to how suitably matched the two groups were at pre-test and whether attempts were made to control for any pre-test differences. As randomised control trials are accepted as more rigorous than non-randomised studies, the potential impact of non-random study design on effect sizes will be explored as part of the subgroup analyses and any significant influences will be controlled

through meta-regression. Control groups can include various types, such as; alternative treatment, placebo, no treatment, waitlist, or usual treatment (standard care). Any study which includes one group pre-test/post-test or in which a treatment group is compared to another treatment group without a control arm will not be eligible for inclusion. Studies with no control or comparison group, unmatched controls or cross-national comparisons with no attempt to control for relevant covariates will not be included. Case studies, opinion pieces or editorials will not be included. Finally, A person cannot serve as their own control, but instead must be compared against a group of untreated participants.

Types of participants

This systematic review will focus on all individuals who are currently experiencing, or at risk of experiencing homelessness irrespective of age or gender. The included studies will include populations from high-income countries. Homelessness is defined as those individuals who are sleeping 'rough' (sometimes defined as street homeless), those in temporary accommodation (such as shelters and hostels), those in insecure accommodation (such as those facing eviction or in abusive or unsafe environments), and those in inadequate accommodation (environments which are unhygienic and/or overcrowded).

Types of interventions

Interventions will include housing first, shelters, hostels, supported housing, or rapid rehousing against either a control group or through head to head comparisons with an alternative treatment. Control groups can include various types, such as; placebo, no treatment, waitlist, or usual treatment (standard care).

Types of outcome measures

The primary outcome will be reducing homelessness.

This review will primarily address how interventions can reduce homelessness for those individuals experiencing, or at risk of experiencing, homelessness.

Duration of follow-up

It is anticipated that the included interventions will report effects at multiple follow-up periods after implementation of the intervention. In instances where this is the case, data relating to multiple points of follow up will be extracted in their entirety. This will allow us to conduct analysis on effect sizes related to similar time points and when outcomes are similar across various timepoints then an average effect size will be calculated to estimate effectiveness.

Types of settings

Settings where these accommodation-based interventions take place may be varied and can include community based settings, vocational settings, treatment centres, clinical settings and the individual's temporary accommodation.

Search strategy

This systematic review will be based on evidence already identified in two existing evidence and gap maps (EGMs) commissioned by the Centre for Homelessness Impact (CHI) and built by White, Saran, Teixeira, Fitzpatrick and Portas (2018). The EGMs present studies on the effectiveness and implementation of interventions aimed at people experiencing, or at risk of experiencing, homelessness.

Description of methods used in primary research

Interventions will include randomised and quasi-randomised trials measuring effectiveness of housing first, shelters, hostels, supported housing, or rapid rehousing against either a control group or through head to head comparisons with an alternative treatment.

Criteria for determination of independent findings

Often, authors will report data on the same participants across more than one outcome, this leads to multiple dependent effect sizes within each single study. If this occurs in more than 20 studies, Robust Variance estimation will be conducted. This technique calculates the variance between effect sizes to give the variable of interest a quantifiable standard error (Hedges, Tipton & Johnson, 2010). If this occurs in less than 20 studies, authors will

combine the dependent variable to produce one combined effect size per study.
Finally, in cases where study authors separate participants into subgroups relating to age, comorbid diagnosis or gender and it's inappropriate to pool their data, these participants will remain independent of each other and will be treated as separate studies which each provide unique information.

Details of study coding categories

Data abstraction sheets will be designed by the authors and piloted by trained research assistants using Eppi-Reviewer. A minimum of the following data will be extracted from each included study:

- Publication details
- Geographical location of study
- Demographic variables relating to the participants
- Intervention details including setting, dosage and implementation
- Delivery personnel
- Descriptions of the outcomes of interest including instruments used to measure
- Design and type of trial
- Sample size of treatment and control groups
- Data required to calculate Hedge's g effect sizes
- Quality assessment

Statistical procedures and conventions

All analyses will be conducted using the R program. Network meta-analysis will be conducted to test effectiveness of accommodation-based interventions across various domains relating to homelessness. The outcomes related to homelessness are continuous and so the effect size metric chosen is Hedges' g, many studies will need to be recalculated into a Standardised Mean Difference (SMD) with a 95% confidence interval to allow appropriate summary of effect sizes across the included studies. SMD will be calculated from means and standard deviations in the first instance, however, if a study does not provide this raw data, authors will be contacted, and this information will be requested. Failing this, many papers have been published to assist authors in calculating the SMD from primary research (Rosnow & Rosenthal, 1996; Rosnow, Rosenthal & Rubin, 2000), and have enabled authors to transform many statistical tests of significance such as t-tests, F tests, and chi square values to a metric which allows comprehension of the magnitude of the intervention effect. A very useful online calculator has also been developed, this allows authors to choose the type of raw data available, and the calculator will automatically transform this to various effect size types, including the SMD (Lipsey & Wilson, 2000).

If it transpires that there is substantial heterogeneity between studies, authors understand it is not suitable to combine these in a meta-analysis as the experimental effects are more different than one would expect based on chance alone. Statistical heterogeneity or lack thereof will be checked in several ways. Firstly, visually using forest plots and checking for overlap of confidence intervals. Secondly, using tests such as the Cochran Q test (Chi-Square or C^2), percentage of total variation across studies (I^2) and the Tau-squared statistic (τ2 or Tau2).

A funnel plot and Egger's linear regression test will be included to check for publication bias across included studies (Stern & Egger, 2005). Where the funnel plot is asymmetrical this indicates either publication bias or bias which relates to smaller studies showing larger treatment effects. The trim and fill method will be used where the funnel plot is asymmetrical (Higgins & Green, 2011), this is a nonparametric technique which removes the smaller studies causing irregularity until there is a new symmetrical pooled estimate, the studies which were eliminated where then filled back in to reflect the new estimate.
To ensure robustness of the review and to account for individual studies that appear to exert an undue influence on findings, process sensitivity analysis will also be carried out on domains relating to the quality of the included studies.

Network Meta-analysis

A traditional pairwise meta-analysis allows a researcher to compare the evidence base of intervention A against the evidence base for intervention B to inform decisions on whether intervention A or B (or no treatment if compared to a control condition) is most effective for

the population, condition, or setting of interest. These meta-analyses provide direct comparisons between two different interventions.

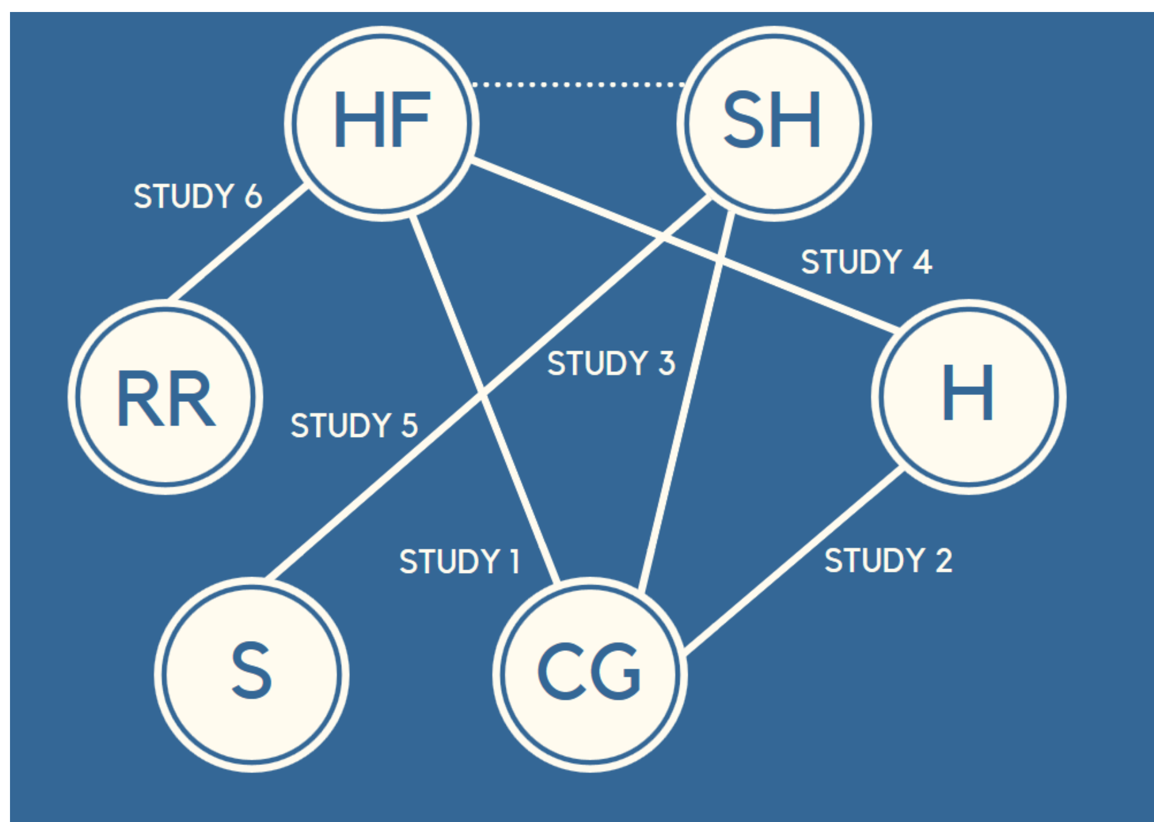
When two or more intervention types exist, as in the case of accommodation-based approaches, researchers can utilise all the available direct comparisons between intervention options and use this data to calculate indirect comparisons (see example below). This not only allows researchers to assess whether the combination of multiple accommodation-based approaches is more effective than using one single approach, but also by this combination of both direct and indirect comparison data, researchers are providing a much stronger and more robust evidence- base to decision makers.

To answer the research question outlined above, network MA allows analysis of data collected at various time points that compare accommodation-based approaches like housing first, shelters, hostels, supported housing, or rapid rehousing against either a control group or through head to head comparisons.

To illustrate how network MA helps to answer the question on effectiveness of accommodation-based interventions to reduce homelessness, we will use six fictional randomised control trials uncovered through a thorough systematic review of the literature.

1. Study 1 compares housing first (labelled HF) to a control group (labelled CG)
2. Study 2 compares hostels (labelled H) to a control group
3. Study 3 three compares supported housing (labelled SH) to control group
4. Study 4 four compares hostels to housing first
5. Study 5 compares shelters (labelled S) to supported housing
6. Study 6 compares housing first (labelled HF) to rapid rehousing (labelled RR)

The example NMA would look like this:



The network MA can use all the information available across the five studies to provide an understanding of the effectiveness of the approaches. Each line in the diagram is a direct comparison between two interventions and so effect sizes will be available.

However, as shown in the example above, the dashed line between housing first and supported housing is illustrative of how an indirect comparison (effect size) could be calculated using the information from Study 1 (housing first compared to control) and Study 3 (supported housing compared to control). This indirect effect comparing housing first and supported housing can be calculated because the two interventions of interest have a

supported housing can be calculated because the two interventions of interest have a common comparator (in this case control). If, when the review is updated, a new RCT that compares housing first and supported housing is located, then this direct effect will be pooled with the earlier indirect effect to create what becomes known as a network treatment effect.

To conclude, the six fictional trials alongside the indirect comparison now create the network of evidence on accommodation-based approaches. These approaches can now be ranked to provide robust conclusions on which approaches (or combinations of approaches) work best to reduce homelessness.

Treatment of qualitative research

Qualitative research included in this review is based on an existing evidence and gap map (EGM) commissioned by the Centre for Homelessness Impact (CHI) and built by White, Saran, Teixeira, Fitzpatrick and Portas (2018). The EGM presents 246 qualitative evaluations on the implementation issues of homelessness interventions.

The implementation issues categories included in the EGM were developed through an iterative process. Initially categories were based on the implementation science framework (Aarons, Hurlburt & Horwitz, 2011). These categories were then independently piloted against process evaluations and agreement was reached by researchers in the Campbell Collaboration, Queen's University Belfast, and Heriot-Watt University. The five broad categories of implementation issues agreed are: contextual factors, policy makers / funders, programme managers / implementing agency, staff / case workers, and recipients.

There are many process evaluations of accommodation based- interventions identified by the EGM and they will be included in the synthesis of qualitative data. We will appraise the quality of the studies using a tool developed by White and Keenan (2018) and will narratively synthesise the barriers and facilitators described in the included process evaluations.

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Roles and responsibilities

The review will be undertaken by systematic review specialists within the Campbell UK & Ireland Centre. Dr Sarah Miller will be the Principal Investigator (PI) of the project and will have overall responsibility for its conduct and delivery. Dr Ciara Keenan will be responsible for the day to day operation of the review. This review will be supported by specialist input from Dr Jennifer Hanratty, Professor Terri Pigott and Mr. John Cowman alongside research support from two full time research assistants.

Dr Ciara Keenan has acquired six years' experience working across 15 Systematic Reviews. Ciara is currently co-convenor of the Campbell Collaboration's Information Scientist Network; methods editor for the Campbell Collaboration's Education coordinating group; and founder and editor of the meta-evidence blog.

Dr Sarah Miller is the Deputy Director of Campbell UK & Ireland. She is co-chair and co-editor of the Campbell Education Coordinating Group and also Deputy Director of the Centre for Evidence and Social Innovation, within which she leads the What Works in Schools programme of research. She has considerable methodological and statistical expertise, which includes the conduct and analysis of randomised controlled trials as well as systematic reviews and meta-analyses.

Dr Jennifer Hanratty has worked in evidence synthesis since 2012 and published reviews with Campbell, Cochrane and NIHR Health Technology Assessment amongst others. Jennifer is associate Editor with Campbell Education Co-ordinating group, on the editorial board of the Campbell Knowledge Translation and Implementation Group, and represents Campbell UK & Ireland on the advisory board for Evidence Synthesis Ireland.

Professor Terri Pigott

John Cowman is a Housing Coordinator in mental health services in Dublin. John is a qualified social worker who had worked in specialist housing roles since 2013. His main focus has been on promoting recovery oriented housing and supports for people with mental health disabilities, in particular, ways to elicit and incorporate the service user's subjective needs and preferences. John has developed several innovative interagency housing projects and also been involved in research and evaluation. He has completed several housing related research studies, one of which led to the MSc in Mental Health in Trinity College Dublin (2008). In addition to his main role, John is currently a PhD student at Queen's University Belfast. His PhD study is exploring the housing needs of people in psychiatric in-patient care and how those needs can be most effectively met.

- Content: JC
- Systematic review methods: CK, SM, JH, TP
- Statistical analysis: CK, SM, JH, TP
- Information retrieval: CK, SM, JH

Sources of support

This review is funded by the Centre for Homelessness Impact. The review is due to be submitted to the coordinating group by the end of September 2019.

Declarations of interest

Please declare any potential conflicts of interest. For example, have any of the authors been

Please declare any potential conflicts of interest. For example, have any of the authors been involved in the development of relevant interventions, primary research, or prior published reviews on the topic?

Preliminary timeframe

Approximate date for submission of the systematic review.

• Date you plan to submit a draft protocol: 31 Jan 2019

• Date you plan to submit a draft review: 27 Sep 2019

Plans for updating the review

Reviews should include in the protocol specifications for how the review, once completed, will be updated. This should include, at a minimum, information on who will be responsible and the frequency with which updates can be expected.

AUTHOR DECLARATION

Authors' responsibilities

By completing this form, you accept responsibility for preparing, maintaining and updating the review in accordance with Campbell Collaboration policy. Campbell will provide as much support as possible to assist with the preparation of the review.

A draft review must be submitted to the relevant Coordinating Group within two years of protocol publication. If drafts are not submitted before the agreed deadlines, or if we are unable to contact you for an extended period, the relevant Coordinating Group has the right to de-register the title or transfer the title to alternative authors. The Coordinating Group also has the right to de-register or transfer the title if it does not meet the standards of the Coordinating Group and/or Campbell.

You accept responsibility for maintaining the review in light of new evidence, comments and criticisms, and other developments, and updating the review at least once every five years, or, if requested, transferring responsibility for maintaining the review to others as agreed with the Coordinating Group.

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Form completed by: Ciara Keenan Date: 28/03/19