National Institute for Health and Care Excellence

FINAL

Rehabilitation after traumatic injury

[B.3] Psychological and psychosocial interventions for people with complex rehabilitation needs after traumatic injury

NICE guideline NG211

Evidence reviews underpinning recommendations 1.1.3, 1.2.21, 1.2.22, 1.5.1, 1.5.4, 1.5.7, 1.9.3, 1.13.1 to 1.13.7 and research recommendations

January 2022

FINAL

These evidence reviews were developed by the National Guideline Alliance, which is a part of the Royal College of Obstetricians and Gynaecologists

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This evidence report contains information on 2 reviews

B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?

Psychological and psychosocial rehabilitation interventions for people with complex rehabilitation needs after traumatic injury

Review question

This evidence report contains information on 2 reviews

B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?

Introduction

Trauma causes disruption to daily life, routines and relationships as well as causing pain, uncertainty about recovery or potential disability and financial pressures due to loss of income. Changes to mood and emotional functioning are common in the initial period after injury and often impact on the ability to fully recover. Later, these features may predominate, as the impact of injury becomes more apparent and continued lack of participation in usual activities and society leads to low mood and social isolation.

Providing support for psychological needs after trauma is an essential part of the rehabilitation process. Often services for these issues are provided in a disjointed and haphazard way (depending on local commissioning arrangements), which do not meet the needs of the trauma survivor population. Standardisation of this part of the care pathway would enhance patients' recovery.

The objective of this review was to examine what psychological and psychosocial rehabilitation interventions are effective and acceptable for people with complex rehabilitation needs after traumatic injury.

Summary of the protocol

Please see Table 1 and Table 2 for a summary of the Population, Intervention, Comparison and Outcome (PICO) characteristics of this review in the adult and children and young people populations, respectively.

Table 1: Summary of the adult protocol (PICO table)

Population	Adults (aged 18 years or above) with complex rehabilitation needs resulting from traumatic injury that required admission to hospital
Intervention	Standard rehabilitation care consisting of: physiotherapy [range of movement exercises, exercises to maintain muscle function, mobilisation and training with mobilisation aids such as crutches or frame], occupational therapy assessment, and identification and support of basic activities of daily living through training or aids (e.g. toileting equipment, perching stools, long-handled aids, adapted eating utensils) in addition to at least one of the following:

	• Cosmetic interventions for trauma induced changes to the body e.g. skin camouflage, tattooing) • Psychological therapies for adjustment and engagement (Compassionate mind therapy, Acceptance and commitment therapy, Mindfulness, Visualisation or 'mentalisation' to support physical rehab, Relaxation [progressive, or breathing based, or other], Cognitive behavioural therapy) • Family support (including education, advice, signposting to useful agencies such as Citizens advice) • Self-management interventions (i.e., education to understand how one might be affected by fatigue, depression, Bridges Self-management, conversation with consultant etc.) • Person-centred goal setting (including motivational interviewing)
Comparison	1) Standard rehabilitation care (as defined above) 2) Studies that employ the same intervention program as listed under 'interventions' but vary it in terms of any of the following: • Frequency • Intensity • Timing
Outcome	• Critical ○ Overall quality of life [EURO-QoL 5D 3L, SF-36, SF-12, SF-6D, SFMA] ○ Patient acceptability (any direct measure) ○ Changes in mood [Depression measures - BDI, DAS, HADS, PHQ-9] • Important ○ Return to work or education ○ Changes in activity of daily living [Barthel ADL index, COPM, E-ADL-Test, FIMFAM, GAS, Katz, OARS, PAT, PSMS,] ○ Pain (e.g. VAS)

ADL: Activities of daily living; BDI: Beck depression inventory; CHQ CF-80: 80 item child health questionnaire; CHQ PF-50: 50 item child health questionnaire, parent completed; COPM: Canadian occupational performance measure; DARE: DAS: Disability assessment schedule; E-ADL-Test: Erlangen Activities of Daily Living test; EURO-QoL 5D 3L: EuroQol 5 dimensions and 3 levels; FIMFAM: Functional independence measure and functional assessment measure; GAS: Goal attainment scaling; HADS: Hospital anxiety and depression scale; OARS: Older Americans resources and services; PAT: Performance ADL test; PHQ-9: 9 item patient health questionnaire; PSMS: Physical self-maintenance scale; SCIM: Spinal cord independence measure; SFMA: Selective functional movement assessment; SF-12: 12 item short-form survey; SF-36: 36 item short-form survey; SF-6D: 6-dimension short-form; VAS: Visual; analogue scale

Table 2: Summary of the children and young people protocol (PICO table)

Population	Children and young people (aged below 18 years) with complex rehabilitation needs resulting from traumatic injury that required admission to hospital
Intervention	Standard rehabilitation care consisting of: physiotherapy [range of movement exercises, exercises to maintain muscle function, mobilisation and training with mobilisation aids such as crutches or frame], occupational therapy assessment, and identification and support of basic activities of daily living through training or aids (e.g. toileting equipment, perching stools, long-handled aids, adapted eating utensils) in addition to at least one of the following: • Cosmetic interventions for trauma induced changes to the body e.g. skin camouflage, tattooing) • Psychological therapies for adjustment and engagement (Compassionate mind therapy, Acceptance and commitment therapy, Mindfulness, Visualisation or 'mentalisation' to support physical rehab,

	Relaxation [progressive, or breathing based, or other], Cognitive behavioural therapy) • Family support (including education, advice, signposting to useful agencies such as Citizens advice or Changing Faces) • Self-management interventions (i.e., education to understand how one might be affected by fatigue, depression, Bridges Self-management, conversation with consultant etc.) • Person-centred goal setting (including motivational interviewing) • Play therapy • Family therapy (including sibling support) • Interventions for adaptive dysfunction and behavioural disturbance
Comparison	1) Standard rehabilitation care (as defined above) 2) Studies that employ the same intervention program as listed under 'interventions' but vary it in terms of any of the following: • Frequency • Intensity • Timing
Outcome	• Critical ○ Overall quality of life including quality of sleep [e.g., CHQ CF-80, CHQ PF-50, EURO-QoL 5D 3L Y, PEDS-QL, SCIM, SF-36, SF-12, SF-6D, Tarn] ○ Patient, families and carers' acceptability ○ Changes in mood [including PEDS-QL, Depression measures - BDI, DAS, HADS, PHQ-9,] [Babies only: ○ Alberta Infant Motor Scale (AIMS; pre-term to 19 months) ○ Bayley Assessment (1 to 42 months)] • Important ○ Return to nursery, education, training or work ○ Changes in activity of daily living [e.g., Barthel ADL index, COPM, E-ADL-Test, FIMFAM, GAS, Katz, OARS, PAT, PSMS,] ○ Pain ○ Changes in the 'Family Needs Questionnaire' scores

ADL: Activities of daily living; BDI: Beck depression inventory; CHQ CF-80: 80 item child health questionnaire; CHQ PF-50: 50 item child health questionnaire, parent completed; COPM: Canadian occupational performance measure; DAS: Disability assessment schedule; E-ADL-Test: Erlangen Activities of Daily Living test; EURO-QoL 5D 3L: EuroQol 5 dimensions and 3 levels; FIMFAM: Functional independence measure and functional assessment measure; GAS: Goal attainment scaling; HADS: Hospital anxiety and depression scale; OARS: Older Americans resources and services; PAT: Performance ADL test; PEDS-QL: Paediatric quality of life inventory; PHQ-9: 9 item patient health questionnaire; PSMS: Physical self-maintenance scale; SCIM: Spinal cord independence measure; SF-12: 12 item short-form survey; SF-36: 36 item short-form survey; SF-6D: 6-dimension short-form

For further details see the review protocol in appendix A.

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in appendix A and in the methods chapter (Supplement 1).

Declarations of interest were recorded according to NICE's 2018 conflicts of interest policy.

Clinical evidence: Adults

Included studies

Sixteen studies were included in this review. Fifteen of these were randomised controlled trials (RCTs; Allegrante 2007, Coker 2019; Elinge 2003, Holmes 2007, Kooijmans 2017, Mercier 2015, Migliorini 2016, Mohaddes Ardebili 2017, Nooijen 2016a, Nooijen 2016b, Nooijen 2017, Pirente 2007, Schulz 2009, Wiechman 2015 and Zidén 2008). One study was a non-randomised cohort study (Castillo 2013). Due to the variety of the interventions identified and trauma populations, it was decided to include non-randomised trials to increase the amount of evidence where possible.

The included studies are summarised in Table 3.

Six were from the United States (Allegrante 2007, Castillo 2013, Coker 2019, Mercier 2015, Schulz 2009 and Wiechman 2015); 4 were from The Netherlands (Kooijmans 2017, Nooijen 2016a, Nooijen 2016b and Nooijen 2017); 2 were from Sweden (Elinge 2003 and Zidén 2008); 2 were from Australia (Holes 2007 and Migliorini 2016); 1 was from Iran (Mohaddes Ardebili 2017); and 1 was from Germany (Pirente 2007).

These included studies examined the following comparisons:

Psychological therapies for adjustment and engagement

Five studies investigated psychological therapies for adjustment and engagement. One RCT compared the effectiveness of standard care plus a post-operative motivational intervention with standard post-operative care and rehabilitation (Allegrante 2007). One RCT compared the effectiveness of interpersonal counselling with standard care (Holmes 2007). Another RCT compared the effectiveness of a scheduled, automated peer support telephone call service and resource book with standard care and resource book (Mercier 2015). Another RCT compared the effectiveness of an online-based CBT schedule with a waitlist control (Migliorini 2016).The final RCT compared the effectiveness of standard care and a CBT-based psychotherapy intervention with standard care alone (Pirente 2007).

Family support

One RCT compared the effectiveness of educational sessions and telephone-based group support sessions for caregivers of individuals with spinal cord injury (SCI) with a written information pack and telephone contact (Schulz 2009).

Self-management interventions

Five studies investigated the use of self-management interventions in adults with complex rehabilitation needs. One cohort study investigated the effectiveness of standard care plus access to a Trauma Support Network compared to standard care alone (Castillo 2013). One RCT compared the effectiveness of an educationally-based group therapy programme with a waitlist control (Coker 2019). One RCT compared the effectiveness of a small-group learning programme and home-training schedule with standard care and rehabilitation (Elinge 2003). Another study compared the effectiveness of an active behaviour intervention programme (Healthy Active Behavioural Intervention in SCI) and information booklet with a single information meeting and information booklet (Kooijmans 2017). The last RCT compared the effectiveness of a motivational self-care CD and routine self-care information in burn patients with routine self-care information alone (Mohaddes Ardebili 2017).

Person-centred goal setting

Five studies investigated the use of person-centred goal setting, all focusing on motivational interviewing. Three papers reported on the Act Active study, which measured the effectiveness of a motivational interviewing intervention in wheelchair users with SCI, compared with standard care (Nooijen 2016a, Nooijen 2016b and Nooijen 2017). Another RCT compared the effectiveness in burn patients of motivational interviewing plus standard outpatient care with standard outpatient care alone (Wiechman 2015). The final RCT compared standard care and rehabilitation plus supported discharge (including a motivational interviewing component) with standard care and rehabilitation alone (Zidén 2008).

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review are listed with the reasons for their exclusion in appendix K.

Summary of studies included in the evidence review

Summaries of the studies that were included in this review are presented in Table 3.

Table 3: Summary of included studies

Study	Population	Intervention[a]	Control[a]	Outcomes
Allegrante 2007 RCT USA	N= 176 Participants with primary unilateral fracture of the hip with a subsequent successful surgical repair. Age in years [Mean (SD)]: • Motivation and support = 78 (7) • Standard post-operative care = 77 (8) Gender (M/F): • Motivation and support (N): 8/24 • Standard post-operative care (N): 6/21	Standard care plus intervention programme consisting of a post-operative motivational videotape, in-hospital support visit from a peer-counsellor, and a tailored outpatient physical therapy.	Standard post-operative care and rehabilitation services offered by hospital and supportive telephone contact.	• Critical ○ Overall quality of life (at 6 months) • Important ○ Pain (at 6 months)
Castillo 2013 Prospective and	N= 251 Participants sustained one or more extremity	Standard care plus access to Trauma Support Network. This programme integrates 4	Standard care.	• Critical ○ Overall quality of life (at 6 months)

Study	Population	Intervention[a]	Control[a]	Outcomes
retrospective cohort study USA	injuries with no serious brain injury. Age in years [Mean (SD)]: • Trauma Support Network = 36.9 (14.1) • Standard care = 38.0 (12.5) Gender (M/F): • Trauma Support Network (N): 95/31 • Standard care (N): 44/81	supportive aspects of peer-support, self-management, information and resources, and provider training.		○ Changes in mood (at 6 months) • Important ○ None
Coker 2019 RCT USA	N=81 People with traumatic or non-traumatic SCI at any level Age in years [Mean (SD)]: • Therapeutic intervention programme: 48.0 (12.8) • Waitlist control: 52.0 (15.3) Gender (M/F): • Therapeutic intervention programme (N): 34/7 • Waitlist control (N): 32/8	Educationally-based group therapeutic programme consisting of weekly 2 hour sessions, for 6 weeks. Skills were aims at acceptance of injury and building confidence.	Waitlist control	• Critical ○ Changes in mood (at 6 weeks; 24 weeks) • Important ○ None
Elinge 2003 RCT Sweden	N= 43 Patients with hip or vertebral fracture. Age in years [Mean (SD)]: • Small group learning = 73.1 (7.3)	Small group learning programme consisting of multi-disciplinary lectures, as well as individually tailored home-training schedule.	Standard care and rehabilitation.	• Critical ○ None • Important ○ Changes in ADL (at intervention completion)

Study	Population	Intervention[a]	Control[a]	Outcomes
	• Standard care and rehab = 73.8 (11.1) Gender (M/F): • Small group learning (N): 5/16 • Standard care and rehab (N): 3/11			
Holmes 2007 RCT Australia	N= 90 Patients with major physical trauma without major head injury. Age in years [Mean (SD)]: • Interpersonal counselling = 39.9 (15.8) • Standard care = 36.4 (14.8) Gender (M/F): • Interpersonal counselling (N): 36/15 • Standard care (N): 27/12	Interpersonal counselling for initial 3 months following trauma. Sessions included identifying the impact of trauma, grief, loss and strategies for adaptation.	Standard care included non-specific psychological support.	• Critical ○ Changes in mood (at 3 months; 6 months) • Important ○ None
Kooijmans 2017 RCT The Netherlands	N= 64 Physically inactive participants with chronic SCI, able to use a hand-rim wheelchair. Age in years [Mean (SD)]: • HABITS = 48 (10) • Single meeting control = 49 (11) Gender (M/F):	Healthy Active Behavioural Intervention in SCI (HABITS) programme involving a home visit and 5 group sessions over 16 weeks, plus an information booklet. Designed to facilitate an active lifestyle and increase self-management.	One group meeting providing information on maintaining an active lifestyle with SCI plus an information booklet.	• Critical ○ Overall quality of life • Important ○ Changes in ADL

Study	Population	Intervention[a]	Control[a]	Outcomes
	• HABITS (N): 21/12 • Single meeting control (N): 24/7			
Mercier 2015 RCT USA	N= 142 Participants with spinal cord dysfunction and using a wheelchair for at least 6 hours a day. Age in years [Mean (SD)]: • CareCall = 45.8 (12.1) • Standard care and resource book = 45.0 (14.0) Gender (M/F): • CareCall (N): 42/11 • Standard care and resource book (N): 34/19	CareCall – 6 months of scheduled, automated telephone calls designed to deliver educational content, peer support and clinical expertise, as well as CareCall resource book.	Standard care plus CareCall resource book.	• Critical ○ Changes in mood (at 6 months) • Important ○ Changes in ADL (at 6 months)
Migliorini 2016 RCT Australia	N=59 Participants with SCI, more than 6 months after trauma and with symptoms of depression. Age in years [Mean (SD)]: • Psycho-educational programme: 47.5 (12.2) • Waitlist control: 52.8 (12.9) Gender (M/F): • Psycho-educational	Psycho-educational programme based on CBT, lasting 10 sessions (10 min – 1 hour duration)	Waitlist control	• Critical ○ Changes in mood (at 10-12 weeks) • Important ○ None

Study	Population	Intervention[a]	Control[a]	Outcomes
	programme (N): 25/9 • Waitlist control Control (N): 17/8			
Mohaddes Ardebili 2017 RCT	N= 100 Burn patients Age in years (18-28/29-38/39-48/49-58): • Multimedia self-care education (N) = 11/15/17/7 • Self-care recommendation (N) = 10/22/14/6 Gender (M/F): • Multi-media self-care education (N): 23/28* • Self-care recommendation (N): 22/28 * Adds up to 51, double checked reported figures.	Individually delivered routine self-care recommendation plus a burn patient self-care CD, educational books and information resources.	Individually delivered routine self-care recommendation	• Critical ○ Overall quality of life (at 3 months) • Important ○ None
Nooijen 2016a RCT The Netherlands	N= 45 Individuals with SCI who have already undergone inpatient rehabilitation and dependent on a manual wheelchair. Age in years [Mean (SD)]: • Motivational interviewing = 44 (15) • Standard care = 44 (15) Gender (M/F):	A motivational interviewing intervention given during 13 individual sessions. The intervention consisted of feedback on daily wheelchair activity from bicycle odometers, planning of when and how to be physically active, a home visit to optimise the home environment and provision of helpful information.	Standard care, including a handcycle training programme and advice on physical activity post-discharge.	• Critical ○ None • Important ○ Changes in ADL (at discharge; 6 months; 12 months)
Nooijen 2016b RCT The Netherlands				• Critical ○ Changes in mood (at discharge; 6 months; 12 months) • Important ○ Pain (at discharge; 6 months; 12 months)
Nooijen 2017				• Critical

Study	Population	Intervention[a]	Control[a]	Outcomes
RCT The Netherlands	• Motivational interviewing (N): 17/3 • Standard care (N): 16/3			○ Overall quality of life (at discharge; 6 months; 12 months) • Important ○ None
Pirente 2007 RCT Germany	N= 171 People with at least 2 recent traumatic injuries. Age in years [Mean (range)]: • CBT-based psychotherapy = 39 (18-69) • Standard care = 38 (21-65) Gender (M/F): • CBT-based psychotherapy (N): 28/17 • Standard care (N): 37/10	Standard care with a CBT-based psychotherapy intervention.	Standard care	• Critical ○ Overall quality of life (at 6 months) ○ Changes in mood (at 6 months; 12 months) • Important ○ None
Schulz 2009 RCT USA	N= 173 caregiver/care recipient dyads Individuals with impaired mobility due to an SCI and their caregivers. Age in years [Mean (SD)]: *Caregivers* • Dual target = 50.7 (14.3) • Caregiver only = 53.7 (14.3) • Writen information = 53.4 (15.8) *Care recipients* • Dual target = 53.4 (12.7) • Caregiver only = 57.7 (12.5)	<u>Caregiver only</u> Seven individual education sessions for caregivers of people with SCI, focusing on cognitive skills to reduce stress and improve mental and physical health. Also received increased access to support resources, and 5 additional telephone-based group support sessions. <u>Dual target intervention</u> Caregiver portion of intervention as described above as well as 7 individual education sessions delivered to SCI care recipients, focusing on SCI knowledge	Written pack containing information SCI and caregiving, as well as 3 telephone contacts during study period.	• Critical ○ Overall quality of life (at 12 months) ○ Changes in mood (at 12 months) • Important ○ None

Study	Population	Intervention[a]	Control[a]	Outcomes
	• Written information = 54.4 (13.2) Gender (M/F): Caregivers • Dual target (N): 9/48 • Caregiver only (N): 14/42 • Written information (N): 19/41 Care recipients • Dual target (N): 41/16 • Caregiver only (N): 18/38 • Written information (N): 27/33	and cognitive skills to reduce stress and improve mental and physical health. Also received increased access to support resources, and 5 additional telephone-based group support sessions.		
Wiechman 2015 RCT USA	N= 81 Participants undergoing outpatient rehabilitation for burns either: greater than 15% body area, less than 15% body area requiring surgical closure or less than 15% body area and located on face, hands or over a joint. Age in years [Mean (SD)]: • Moitvational interviewing = 43.23 (16.92) • Standard care = 43.68 (17.13) Gender (M/F): • Motivational interviewing (N): 25/15	Motivational interviewing plus standard outpatient care from clinic. Participants were contacted 8 times throughout the study by an expanded care coordinator. Each call reviewed medical and psychological issues, as well as participant goals and progress towards them.	Standard outpatient care from burn clinic, involving a multi-disciplinary team of nurse, surgeon, physical and occupational therapist, vocational counsellor and psychologist.	• Critical ○ Overall quality of life (at 6 months; 12 months) ○ Patient acceptability (at 6 months; 12 months) • Important ○ Changes in ADL (at 6 months; 12 months)

Study	Population	Intervention[a]	Control[a]	Outcomes
	• Standard care (N): 29/12			
Zidén 2008 RCT Sweden	N= 212 Individuals after acute hip fracture surgery. Age in years [Mean (SD)]: • Supported discharge = 81.2 (5.9) • Standard care and rehab = 82.5 (7.6) Gender (M/F): • Supported discharge (N): 19/29 • Standard care and rehab (N): 12/42	Standard care and rehabilitation, plus support discharge for home rehabilitation. Patients were offered a tailored rehabilitation programme while in hospital, as well as increased support and prior planning of discharge. Home rehabilitation included a motivational interviewing component to increase a patient's motivation and self-efficacy.	Standard care and rehabilitation, consisting of training for everyday tasks, transfer techniques, training with technical aids and stair walking. Group-based physiotherapy and occupational therapy training sessions were also provided.	• Critical ○ None • Important ○ Changes in ADL (at 1 month)

CBT: cognitive behavioural therapy; F: female; M: male; N: number; RCT: randomised controlled trial; SCI: spinal cord injury; SD: standard deviation
(a) For full details about the intervention/comparison, please see the evidence tables in Appendix D

See the full evidence tables in appendix D. No meta-analysis was conducted (and so there are no forest plots in appendix E).

Results and quality assessment of clinical outcomes included in the evidence review

Summary of the evidence

No meta-analyses were performed as the interventions or outcomes were either not sufficiently similar to allow them to be combined or they were not reported by more than one study.

No evidence was found about cosmetic interventions for trauma-induced changes to the body.

Included evidence showed:

Psychological therapies for adjustment and engagement

One study investigated a motivational intervention versus standard post-operative care (Allegrante 2007). At 6 months, no statistically or clinically important differences were found between the groups in physical functioning (low quality evidence), general health (very low quality evidence), mental health (very low quality evidence) and pain (very low quality evidence). One study investigated an interpersonal counselling intervention versus standard care (Holmes 2007) and found no clinically important differences between the groups in depression or anxiety at 3 or 6 months (all very low quality evidence). One study investigated a peer support telephone call service versus standard care (Mercier 2015) and measured

depression and physical independence at 6 months' follow-up. No clinically important differences were found between the groups for either outcome (low quality evidence for depression, moderate quality evidence for physical independence). One RCT (Migliorini 2016) did not find any differences in levels of anxiety or depression between people receiving on-line based CBT and waitlist controls at intervention completion (10-12 weeks from baseline) (very low quality evidence). The final study compared the effectiveness of CBT-based psychotherapy versus standard care (Pirente 2007) and measured health related quality of life, depression and anxiety in participants at 6 months' post trauma, as well as depression and anxiety at 12 months' post trauma. No clinically important differences were found between the 2 groups for overall quality of life or depression and anxiety (as measured by STAI, all very low quality evidence). However, anxiety measured using SSCS5 was statically significantly, but not clinically importantly, higher (worse) in the group receiving the CBT-psychotherapy at both 6 and 12 months (very low quality evidence).

Family support

One study was a three-arm RCT comparing the following three interventions: 1) a caregiver only education and group telephone support intervention, 2) a dual target caregiver and care-recipient education and group telephone support intervention, and 3) a written information pack (Schulz 2009). No clinically important differences between groups were found in health symptoms, social integration and depression at 12 months' follow-up between the caregiver only education and support group and the written information only group (low quality evidence). Additionally, no clinically important difference was found between the dual target intervention group and control groups for depression at 12 months' follow-up (low quality evidence). Health symptoms were statistically significantly, but not clinically importantly, lower (better) in dual target group when compared to the information only group at 12 months' follow-up, while social integration at 12 months' follow-up was both statistically significantly and clinically importantly lower (worse) in the dual target intervention group (both low quality evidence).

Self-management interventions

One cohort study investigated the effect of a Trauma Support Network programme compared to historical standard care (Castillo 2013). No clinically important differences were found between the two groups in mental component scores (SF-12), physical component score (SF-12) or anxiety at 6 months from baseline (low quality evidence). However, there was a statistically significantly, but not clinically importantly, lower (better) depression score in the Trauma Support Network group when compared to the control group at 6 months following baseline (very low quality evidence). One RCT (Coker 2019) did not find any differences in mood (measured using the Patient Health Questionnaire) between people receiving an 'Educationally-based group therapeutic programme' and 'Waitlist controls' after intervention completion and at 24 weeks follow-up after intervention completion (both very low quality evidence). One RCT investigated a group learning programme versus standard care (Elinge 2003). According to analyses performed by the authors, no statistically significant difference was found for changes in ADL at either intervention completion or 12 months after intervention completion (very low quality evidence). There was a lack of published MIDs and the committee were not confident in stating their own, so clinical importance could not be judged. One RCT investigated the effectiveness of the Health Active Behavioural intervention in SCI (HABITS) programme versus a single information meeting (Kooijmans 2017). No clinically important difference was found between groups for overall quality of life and changes in ADL at either 16 weeks or 42 weeks following baseline (very low quality evidence). The final study investigated the effectiveness of a multimedia self-care education and information package compared to self-care information only (Mohaddes Ardebili 2017) and found that overall quality of life was statistically significantly and clinically importantly higher (better) in the intervention group compared to the control group at 3 months after intervention completion (low quality evidence).

Person-centred goal setting

Two RCTs investigated the effectiveness of motivational interviewing compared to standard care (Nooijen 2016a, Wiechman 2015). No clinically important differences were found between groups for any measure of overall quality of life at any time point (moderate to very low quality evidence), apart from participation and the mental health component of SF-12. Participation was reported to be statistically significantly and clinically importantly lower (worse) in participants receiving motivational interviewing compared to standard care at discharge (2 months from baseline) (very low quality evidence). Additionally, a statistically significantly, though not clinically importantly, higher (better) mental health score (SF-12) at 12 months after discharge was reported in participants receiving motivational interviewing when compared to participants receiving standard care (low quality evidence). No clinically important difference was found in patient satisfaction between the groups at 6 months, but a statistically significantly and clinically importantly higher (better) patient satisfaction was found in the motivational interviewing group at 12 months compared to control (both low quality evidence). No clinically important differences were found for changes of mood between the groups at 2 months after baseline, 6 months after discharge or 12 months after discharge (very low quality evidence). No clinically important differences were found in goal attainment scores between groups at 6 months (low quality evidence) or 12 months (moderate quality evidence). No clinically important difference was found in wheel physical activity between groups at 2 months after baseline or 12 months (both very low quality evidence), but a statistically significantly and clinically importantly higher (better) level of wheel physical activity was found at 6 months in participants receiving motivational interviewing compared to control participants (very low quality evidence). Similarly, self-reported activities of daily living (measured using Physical Activity Scale for Individuals with Physical Disabilities) were statistically significantly and clinically importantly higher (better) in people receiving motivational interviewing compared to those receiving standard care at 6 and 12 months (both low quality evidence). No clinically important difference was found in levels of pain intensity between groups at 2 months after baseline, or 6 months and 12 months after discharge (all very low quality evidence). Similarly, no clinically important difference was found in pain disability between groups 6 months after discharge (very low quality evidence). However, a statistically significantly and clinically importantly higher (worse) pain disability score was found in participants receiving motivational interviewing compared to standard care at 12 months after discharge (very low quality evidence).

One RCT investigated the effectiveness of supported discharge plus motivational interviewing versus standard care and rehabilitation (Zidén 2008). There was a statistically significantly and clinically importantly higher (better) ADL in the motivational interview group compared to the standard care group at 1-month follow-up (moderate quality evidence).

The quality of the evidence was assessed using GRADE. See the evidence profiles in appendix F.

Clinical evidence: Children and young people

Included studies

One RCT was found for this review (Maskell 2014). This study examined quality of life in child and adolescent burn patients using a skin camouflage intervention (Microskin™) compared to a wait-list control group.

The included studies are summarised in Table 3.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix K.

Summary of studies included in the evidence review

Summaries of the studies that were included in this review are presented in Table 4.

Table 4: Summary of included studies.

Study	Population	Intervention[a]	Control[a]	Outcomes
Maskell 2014 RCT Australia and New Zealand	N= 63 Children and young people with a post-acute healing stage burn and mature scarring. Age in years [Mean (SD)]: • Skin camouflage = 12.23 (1.97) • Wait-list = 13.31 (2.22) Gender (M/F): • Skin camouflage (N): 11/24 • Wait-list (N): 4/24 Percentage TBSA [Mean (SD)]: • Skin camouflage: 23.53 (19.48) • Wait-list: 21.19 (19.52)	Microskin™ Skin Camouflage Training for participants, parents and carers in how to apply Microskin™ and provision of necessary equipment before the start of the study. Participants used the camouflage product for 8 weeks.	Wait-list control	• Critical ○ Overall quality of life (at 8 weeks) • Important ○ None

F: Female; M: Male; N: Number; RCT: Randomised controlled trial; SD: Standard deviation; TBSA: Total burn surface area; TM: Trademark
(a) For full details about the intervention/comparison, please see the evidence tables in Appendix D

See the full evidence tables in appendix D. No meta-analysis was conducted (and so there are no forest plots in appendix E).

Results and quality assessment of clinical outcomes included in the evidence review

Summary of evidence

No meta-analyses were performed as there was only one study.

Evidence was found for overall quality of life. No evidence was found for the following pre-defined clinical outcomes:

- Patient, families and carers' acceptability
- Changes in mood
- Return to nursery, education, training or work
- Changes in ADL
- Pain
- Changes in the 'Family Needs Questionnaire' scores

No evidence was found for the following pre-defined interventions:

- Psychological therapies for adjustment and engagement family support
- Self-management interventions
- Person-centred goal setting
- Play therapy
- Family therapy
- Interventions for adaptive dysfunction and behavioural disturbance

Evidence showed no statistically significant or clinically important difference in overall quality of life between participants receiving the Microskin™ skin camouflage and the wait-list control group when measured at 8 weeks (very low quality evidence).

The quality of the evidence was assessed using GRADE. See the evidence profiles in appendix F.

Economic evidence: Adults and children and young people

Included studies

A systematic review of the economic literature was conducted but no economic studies were identified which were applicable to these review questions. A single economic search was undertaken for adult, and children and young people reviews. Please see the study selection flow chart in appendix G.

Excluded studies

Studies not included in these reviews with reasons for their exclusions are provided in appendix K.

Summary of studies included in the economic evidence reviews

No economic evidence was identified which was applicable to these review questions.

Economic model

No economic modelling was undertaken for these reviews because the committee agreed that other topics were higher priorities for economic evaluation.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

When selecting the critical and important outcomes, the committee agreed that the outcomes needed to be sufficiently generalisable to adequately capture patient-important outcomes for the whole adult and child and young people populations, respectively, which they recognised are quite large and very heterogeneous.

For both adults and children and young people, they therefore prioritised overall quality of life, patient acceptability (including family or carer) and changes in mood as critical outcomes. Overall quality of life was selected as the committee considered that one of the main aims of people with traumatic injury would be to achieve similar quality of life as before the injury. Patient acceptability was also included as a critical outcome as how acceptable a patient finds the rehabilitation intervention is likely to have a large impact in their compliance. Changes in mood was also included as a critical outcome because mood disorders are common in people with traumatic injury and this outcome reflects the psychological wellbeing.

The committee selected return to education or work and changes in ADL as important outcomes, as these outcomes measure the level of functional independence after traumatic injury. Pain was also selected as an important outcome because pain plays a pivotal role in a person's compliance with rehabilitation programmes and affects quality of life and the ability to undertake ADL. The committee realised that there are many difficulties in measuring these domains for babies, due to their inability to self-report and the lack of validated measurement tools available. Therefore, 2 early childhood-specific outcomes (Alberta Infant Motor Scale and Bayley Assessment score) were also included as critical outcomes for babies with complex rehabilitation needs following trauma. For children and young people, changes in the 'Family Needs Questionnaire' was also considered to be an important outcome, as it measures how reflect how rehabilitation is affecting the family unit as a whole.

Evidence was found for 6 of these outcomes: overall quality of life, patient acceptability, changes in mood, changes in activity of daily living and pain. No evidence was found for return to work or education.

The quality of the evidence

For adults, 13 RCTs and 1 cohort study were included as evidence for psychological and psychosocial rehabilitation interventions. The overall quality of the evidence was assessed using GRADE and ranged from very low to moderate quality, with the majority being very low quality. The main reasons for downgrading the evidence were risk of bias in the study designs (for example, insufficient information provided on randomisation processes and lack of participant blinding), imprecision of the effect size and indirectness (for example, if study population included a mixture of non-traumatic and traumatic injuries).

For children and young people, 1 RCT was included as evidence for psychological and psychosocial rehabilitation interventions. The overall quality of the evidence was assessed using GRADE and was very low quality. The main reasons for downgrading the evidence were risk of bias in the study designs (for example, lack of information on the frequency of intervention and high loss to follow-up) and imprecision of the effect size.

The committee therefore made the recommendations based on a combination of the evidence and their experience and expertise.

Benefits and harms

The adult evidence review did not identify any evidence on immediate psychological and emotional support for people following traumatic injury. In the committee's experience, healthcare professionals may not feel comfortable in offering emotional and psychological support to people following traumatic injury if they are not psychologically trained. However, the committee wanted to highlight that this support is invaluable to people following traumatic injury, and can be as simple as listening to concerns. Healthcare professionals should not feel reticent about seeking advice and support from psychology services if needed, which could prevent unnecessary referrals delays in people receiving emotional and psychological support.

Psychological management should be included from the start of a person's rehabilitation journey, forming part of the rehabilitation needs assessment. The committee wanted to highlight the risk factors that may be present in a patient's history or background, including past and current psychological symptoms beyond what is expected from an acute stress response. Additionally, the committee discussed several social factors that may affect rehabilitation engagement. These factors may change the rehabilitation needs or goals of a person, and should be taken into consideration in order to ensure equal treatment of individuals with traumatic injury. If needed, a referral for a formal psychological assessment with a psychologist experienced in physical trauma and rehabilitation or a member of the liaison psychiatry team can should be made to ensure that these pre-identified psychological and psychosocial risk factors are appropriately considered during the development of the rehabilitation plan is appropriately developed.

The committee discussed the importance of reassuring individuals that an acute stress response is normal following traumatic injury, and that this transient disorder does not necessarily mean that they will require psychological or psychosocial intervention. The committee highlighted common several psychological symptoms that may accompany ongoing adjustments after a traumatic injury, in order for people to better identify if and when psychological services may need to be referred to.

The committee discussed the importance of setting goals throughout rehabilitation after traumatic injury. Rehabilitation goals can be motivational, both as something to attain and something to mark progress. The committee noted that, although evidence was searched for all person-centred goal setting interventions, identified evidence was limited to motivational interviewing, which is a very specific technique within goal setting and not suitable for every individual. Additionally, evidence was judged to be mostly very low or low quality. For these reasons, the committee decided to not specify this technique within the recommendations and instead allow physicians to determine which modality is best for each individual. Using thir clinical expertise and experience, the committee agreed to recommend that goal setting should be introduced as early as possible in rehabilitation and that these goals should be revisited with the patient at regular intervals to help manage levels of psychological adjustment.

While the adult component of this evidence review found 5 studies investigating psychological therapies for adjustment and engagement of patients following traumatic injury, no clinically important differences were reported between groups for measures of changes in mood, changes in ADL, overall quality of life and pain. Evidence was mainly of low or very low quality. The committee discussed how these findings disagreed with their own professional experiences,reporting many beneficial results in their patients. They discussed that a possible reason for this is because there is no 'one size does not fit all' within psychological and psychosocial therapies. Due to people's unique pyschology and traumatic injury, not everyone will see benefits from the same study intervention. The committee discussed that often people will have to try multiple different therapies until they find the one that works for them, which is not possible in study conditions. The committee agreed that it is important to offer psychological and emotional support to all people who report or

demonstrate symptoms of anxiety, depression and distress interfering with return to their daily life after trauma. They further agreed that this support can be delivered by any member of the MDT with appropriate skills and expertise in supporting patients after traumatic injury, but that an urgent referral for timely access to psychology services (ideally with expertise in physical trauma) is warranted when rehabilitation is adversely affected by psychological factors. These can include failure to progress or failure to engage.

No clinically important difference was detected between groups in health symptoms, social integration or depression in a study investigating the effectiveness of family-support interventions for adults with rehabilitation needs following traumatic injury. Again, this disagreed with many of the committee's experiences, who reported that including family-support interventions was beneficial following traumatic injury. This is because trauma does not just affect the individual, but their family and friends too. People in the external support network also need to accept changes and adapt post-injury. However, the committee agreed that each individual's personal circumstances and support needs are different. Rather than making specific recommendations about the use of family-support interventions, the committee decided to highlight the importance of including family in care discussions about psychological interventions.

The committee discussed the importance of recognising the increased risk of mood disorders accompanying traumatic injuries, and rehabilitation afterwards, and the lay members of the committee stressed how easy it is for patients to hide such symptoms from healthcare staff. Additionally, psychological disorders may develop and reoccur at any stage of the recovery pathway. In the committee's experience, psychological symptoms can often be overlooked once a patient is transferred to outpatient services, as well as transferring to another unit. Psychological disorders (for example, anxiety, depression or PTSD) may occur or reoccur during these key rehabilitation milestones, and it is therefore important that healthcare professionals check regularly for these symptoms so they can factor potential barriers to a rehabilitation programme (for example, decreased engagement). It is important that safe-guarding is prioritised at these points as well, with healthcare professionals actively ask people about thoughts of self-harm and suicide at all stages of patient's recovery.

Evidence was identified from 4 RCTs and 1 cohort study investigating self-management interventions in the adult population. Four of these studies did not report any clinically important differences in outcomes between groups and the majority of the evidence was of low or very low quality. These studies all consisted of rigid learning protocols, which the committee felt was not beneficial in psychological treatment because everybody's personal circumstances and support needs are different, and therefore did not wish to make any recommendations based on these studies. The committee discussed the evidence from the remaining study, on the beneficial impact on quality of life of multimedia self-care education and information packages on individuals with traumatic injury. Although they noted that the evidence was of low quality and only from one trauma population (burn injuries), the committee discussed that the results of the study agreed with their clinical experience. This was further strengthened by testimony from the expert witness on using standardised educational materials to prepare people for their residential rehabilitation programmes. This has been a relatively recent modification to the rehabilitation programme and driven by national pandemic legislation, so there was no data presented. However, the expert witness commented that a pre-rehabilitation virtual education programme has been well received by healthcare professionals and people undergoing rehabilitation, as well as decreasing the length of inpatient rehabilitation programme. Due to the low quality of the evidence showing a beneficial effect, the committee agreed with increasing access to education and access to information for people with rehabilitation needs, and recommended considering using a multimedia self-care package to supplement rehabilitation and used their experience and knowledge to suggest areas to include information on. Additionally, they highlighted that not everyone will have access to the internet, but that this should not affect their ability to access these materials. If this is the case, healthcare professionals should explore other ways of

delivering information. The committee also included a research recommendation to investigate the effectiveness of a self-management intervention for rehabilitation after traumatic injury in order for stronger recommendations to be made in future updates.

Only 1 study was identified for psychological rehabilitation programmes in children and young people following complex trauma, measuring the effectiveness of skin camouflage following burn injury on quality of life. No clinically important difference was reported between groups for this outcome and evidence was judged to be of very low quality. Additionally, the committee discussed that children with burn injuries have a very different rehabilitation when compared to other traumatic injury populations, often requiring extended inpatient stays and multiple re-admissions. This limits the generalisability of the study findings. Due to this, the committee decided not to make any recommendations in this area.

NICE guidance on post-traumatic stress disorder, anxiety, and depression already exist, and the committee recommended that people be treated in line with the appropriate guidelines; post-traumatic stress disorder, social anxiety disorder, generalised anxiety disorder and panic disorder in adults, depression in adults, depression in adults with a chronic physical health problem, depression in children and young people, and service user experience in adult mental health. However, they caveated that, in order for this treatment to be most effective, it should form part of an overall rehabilitation programme rather than being treated separately.

Cost effectiveness and resource use

There was no existing economic evidence for these reviews.

The committee explained that additional time might be required to reassure patients, discuss their goals in rehabilitation, assess past or present psychological symptoms, explore the presence of additional risk factors. The committee explained that all of the above are currently done and are good care principles, and will not incur substantial resources to services.

The committee explained that basic psychological and emotional support is currently available across their services. Anyone could deliver such support within multidisciplinary teams. The committee acknowledged that there might be additional training needs. However, services should be able to draw on existing expertise within their broader services. This recommendation reflects standard practice.

Similarly, referring individuals who fail to progress or fail to engage with psychological services reflect standard practice and are justified by a clinical need. Referrals happen currently, and this recommendation will not result in substantial additional referrals to psychological services. The recommended treatment pathways have also established cost-effectiveness in the respective cross-referred guidelines, e.g. the NICE guidelines on depression in adults and common mental health problems.

The recommendations on the ongoing risk of low mood, discussing and providing information on psychological support modalities, and signposting for support are based on the committee expert opinion, represent good care principles, and will not incur additional resources to services.

The committee explained that including information on, e.g. mental health, peer support services, in a tailored package of online education and learning materials as part of a self-management rehabilitation programme would not incur additional costs to the services. It would be mainly signposting to existing resources. The committee also explained that various charities provide self-care information that could be included in such a package.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.1.3, 1.2.21, 1.2.22, 1.5.1, 1.5.4, 1.5.7, 1.9.3, 1.13.1 to 1.13.7 and research recommendations in the NICE guideline

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Appendices

Appendix A – Review protocols

Review protocol for review question: What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

Table 5: Review protocol for psychological and psychosocial rehabilitation interventions for adults

ID	Field	Content
0.	PROSPERO registration number	CRD42019135320
1.	Review title	Rehabilitation packages and programmes for adults
2.	Review question	2.3a: What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?
3.	Objective	To evaluate the effectiveness of psychological and psychosocial rehabilitation interventions among adults with complex rehabilitation needs after traumatic injury
4.	Searches	The following databases will be searched: • Cochrane Central Register of Controlled Trials (CENTRAL) • Cochrane Database of Systematic Reviews (CDSR) • Embase • MEDLINE Searches will be restricted by: • Date: 1995 onwards as there has been significant change in practice since then • English language • Human studies The full search strategies for MEDLINE database will be published in the final review.
5.	Condition or domain being studied	Complex rehabilitation needs resulting from traumatic injury 'Complex rehab needs' refers to 'multiple needs, and will always involve coordinated multidisciplinary input from 2 or more allied health professional disciplines, and also include the following: • Vocational or educational social support for the person to return to their pervious functional level, including return to work, school or college

ID	Field	Content
		• Emotional, psychological and psychosocial support • Equipment or adaptations • Ongoing recovery from injury that may change the person's rehabilitation needs (for example, restrictions of weight bearing, cast immobilisation in feature clinic) Further surgery and readmissions to hospital Traumatic injury is defined as 'traumatic injury as injury that requires admission to hospital at the time of injury.'
6	Population	Inclusion: Adults (aged 18 years or above) with complex rehabilitation needs resulting from traumatic injury that required admission to hospital Exclusion: • Adults with complex rehabilitation needs resulting from traumatic brain injury (including anoxic brain injury, for example, drowning and strangulation) • Adults with traumatic injuries who do not have complex rehabilitation needs and/or do not require admission to hospital • Adults with complex rehabilitation needs resulting from traumatic injury who are admitted to the ICU
7	Intervention	Standard rehabilitation care consisting of: physiotherapy [range of movement exercises, exercises to maintain muscle function, mobilisation and training with mobilisation aids such as crutches or frame], occupational therapy assessment, and identification and support of basic activities of daily living through training or aids (e.g. toileting equipment, perching stools, long-handled aids, adapted eating utensils) in addition to at least one of the following: • Cosmetic interventions for trauma induced changes to the body e.g. skin camouflage, tattooing) • Psychological therapies for adjustment and engagement (Compassionate mind therapy, Acceptance and commitment therapy, Mindfulness, Visualisation or 'mentalisation' to support physical rehab, Relaxation [progressive, or breathing based, or other], Cognitive behavioural therapy) • Family support (including education, advice, signposting to useful agencies such as Citizens advice) • Self-management interventions (i.e., education to understand how one might be affected by fatigue, depression, Bridges Self-management, conversation with consultant etc.) • Person-centred goal setting (including motivational interviewing) Exclusion: • Rehabilitation packages and programmes relating to traumatic brain injury, sight loss and hearing loss

ID	Field	Content
		• Social care interventions (for example, home care or personal assistance) • Long-term care and rehabilitation packages for people with long-term care needs • Specific pain management interventions
8	Comparator/Reference standard/Confounding factors	1) Standard rehabilitation care consisting of: physiotherapy [range of movement exercises, exercises to maintain muscle function, mobilisation and training with mobilisation aids such as crutches or frame], occupational therapy assessment, and identification and support of basic activities of daily living through training or aids (e.g. toileting equipment, perching stools, long-handled aids, adapted eating utensils). 2) Studies that employ the same intervention program as listed under 'interventions' but vary it in terms of any of the following: • Frequency • Intensity • Timing
9	Types of study to be included	• Randomised controlled trials (RCTs) • Systematic review of RCTs If no RCT data are available for an intervention, evidence from the followings will be considered in order • Cluster-randomised trial • Systematic review of non-randomised studies • Comparative prospective cohort studies with N≥100 per treatment arm • Comparative retrospective cohort studies with N≥100 per treatment arm
10	Other exclusion criteria	Study design: • Cross-over design • Case-controls • Cross-sectional • Case series and case reports • Audits Language: • Non-English

ID	Field	Content
		Publication status: • Abstract only
11	Context	Settings - Inclusion: • All inpatient, outpatient and community settings in which rehabilitation services following traumatic injury are provided Exclusion: • Accident and emergency departments • Critical care units • Prisons
12	Primary outcomes (critical outcomes)	Critical: • Overall quality of life [EURO-QoL 5D 3L, SF-36, SF-12, SF-6D, SFMA] • Patient acceptability (any direct measure) • Changes in mood [Depression measures – HADS, PHQ-9, BDI, DAS] Timeframe for the follow-up will be 0 to 18 months. This will be grouped into short-term (0 to 6 months) and long-term (>6 to 18 months).
13	Secondary outcomes (important outcomes)	Important: • Return to work or education • Changes in activity of daily living (COPM, Barthel ADL index, Katz, PSMS, OARS, PAT, E-ADL-Test, GAS, FIMFAM) • Pain (e.g. VAS) Timeframe for the follow-up will be 0 to 18 months. This will be grouped into short-term (0 to 6 months) and long-term (>6 to 18 months).
14	Data extraction (selection and coding)	All references identified by the searches and from other sources will be uploaded into STAR and de-duplicated. 5% of the abstracts will be reviewed by two reviewers, with any disagreements resolved by discussion or, if necessary, a third independent reviewer. The full text of potentially eligible studies will be

ID	Field	Content
		retrieved and will be assessed in line with the criteria outlined above. A standardised form will be used to extract data from studies (see Developing NICE guidelines: the manual section 6.4).
15	Risk of bias (quality) assessment	Risk of bias will be assessed using the appropriate checklist as described in Developing NICE guidelines: the manual.
16	Strategy for data synthesis	NGA STAR software will be used for generating bibliographies/citations, study sifting and data extraction. If pairwise meta-analyses are undertaken, they will be performed using Cochrane Review Manager (RevMan). 'GRADEpro' will be used to assess the quality of evidence for each outcome.
17	Analysis of sub-groups	No subgroups were specified for this question for stratification of the data, but if there is heterogeneity, we will look at the following subgroups to try to identify the source of it: • Upper limb / lower limb • People with pre-existing physical and/or mental health conditions (including substance misuse), physical and learning disability • Age below 65 years / age above 65 years • Frail / not frail • Vulnerable adults or those who require safeguarding
18	Type and method of review	Intervention
19	Language	English
20	Country	England
21	Anticipated or actual start date	07/09/2019
22	Anticipated completion date	23/10/2019
23	Stage of review at time of this submission	Review stage — Started — Completed Preliminary searches Piloting of the study selection process Formal screening of search results against eligibility criteria

ID	Field	Content
		Data extraction Risk of bias (quality) assessment Data analysis
24	Named contact	National Guideline Alliance
25	Review team members	National Guideline Alliance
26	Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance which receives funding from NICE.
27	Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.
28	Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/ng211/history
29	Other registration details	
30	Reference/URL for published protocol	
31	Dissemination plans	
32	Keywords	
33	Details of existing review of same topic by same authors	
34	Current review status	
35	Additional information	
36	Details of final publication	www.nice.org.uk

ADL: Activities of daily living; BDI: Beck depression inventory; CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; CHQ CF-80: 80 item child health questionnaire; CHQ PF-50: 50 item child health questionnaire, parent completed; COPM: Canadian occupational performance measure; DARE: Database of Abstracts of Reviews of Effects; DAS: Disability assessment schedule; E-ADL-Test: Erlangen Activities of Daily Living test; EURO-QoL 5D 3L: EuroQol 5 dimensions and 3 levels; FIMFAM: Functional independence measure and functional assessment measure; GAS: Goal attainment scaling; GRADE: Grading of Recommendations Assessment, Development and Evaluation; HADS: Hospital anxiety and depression scale; HTA: Health Technology Assessment; ICU: intensive care unit; N: number; NGA: National Guideline Alliance; NHS: National health service; NICE: National Institute for Health and Care Excellence; OARS: Older Americans resources and services; PAT: Performance ADL test; PHQ-9: 9 item patient health questionnaire; PSMS: Physical self-maintenance scale; RCT: randomised controlled trial; RoB: risk of bias; SCIM: Spinal cord independence measure; SD: standard deviation; SFMA: Selective functional movement assessment; SF-12: 12 item short-form survey; SF-36: 36 item short-form survey; SF-6D: 6-dimension short-form; VAS: Visual; analogue scale

Review protocol for review question: What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?

Table 6: Review protocol for psychological and psychosocial rehabilitation interventions for children and young people

ID	Field	Content
0.	PROSPERO registration number	CRD42019135321
1.	Review title	Rehabilitation packages and programmes for children and young people
2.	Review question	2.3b: What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?
3.	Objective	To evaluate the effectiveness of psychological and psychosocial rehabilitation interventions among children and young people with complex rehabilitation needs after traumatic injury
4.	Searches	The following databases will be searched: • Cochrane Central Register of Controlled Trials (CENTRAL) • Cochrane Database of Systematic Reviews (CDSR) • Embase • MEDLINE • PsycInfo Searches will be restricted by: • Date: 1995 onwards as there has been significant change in practice since then • English language • Human studies

ID	Field	Content
		The full search strategies for MEDLINE database will be published in the final review.
5.	Condition or domain being studied	Complex rehabilitation needs resulting from traumatic injury 'Complex rehab needs' refers to 'multiple needs, and will always involve coordinated multidisciplinary input from 2 or more allied health professional disciplines, and also include the following: • Vocational or educational social support for the person to return to their pervious functional level, including return to work, school or college • Emotional, psychological and psychosocial support • Equipment or adaptations • Ongoing recovery from injury that may change the person's rehabilitation needs (for example, restrictions of weight bearing, cast immobilisation in feature clinic) • Further surgery and readmissions to hospital Traumatic injury is defined as 'traumatic injury as injury that requires admission to hospital at the time of injury.'
6	Population	Inclusion: Children and young people (aged below 18 years) with complex rehabilitation needs resulting from traumatic injury that required admission to hospital Exclusion: • Children and young people with complex rehabilitation needs resulting from traumatic brain injury (including anoxic brain injury, for example, drowning and strangulation) • Children and young people with traumatic injuries who do not have complex rehabilitation needs and/or do not require admission to hospital • Children and young people with complex rehabilitation needs resulting from traumatic injury who are admitted to the PICU
7	Intervention	Standard rehabilitation care consisting of: physiotherapy [range of movement exercises, exercises to maintain muscle function, mobilisation and training with mobilisation aids such as crutches or frame], occupational therapy assessment, and identification and support of basic activities of daily living through training or aids (e.g. toileting equipment, perching stools, long-handled aids, adapted eating utensils) in addition to at least one of the following:

ID	Field	Content
		• Cosmetic interventions for trauma induced changes to the body e.g. skin camouflage, tattooing) • Psychological therapies for adjustment and engagement (Compassionate mind therapy, Acceptance and commitment therapy, Mindfulness, Visualisation or 'mentalisation' to support physical rehab, Relaxation [progressive, or breathing based, or other], Cognitive behavioural therapy) • Family support (including education, advice, signposting to useful agencies such as Citizens advice or Changing Faces) • Self-management interventions (i.e., education to understand how one might be affected by fatigue, depression, Bridges self-management, conversation with consultant etc.) • Person-centred goal setting (including motivational interviewing • Play therapy • Family therapy (including sibling support) • Interventions for adaptive dysfunction and behavioural disturbance Exclusion: • Rehabilitation packages and programmes relating to traumatic brain injury, sight loss and hearing loss • Social care interventions (for example, home care or personal assistance) • Long-term care and rehabilitation packages for people with long-term care needs • Specific pain management interventions
8	Comparator/Reference standard/Confounding factors	1) Standard rehabilitation care consisting of: physiotherapy [range of movement exercises, exercises to maintain muscle function, mobilisation and training with mobilisation aids such as crutches or frame], occupational therapy assessment, and identification and support of basic activities of daily living through training or aids (e.g. toileting equipment, perching stools, long-handled aids, adapted eating utensils). 2) Studies that employ the same intervention program as listed under 'interventions' but vary it in terms of any of the following: • Frequency • Intensity • Timing
9	Types of study to be included	• Systematic review of RCTs

ID	Field	Content
		• Randomised controlled trial If no RCT data are available for an intervention, evidence from the followings will be considered in order • Cluster-randomised trial • Systematic review of non-randomised studies • Comparative prospective cohort studies with N≥100 per treatment arm • Comparative retrospective cohort studies with N≥100 per treatment arm
10	Other exclusion criteria	Study design: • Cross-over design • Case-controls • Cross-sectional • Case series and case reports • Audits Language: • Non-English Publication status: • Abstract only
11	Context	Settings - Inclusion: • All inpatient, outpatient and community settings in which rehabilitation services following traumatic injury are provided Exclusion: • Accident and emergency departments • Critical care units • Prisons
12	Primary outcomes (critical outcomes)	Critical:

ID	Field	Content
		• Overall quality of life including quality of sleep [e.g., CHQ-CF80, CHQ-PF-50, PEDS-QL, EURO-QoL 5D 3L Y, SF-36, SF-12, SF-6D, Tarn, SCIM]] • Patient and families and carers' acceptability (any direct measure; if not reported, but patient satisfaction is, this will be reported instead) • Changes in mood [Any measure, PEDS-QL, Depression measures – HADS, PH-Q9, BDI, DAS] Babies only: • Alberta Infant Motor Scale (AIMS; pre-term to 19 months. • Bayley Assessment (1 to 42 months) Timeframe for the follow-up will be 0 to 5 years. This will be grouped into short-term (0 to 6 months) and long-term (> 6 months to 5 years).
13	Secondary outcomes (important outcomes)	Important: • Return to nursery, education, training or work • Changes in activity of daily living (e.g., COPM, Barthel ADL index, Katz, PSMS, OARS, PAT, E-ADL-Test, GAS, FIMFAM) • Pain (VAS, any measure) • Changes in the 'Family Needs Questionnaire' scores. Timeframe for the follow-up will be 0 to 5 years. This will be grouped into short-term (0 to 6 months) and long-term (> 6 months to 5 years).
14	Data extraction (selection and coding)	All references identified by the searches and from other sources will be uploaded into STAR and de-duplicated. 5% of the abstracts will be reviewed by two reviewers, with any disagreements resolved by discussion or, if necessary, a third independent reviewer. The full text of potentially eligible studies will be retrieved and will be assessed in line with the criteria outlined above. A standardised form will be used to extract data from studies (see Developing NICE guidelines: the manual section 6.4.
15	Risk of bias (quality) assessment	Risk of bias will be assessed using the appropriate checklist as described in Developing NICE guidelines: the manual.
16	Strategy for data synthesis	NGA STAR software will be used for generating bibliographies/citations, study sifting and data extraction.

ID	Field	Content
		If pairwise meta-analyses are undertaken, they will be performed using Cochrane Review Manager (RevMan). 'GRADEpro' will be used to assess the quality of evidence for each outcome.
17	Analysis of sub-groups	The following subgroups were specified for this question for stratification of the data: • Children and young people who are suspected of sustaining non-accidental injuries versus accidental injuries • Children and young people with parents known to social services versus not known • Children and young people with young (< 20 years at birth of child) parents versus not young (≥ 20 years at birth of child) • Children and young people with parents from deprived backgrounds versus not deprived backgrounds • Children and young people with parents who have mental health issues versus none If there is any further unexplained heterogeneity, we will look at the following subgroups to try to identify the source of it: • Upper limb / lower limb • Children and young people with pre-existing physical and/or mental health conditions (including substance misuse), physical and learning disability versus no pre-existing conditions • Children and young people whose parents are very involved in their rehabilitation/recovery (e.g., by staying overnight in hospital) versus not involved • Age (0-3 versus 4-7 versus 8-12 versus 13-17
18	Type and method of review	Intervention
19	Language	English
20	Country	England
21	Anticipated or actual start date	16/08/2019
22	Anticipated completion date	21/10/2019
23	Stage of review at time of this submission	Review stage: Started ☑, Completed ☑ Preliminary searches

ID	Field	Content
		Piloting of the study selection process ☑ ☑ Formal screening of search results against eligibility criteria ☑ ☑ Data extraction ☑ ☑ Risk of bias (quality) assessment ☑ ☑ Data analysis ☑ ☑
24	Named contact	National Guideline Alliance
25	Review team members	National Guideline Alliance
26	Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance which receives funding from NICE.
27	Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.
28	Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/ng211/history
29	Other registration details	-
30	Reference/URL for published protocol	https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=135321

ID	Field	Content
31	Dissemination plans	
32	Keywords	
33	Details of existing review of same topic by same authors	
34	Current review status	
35	Additional information	
36	Details of final publication	www.nice.org.uk

ADL: Activities of daily living; BDI: Beck depression inventory; CCTR: Cochrane Controlled Trials Register; CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; CHQ CF-80: 80 item child health questionnaire; CHQ PF-50: 50 item child health questionnaire, parent completed; COPM: Canadian occupational performance measure; DARE: Database of Abstracts of Reviews of Effects; DAS: Disability assessment schedule; E-ADL-Test: Erlangen Activities of Daily Living test; EURO-QoL 5D 3L: EuroQol 5 dimensions and 3 levels; FIMFAM: Functional independence measure and functional assessment measure; GAS: Goal attainment scaling; GRADE: Grading of Recommendations Assessment, Development and Evaluation; HADS: Hospital anxiety and depression scale; HTA: Health Technology Assessment; ICU: intensive care unit; NGA: National Guideline Alliance; NICE: National Institute for Health and Care Excellence; NIHR: National Institute for Health Research; OARS: Older Americans resources and services; PAT: Performance ADL test; PEDS-QL: Paediatric quality of life inventory; PHQ-9: 9 item patient health questionnaire; PICU; paediatric intensive care unit; PSMS: Physical self-maintenance scale; SCIM: Spinal cord independence measure; SF-12: 12 item short-form survey; SF-36: 36 item short-form survey; SF-6D: 6-dimension short-form; RCT(s): Randomised controlled trial(s)

Appendix B – Literature search strategies

Literature search strategies for review questions:

B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?)

A combined search was conducted for both review questions.

Review question search strategies

Databases: Medline; Medline EPub Ahead of Print; and Medline In-Process & Other Non-Indexed Citations

Date of last search: 08/08/2019

#	Searches
1	ADOLESCENT/ or MINORS/
2	(adolescen$ or teen$ or youth$ or young or juvenile? or minors or highschool$).ti,ab,jw,nw.
3	exp CHILD/
4	(child$ or schoolchild$ or "school age" or "school aged" or preschool$ or toddler$ or kid? or kindergar$ or boy? or girl?).ti,ab,jw,nw.
5	exp INFANT/
6	(infan$ or neonat$ or newborn$ or baby or babies).ti,ab,jw,nw.
7	exp PEDIATRICS/ or exp PUBERTY/
8	(p?ediatric$ or pubert$ or prepubert$ or pubescen$ or prepubescen$).ti,ab,jw,nw.
9	or/1-8
10	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and (HOSPITALIZATION/ or PATIENT ADMISSION/ or ADOLESCENT, HOSPITALIZED/ or CHILD, HOSPITALIZED/ or exp HOSPITALS/ or exp EMERGENCY SERVICE, HOSPITAL/ or exp INTENSIVE CARE UNITS/ or REHABILITATION CENTERS/)
11	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
12	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
13	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
14	(patient? adj5 trauma$).ti,ab.
15	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
16	wound$ patient?.ti,ab.
17	injur$ patient?.ti,ab.
18	accident$ patient?.ti,ab.
19	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and trauma$.ti.
20	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and trauma$.ab. /freq=2
21	exp MULTIPLE TRAUMA/
22	TRAUMATOLOGY/

#	Searches
23	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
24	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
25	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
26	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
27	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
28	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
29	(polytrauma? or poly-trauma?).ti,ab.
30	traumatolog$.ti,ab.
31	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (exp *"WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/))
32	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti.
33	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ab. /freq=2
34	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
35	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
36	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (HOSPITALIZATION/ or PATIENT ADMISSION/ or ADOLESCENT, HOSPITALIZED/ or CHILD, HOSPITALIZED/ or exp HOSPITALS/ or exp EMERGENCY SERVICE, HOSPITAL/ or exp INTENSIVE CARE UNITS/ or REHABILITATION CENTERS/)
37	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
38	*SPINAL CORD INJURIES/ or *SPINAL CORD COMPRESSION/
39	exp *THORACIC INJURIES/ or *ACUTE LUNG INJURY/
40	*PERIPHERAL NERVE INJURIES/ or exp *CRANIAL NERVE INJURIES/
41	exp *AMPUTATION/ or *AMPUTATION, TRAUMATIC/ or *AMPUTEES/ or *AMPUTATION STUMPS/ or *LIMB SALVAGE/
42	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
43	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
44	((Flail$ or stove in) adj3 chest?).ti.
45	(rib? adj3 fractur$).ti.
46	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
47	(amputat$ or amputee?).ti.
48	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
49	*HEAD INJURIES, CLOSED/ or *HEAD INJURIES, PENETRATING/
50	(head adj3 injur$).ti.
51	or/10-50
52	exp BRAIN INJURIES/
53	(brain adj3 injur$).ti,ab.
54	or/52-53
55	51 not 54
56	COSMETICS/
57	COSMETIC TECHNIQUES/
58	camouflag$.ti,ab.
59	cosmetics.ti,ab.
60	or/56-59
61	(Compassion$ adj3 mind$ adj3 (therap$ or train$)).ti,ab.
62	"ACCEPTANCE AND COMMITMENT THERAPY"/
63	(Accept$ adj3 commit$ adj3 (therap$ or train$)).ti,ab.
64	MINDFULNESS/
65	Mindfulness.ti,ab.
66	(Visuali?ation adj3 (therap$ or train$)).ti,ab.
67	mentali?ation.ti,ab.
68	RELAXATION THERAPY/
69	BREATHING EXERCISES/
70	((Relax$ or progressive$ or breath$) adj3 (therap$ or train$ or exercis$)).ti,ab.
71	COGNITIVE BEHAVIORAL THERAPY/
72	(Cognit$ adj3 behav$ adj3 (therap$ or train$)).ti,ab.
73	CBT.ti,ab.
74	MOTIVATIONAL INTERVIEWING/
75	(motivat$ adj3 interview$).ti,ab.
76	or/61-75
77	(FAMILY/ or SPOUSES/ or GRANDPARENTS/ or exp PARENTS/ or SIBLINGS/ or CAREGIVERS/) and (SOCIAL SUPPORT/ or COUNSELING/ or DIRECTIVE COUNSELING/ or *EDUCATION/ or *HEALTH EDUCATION/ or COMMUNICATION/ or exp CONSUMER HEALTH INFORMATION/)
78	((family or families or spouse? or wife or wives or husband? or parent? or parental or father? or mother? or grandparent? or grandfather? or grandmother? or sibling? or brother? or sister? or carer? or caregiver?) adj3

#	Searches
	(support$ or educat$ or advice or advise? or advising or signpost$ or sign post$ or counsel$ or informat$ or communicat$)).ti.
79	((family or families) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$)).ab.
80	or/77-79
81	SELF-MANAGEMENT/
82	*SELF CARE/
83	*SELF EFFICACY/
84	(self adj1 (manag$ or care or help or responsib$ or efficacy)).ti.
85	(self adj1 manag$).ab.
86	((fatigue? or depress$) adj3 (information or educat$ or communicat$ or advice or advise? or advising or counsel$)).ti,ab.
87	or/81-86
88	GOALS/
89	((patient? or person$ or individual$ or client? or user? or participant?) adj10 goal? adj3 (centre$ or center$ or plan$ or set$ or adjust$ or rehab$)).ti,ab.
90	or/88-89
91	PLAY THERAPY/
92	(play$ adj3 therap$).ti,ab.
93	or/91-92
94	FAMILY THERAPY/
95	(famil$ adj3 therap$).ti,ab.
96	SIBLINGS/ and (SOCIAL SUPPORT/ or COUNSELING/ or DIRECTIVE COUNSELING/ or *EDUCATION/ or *HEALTH EDUCATION/ or COMMUNICATION/ or exp CONSUMER HEALTH INFORMATION/)
97	((sibling? or brother? or sister?) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$ or counsel$ or informat$ or communicat$)).ti,ab.
98	or/94-97
99	PROBLEM BEHAVIOR/
100	((intervention? or therapy or therapies) adj3 (adapt$ or behavio$)).ti,ab.
101	or/99-100
102	55 and 60
103	55 and 76
104	55 and 80
105	55 and 87
106	55 and 90
107	9 and 55 and 93
108	9 and 55 and 98
109	9 and 55 and 101
110	or/102-109
111	limit 110 to english language
112	limit 111 to yr="1995 -Current"
113	LETTER/
114	EDITORIAL/
115	NEWS/
116	exp HISTORICAL ARTICLE/
117	ANECDOTES AS TOPIC/
118	COMMENT/
119	CASE REPORT/
120	(letter or comment*).ti.
121	or/113-120
122	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
123	121 not 122
124	ANIMALS/ not HUMANS/
125	exp ANIMALS, LABORATORY/
126	exp ANIMAL EXPERIMENTATION/
127	exp MODELS, ANIMAL/
128	exp RODENTIA/
129	(rat or rats or mouse or mice).ti.
130	or/123-129
131	112 not 130

Databases: Embase; and Embase Classic

Date of last search: 08/08/2019

#	Searches
1	exp ADOLESCENT/
2	(adolescen$ or teen$ or youth$ or young or juvenile? or minors or highschool$).ti,ab,jx.
3	exp CHILD/
4	(child$ or schoolchild$ or "school age" or "school aged" or preschool$ or toddler$ or kid? or kindergar$ or boy? or girl?).ti,ab,jx.

#	Searches
5	exp INFANT/
6	(infan$ or neonat$ or newborn$ or baby or babies).ti,ab,jx.
7	exp PEDIATRICS/ or exp PUBERTY/
8	(p?ediatric$ or pubert$ or prepubert$ or pubescen$ or prepubescen$).ti,ab,jx,ec.
9	or/1-8
10	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED ADOLESCENT/ or HOSPITALIZED CHILD/ or exp HOSPITAL/ or EMERGENCY HOSPITAL SERVICE/ or exp INTENSIVE CARE UNIT/ or REHABILITATION CENTER/)
11	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
12	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
13	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
14	(patient? adj5 trauma$).ti,ab.
15	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
16	wound$ patient?.ti,ab.
17	injur$ patient?.ti,ab.
18	accident$ patient?.ti,ab.
19	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and trauma$.ti.
20	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and trauma$.ab. /freq=2
21	MULTIPLE TRAUMA/
22	TRAUMATOLOGY/
23	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
24	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
25	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
26	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
27	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
28	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
29	(polytrauma? or poly-trauma?).ti,ab.
30	traumatolog$.ti,ab.
31	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/))
32	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti.
33	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ab. /freq=2
34	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
35	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
36	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED ADOLESCENT/ or HOSPITALIZED CHILD/ or exp HOSPITAL/ or EMERGENCY HOSPITAL SERVICE/ or exp INTENSIVE CARE UNIT/ or REHABILITATION CENTER/)
37	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.

#	Searches
38	*SPINAL CORD INJURY/ or *SPINAL CORD COMPRESSION/
39	exp *THORAX INJURY/ or *ACUTE LUNG INJURY/ or exp *RIB FRACTURE/
40	exp *NERVE INJURY/
41	exp *AMPUTATION/ or *AMPUTEE/ or *LIMB SALVAGE/
42	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
43	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
44	((Flail$ or stove in) adj3 chest?).ti.
45	(rib? adj3 fractur$).ti.
46	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
47	(amputat$ or amputee?).ti.
48	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
49	*HEAD INJURY/
50	(head adj3 injur$).ti.
51	or/10-50
52	exp BRAIN INJURY/
53	(brain adj3 injur$).ti,ab.
54	or/52-53
55	51 not 54
56	*COSMETIC/
57	*ESTHETIC SURGERY/
58	camouflag$.ti,ab.
59	cosmetics.ti,ab.
60	or/56-59
61	(Compassion$ adj3 mind$ adj3 (therap$ or train$)).ti,ab.
62	*"ACCEPTANCE AND COMMITMENT THERAPY"/
63	(Accept$ adj3 commit$ adj3 (therap$ or train$)).ti,ab.
64	*MINDFULNESS/
65	Mindfulness.ti,ab.
66	(Visuali?ation adj3 (therap$ or train$)).ti,ab.
67	mentali?ation.ti,ab.
68	*RELAXATION TRAINING/
69	*BREATHING EXERCISE/
70	((Relax$ or progressive$ or breath$) adj3 (therap$ or train$ or exercis$)).ti,ab.
71	*COGNITIVE BEHAVIORAL THERAPY/
72	(Cognit$ adj3 behav$ adj3 (therap$ or train$)).ti,ab.
73	CBT.ti,ab.
74	*MOTIVATIONAL INTERVIEWING/
75	(motivat$ adj3 interview$).ti,ab.
76	or/61-75
77	(FAMILY/ or exp SPOUSE/ or exp GRANDPARENT/ or PARENT/ or FATHER/ or MOTHER/ or exp SIBLING/ or CAREGIVER/) and (SOCIAL SUPPORT/ or COUNSELING/ or DIRECTIVE COUNSELING/ or *EDUCATION/ or *HEALTH EDUCATION/ or INTERPERSONAL COMMUNICATION/ or exp CONSUMER HEALTH INFORMATION/)
78	((family or families or spouse? or wife or wives or husband? or parent? or parental or father? or mother? or grandparent? or grandfather? or grandmother? or sibling? or brother? or sister? or carer? or caregiver?) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$ or counsel$ or informat$ or communicat$)).ti.
79	((family or families) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$)).ab.
80	or/77-79
81	*SELF CARE/
82	(self adj1 (manag$ or care or help or responsib$ or efficacy)).ti.
83	(self adj1 manag$).ab.
84	((fatigue? or depress$) adj3 (information or educat$ or communicat$ or advice or advise? or advising or counsel$)).ti,ab.
85	or/81-84
86	*MOTIVATION/
87	GOAL ATTAINMENT/
88	((patient? or person$ or individual$ or client? or user? or participant?) adj10 goal? adj3 (centre$ or center$ or plan$ or set$ or adjust$ or rehab$)).ti,ab.
89	or/86-88
90	PLAY THERAPY/
91	(play$ adj3 therap$).ti,ab.
92	or/90-91
93	FAMILY THERAPY/
94	(famil$ adj3 therap$).ti,ab.
95	exp SIBLING/ and (SOCIAL SUPPORT/ or COUNSELING/ or DIRECTIVE COUNSELING/ or *EDUCATION/ or *HEALTH EDUCATION/ or INTERPERSONAL COMMUNICATION/ or exp CONSUMER HEALTH INFORMATION/)
96	((sibling? or brother? or sister?) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$ or counsel$ or informat$ or communicat$)).ti,ab.
97	or/93-96
98	PROBLEM BEHAVIOR/

#	Searches
99	((intervention? or therapy or therapies) adj3 (adapt$ or behavio$)).ti,ab.
100	or/98-99
101	55 and 60
102	55 and 76
103	55 and 80
104	55 and 85
105	55 and 89
106	9 and 55 and 92
107	9 and 55 and 97
108	9 and 55 and 100
109	or/101-108
110	limit 109 to english language
111	limit 110 to yr="1995 -Current"
112	letter.pt. or LETTER/
113	note.pt.
114	editorial.pt.
115	CASE REPORT/ or CASE STUDY/
116	(letter or comment*).ti.
117	or/112-116
118	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
119	117 not 118
120	ANIMAL/ not HUMAN/
121	NONHUMAN/
122	exp ANIMAL EXPERIMENT/
123	exp EXPERIMENTAL ANIMAL/
124	ANIMAL MODEL/
125	exp RODENT/
126	(rat or rats or mouse or mice).ti.
127	or/119-126
128	111 not 127

Databases: Cochrane Central Register of Controlled Trials; and Cochrane Database of Systematic Reviews

Date of last search: 08/08/2019

#	Searches
#1	[mh ^ADOLESCENT]
#2	[mh ^MINORS]
#3	(adolescen* or teen* or youth* or young or juvenile* or minors or highschool*):ti,ab
#4	[mh CHILD]
#5	(child* or schoolchild* or "school age" or "school aged" or preschool* or toddler* or kid* or kindergar* or boy* or girl*):ti,ab
#6	[mh INFANT]
#7	(infan* or neonat* or newborn* or baby or babies):ti,ab
#8	[mh PEDIATRICS]
#9	[mh PUBERTY]
#10	(pediatric* or paediatric* or pubert* or prepubert* or pubescen* or prepubescen*):ti,ab
#11	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10
#12	([mh "WOUNDS AND INJURIES"] not ([mh ^ASPHYXIA] or [mh ^"BATTERED CHILD SYNDROME"] or [mh "BIRTH INJURIES"] or [mh "BITES AND STINGS"] or [mh DROWNING] or [mh ^"EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"] or [mh ^FROSTBITE] or [mh "HEAT STRESS DISORDERS"] or [mh "RADIATION INJURIES"] or [mh ^RETROPNEUMOPERITONEUM] or [mh ^"SURGICAL WOUND"]))
#13	([mh ^HOSPITALIZATION] or [mh ^"PATIENT ADMISSION"] or [mh ^"ADOLESCENT, HOSPITALIZED"] or [mh ^"CHILD, HOSPITALIZED"] or [mh HOSPITALS] or [mh "EMERGENCY SERVICE, HOSPITAL"] or [mh "INTENSIVE CARE UNITS"] or [mh ^"REHABILITATION CENTERS"])
#14	#12 and #13
#15	(hospitalised or hospitalized or hospitalistion* or hospitaliztion* or ((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or "intensive care" or ICU* or PICU* or NICU* or department* or centre* or center*))):ti,ab
#16	#12 and #15
#17	((hospitalised or hospitalized or hospitalistion* or hospitaliztion*) near/10 (injur* or wound* or trauma* or burn* or burned or fractur* or accident*)):ti,ab
#18	((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or "intensive care" or ICU* or PICU* or NICU* or department* or centre* or center*) near/5 (injur* or wound* or trauma* or burn* or burned or fractur* or accident*)):ti,ab
#19	(patient* near/5 trauma*):ti,ab
#20	(patient* near/3 (burn* or burned or fractur*)):ti,ab
#21	"wound* patient*":ti,ab
#22	"injur* patient*":ti,ab
#23	"accident* patient*":ti,ab

#	Searches
#24	trauma*:ti,ab
#25	#12 and #24
#26	[mh "MULTIPLE TRAUMA"]
#27	[mh ^TRAUMATOLOGY]
#28	(trauma* near/5 (injur* or wound* or burn* or burned or fractur*)):ti,ab
#29	((complex* or multiple or critical*) near/3 (injur* or wound* or burn* or burned or fractur*)):ti,ab
#30	(trauma* near/3 (severe or severely or major or multiple)):ti,ab
#31	((injur* or wound* or burn* or burned or fractur*) near/2 (severe or severely or major or multiple)):ti,ab
#32	((physical* or body or bodily) near/3 (injur* or wound* or trauma* or burn* or burned or fractur*)):ti,ab
#33	(acute near/1 (injur* or trauma* or wound* or burn* or burned or fractur*)):ti,ab
#34	(polytrauma* or poly-trauma*):ti,ab
#35	traumatolog*:ti,ab
#36	([mh ^ACCIDENTS] or [mh ^"ACCIDENTAL FALLS"] or [mh ^"ACCIDENTS, HOME"] or [mh ^"ACCIDENTS, OCCUPATIONAL"] or [mh ^"ACCIDENTS, TRAFFIC"])
#37	#12 and #36
#38	(injur* or wound* or trauma* or burn* or burned or fractur*):ti,ab
#39	#36 and #38
#40	(accident* near/5 (injur* or wound* or trauma* or burn* or burned or fractur*)):ti,ab
#41	(accident* near/3 (serious* or severe or severely or major)):ti,ab
#42	#13 and #36
#43	(hospitalised or hospitalized or hospitalistion* or hospitaliztion* or ((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or intensive care or ICU* or PICU* or NICU* or department* or centre* or center*))):ti,ab
#44	#36 and #43
#45	[mh ^"SPINAL CORD INJURIES"] or [mh ^"SPINAL CORD COMPRESSION"]
#46	[mh "THORACIC INJURIES"] or [mh ^"ACUTE LUNG INJURY"]
#47	[mh ^"PERIPHERAL NERVE INJURIES"] or [mh "CRANIAL NERVE INJURIES"]
#48	[mh AMPUTATION] or [mh ^"AMPUTATION, TRAUMATIC"] or [mh ^AMPUTEES] or [mh ^"AMPUTATION STUMPS"] or [mh ^"LIMB SALVAGE"]
#49	((spinal* or spine* or chest* or thoracic* or nerve*) near/3 injur*):ti
#50	((spinal* or spine*) near/3 cord* near/3 compress*):ti
#51	((Flail* or stove in) near/3 chest*):ti
#52	(rib* near/3 fractur*):ti
#53	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) near/3 plexus near/3 injur*):ti
#54	(amputat* or amputee*):ti
#55	(limb* near/3 (loss or losing or lost or salvag* or re-construct* or reconstruct*)):ti
#56	[mh ^"HEAD INJURIES, CLOSED"] or [mh ^"HEAD INJURIES, PENETRATING"]
#57	(head near/3 injur*):ti
#58	#14 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34 or #35 or #37 or #39 or #40 or #41 or #42 or #44 or #45 or #46 or #47 or #48 or #49 or #50 or #51 or #52 or #53 or #54 or #55 or #56 or #57
#59	[mh "BRAIN INJURIES"]
#60	(brain near/3 injur*):ti,ab
#61	#59 or #60
#62	#58 not #61
#63	[mh ^COSMETICS]
#64	[mh ^"COSMETIC TECHNIQUES"]
#65	camouflag*:ti,ab
#66	cosmetics:ti,ab
#67	#63 or #64 or #65 or #66
#68	(Compassion* near/3 mind* near/3 (therap* or train*)):ti,ab
#69	[mh ^"ACCEPTANCE AND COMMITMENT THERAPY"]
#70	(Accept* near/3 commit* near/3 (therap* or train*)):ti,ab
#71	[mh ^MINDFULNESS]
#72	Mindfulness:ti,ab
#73	((Visualisation or visualization) near/3 (therap* or train*)):ti,ab
#74	(mentalisation or mentalization):ti,ab
#75	[mh ^"RELAXATION THERAPY"]
#76	[mh ^"BREATHING EXERCISES"]
#77	((Relax* or progressive* or breath*) near/3 (therap* or train* or exercis*)):ti,ab
#78	[mh ^"COGNITIVE THERAPY"]
#79	(Cognit* near/3 behav* near/3 (therap* or train*)):ti,ab
#80	CBT:ti,ab
#81	[mh ^"MOTIVATIONAL INTERVIEWING"]
#82	(motivat* near/3 interview*):ti,ab
#83	#68 or #69 or #70 or #71 or #72 or #73 or #74 or #75 or #76 or #77 or #78 or #79 or #80 or #81 or #82
#84	([mh ^FAMILY] or [mh ^SPOUSES] or [mh ^GRANDPARENTS] or [mh PARENTS] or [mh ^SIBLINGS] or [mh ^CAREGIVERS]) and ([mh ^"SOCIAL SUPPORT"] or [mh ^COUNSELING] or [mh ^"DIRECTIVE COUNSELING"] or [mh ^EDUCATION] or [mh ^"HEALTH EDUCATION"] or [mh ^COMMUNICATION] or [mh "CONSUMER HEALTH INFORMATION"])

#	Searches
#85	((family or families or spouse* or wife or wives or husband* or parent* or parental or father or fathers or mother or mothers or grandparent* or grandfather* or grandmother* or sibling* or brother* or sister* or carer* or caregiver*) near/3 (support* or educat* or advice or advise* or advising or signpost* or sign post* or counsel* or informat* or communicat*)):ti
#86	((family or families) near/3 (support* or educat* or advice or advise* or advising or signpost* or sign post*)):ab
#87	#84 or #85 or #86
#88	[mh ^"SELF-MANAGEMENT"]
#89	[mh ^"SELF CARE"]
#90	[mh ^"SELF EFFICACY"]
#91	(self near/1 (manag* or care or help or responsib* or efficacy)):ti
#92	(self near/1 manag*):ab
#93	((fatigue* or depress*) near/3 (information or educat* or communicat* or advice or advise* or advising or counsel*)):ti,ab
#94	#88 or #89 or #90 or #91 or #92 or #93
#95	[mh ^GOALS]
#96	((patient* or person* or individual* or client* or user* or participant*) near/10 goal* near/3 (centre* or center* or plan* or set* or adjust* or rehab*)):ti,ab
#97	#95 or #96
#98	[mh ^"PLAY THERAPY"]
#99	(play* near/3 therap*):ti,ab
#100	#98 or #99
#101	[mh ^"FAMILY THERAPY"]
#102	(famil* near/3 therap*):ti,ab
#103	[mh ^SIBLINGS] and ([mh ^"SOCIAL SUPPORT"] or [mh ^COUNSELING] or [mh ^"DIRECTIVE COUNSELING"] or [mh ^EDUCATION] or [mh ^"HEALTH EDUCATION"] or [mh ^COMMUNICATION] or [mh "CONSUMER HEALTH INFORMATION"])
#104	((sibling* or brother* or sister*) near/3 (support* or educat* or advice or advise* or advising or signpost* or sign post* or counsel* or informat* or communicat*)):ti,ab
#105	#101 or #102 or #103 or #104
#106	[mh ^"PROBLEM BEHAVIOR"]
#107	((intervention* or therapy or therapies) near/3 (adapt* or behavio*)):ti,ab
#108	#106 or #107
#109	#62 and #67
#110	#62 and #83
#111	#62 and #87
#112	#62 and #94
#113	#62 and #97
#114	#11 and #62 and #100
#115	#11 and #62 and #105
#116	#11 and #62 and #108
#117	#109 or #110 or #111 or #112 or #113 or #114 or #115 or #116
#118	#109 or #110 or #111 or #112 or #113 or #114 or #115 or #116 with Cochrane Library publication date Between Jan 1995 and Aug 2019, in Cochrane Reviews
#119	#109 or #110 or #111 or #112 or #113 or #114 or #115 or #116 with Publication Year from 1995 to 2019, in Trials

Databases: Psycinfo

Date of last search: 19/08/2019

#	Searches
1	(adolescen$ or teen$ or youth$ or young or juvenile? or minors or highschool$).ti,ab.
2	(child$ or schoolchild$ or "school age" or "school aged" or preschool$ or toddler$ or kid? or kindergar$ or boy? or girl?).ti,ab.
3	(infan$ or neonat$ or newborn$ or baby or babies).ti,ab.
4	PEDIATRICS/ or PUBERTY/
5	(p?ediatric$ or pubert$ or prepubert$ or pubescen$ or prepubescen$).ti,ab.
6	or/1-5
7	(exp INJURIES/ not BIRTH INJURIES/) and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED PATIENTS/ or HOSPITALS/ or exp INTENSIVE CARE/ or REHABILITATION CENTERS/)
8	(exp INJURIES/ not BIRTH INJURIES/) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
9	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
10	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
11	(patient? adj5 trauma$).ti,ab.
12	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
13	wound$ patient?.ti,ab.
14	injur$ patient?.ti,ab.

#	Searches
15	accident$ patient?.ti,ab.
16	(exp INJURIES/ not BIRTH INJURIES/) and trauma$.ti,ab.
17	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
18	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
19	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
20	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
21	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
22	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
23	(polytrauma? or poly-trauma?).ti,ab.
24	traumatolog$.ti,ab.
25	exp ACCIDENTS/ and (exp INJURIES/ not BIRTH INJURIES/)
26	exp ACCIDENTS/ and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti,ab.
27	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
28	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
29	exp ACCIDENTS/ and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED PATIENTS/ or HOSPITALS/ or exp INTENSIVE CARE/ or REHABILITATION CENTERS/)
30	exp ACCIDENTS/ and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
31	SPINAL CORD INJURIES/
32	AMPUTATION/
33	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
34	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
35	((Flail$ or stove in) adj3 chest?).ti.
36	(rib? adj3 fractur$).ti.
37	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
38	(amputat$ or amputee?).ti.
39	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
40	HEAD INJURIES/
41	(head adj3 injur$).ti.
42	or/7-41
43	exp BRAIN INJURIES/
44	(brain adj3 injur$).ti,ab.
45	or/43-44
46	42 not 45
47	COSMETIC TECHNIQUES/
48	camouflag$.ti,ab.
49	cosmetics.ti,ab.
50	or/47-49
51	(Compassion$ adj3 mind$ adj3 (therap$ or train$)).ti,ab.
52	"ACCEPTANCE AND COMMITMENT THERAPY"/
53	(Accept$ adj3 commit$ adj3 (therap$ or train$)).ti,ab.
54	MINDFULNESS/
55	MINDFULNESS-BASED INTERVENTIONS/
56	Mindfulness.ti,ab.
57	IMAGERY/
58	(Visuali?ation adj3 (therap$ or train$)).ti,ab.
59	MENTALIZATION/
60	mentali?ation.ti,ab.
61	exp RELAXATION THERAPY/
62	RESPIRATION/ and EXERCISE/
63	((Relax$ or progressive$ or breath$) adj3 (therap$ or train$ or exercis$)).ti,ab.
64	COGNITIVE BEHAVIOR THERAPY/
65	(Cognit$ adj3 behav$ adj3 (therap$ or train$)).ti,ab.
66	CBT.ti,ab.
67	MOTIVATIONAL INTERVIEWING/
68	(motivat$ adj3 interview$).ti,ab.
69	or/51-68
70	(FAMILY/ or SPOUSES/ or HUSBANDS/ or WIVES/ or GRANDPARENTS/ or PARENTS/ or FATHERS/ or MOTHERS/ or SIBLINGS/ or BROTHERS/ or SISTERS/ or CAREGIVERS/) and (SOCIAL SUPPORT/ or COUNSELING/ or *EDUCATION/ or *HEALTH EDUCATION/ or COMMUNICATION/)
71	((family or families or spouse? or wife or wives or husband? or parent? or parental or father? or mother? or grandparent? or grandfather? or grandmother? or sibling? or brother? or sister? or carer? or caregiver?) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$ or counsel$ or informat$ or communicat$)).ti.
72	((family or families) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$)).ab.
73	or/70-72
74	exp SELF-MANAGEMENT/
75	SELF-CARE SKILLS/
76	SELF-EFFICACY/
77	(self adj1 (manag$ or care or help or responsib$ or efficacy)).ti.

#	Searches
78	(self adj1 manag$).ab.
79	((fatigue? or depress$) adj3 (information or educat$ or communicat$ or advice or advise? or advising or counsel$)).ti,ab.
80	or/74-79
81	CLIENT CENTERED THERAPY/
82	GOALS/
83	GOAL SETTING/
84	GOAL ORIENTATION/
85	((patient? or person$ or individual$ or client? or user? or participant?) adj10 goal? adj3 (centre$ or center$ or plan$ or set$ or adjust$ or rehab$)).ti,ab.
86	or/81-85
87	PLAY THERAPY/
88	(play$ adj3 therap$).ti,ab.
89	or/87-88
90	exp FAMILY THERAPY/
91	(famil$ adj3 therap$).ti,ab.
92	(SIBLINGS/ or BROTHERS/ or SISTERS/) and (SOCIAL SUPPORT/ or COUNSELING/ or *EDUCATION/ or *HEALTH EDUCATION/ or COMMUNICATION/)
93	((sibling? or brother? or sister?) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$ or counsel$ or informat$ or communicat$)).ti,ab.
94	or/90-93
95	ADAPTATION/
96	ADJUSTMENT/
97	EMOTIONAL ADJUSTMENT/
98	SOCIAL ADJUSTMENT/
99	BEHAVIOR PROBLEMS/
100	((intervention? or therapy or therapies) adj3 (adapt$ or behavio$)).ti,ab.
101	or/95-100
102	46 and 50
103	46 and 69
104	46 and 73
105	46 and 80
106	46 and 86
107	6 and 46 and 89
108	6 and 46 and 94
109	6 and 46 and 101
110	or/102-109
111	limit 110 to english language
112	limit 111 to yr="1995 -Current"
113	limit 112 to ("0100 journal" or "0110 peer-reviewed journal" or "0120 non-peer-reviewed journal")

Health economics search strategies

Databases: Medline; Medline EPub Ahead of Print; and Medline In-Process & Other Non-Indexed Citations

Date of last search: 19/08/2019

#	Searches
1	ECONOMICS/
2	VALUE OF LIFE/
3	exp "COSTS AND COST ANALYSIS"/
4	exp ECONOMICS, HOSPITAL/
5	exp ECONOMICS, MEDICAL/
6	exp RESOURCE ALLOCATION/
7	ECONOMICS, NURSING/
8	ECONOMICS, PHARMACEUTICAL/
9	exp "FEES AND CHARGES"/
10	exp BUDGETS/
11	budget*.ti,ab.
12	cost*.ti,ab.
13	(economic* or pharmaco?economic*).ti,ab.
14	(price* or pricing*).ti,ab.
15	(financ* or fee or fees or expenditure* or saving*).ti,ab.
16	(value adj2 (money or monetary)).ti,ab.
17	resourc* allocat*.ti,ab.
18	(fund or funds or funding* or funded).ti,ab.
19	(ration or rations or rationing* or rationed).ti,ab.

#	Searches
20	ec.fs.
21	or/1-20
22	ADOLESCENT/ or MINORS/
23	(adolescen$ or teen$ or youth$ or young or juvenile? or minors or highschool$).ti,ab,jw,nw.
24	exp CHILD/
25	(child$ or schoolchild$ or "school age" or "school aged" or preschool$ or toddler$ or kid? or kindergar$ or boy? or girl?).ti,ab,jw,nw.
26	exp INFANT/
27	(infan$ or neonat$ or newborn$ or baby or babies).ti,ab,jw,nw.
28	exp PEDIATRICS/ or exp PUBERTY/
29	(p?ediatric$ or pubert$ or prepubert$ or pubescen$ or prepubescen$).ti,ab,jw,nw.
30	or/22-29
31	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and (HOSPITALIZATION/ or PATIENT ADMISSION/ or ADOLESCENT, HOSPITALIZED/ or CHILD, HOSPITALIZED/ or exp HOSPITALS/ or exp EMERGENCY SERVICE, HOSPITAL/ or exp INTENSIVE CARE UNITS/ or REHABILITATION CENTERS/)
32	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
33	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
34	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
35	(patient? adj5 trauma$).ti,ab.
36	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
37	wound$ patient?.ti,ab.
38	injur$ patient?.ti,ab.
39	accident$ patient?.ti,ab.
40	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and trauma$.ti.
41	(exp "WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/)) and trauma$.ab. /freq=2
42	exp MULTIPLE TRAUMA/
43	TRAUMATOLOGY/
44	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
45	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
46	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
47	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
48	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
49	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
50	(polytrauma? or poly-trauma?).ti,ab.
51	traumatolog$.ti,ab.
52	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (exp *"WOUNDS AND INJURIES"/ not (ASPHYXIA/ or BATTERED CHILD SYNDROME/ or exp BIRTH INJURIES/ or exp "BITES AND STINGS"/ or exp DROWNING/ or "EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"/ or exp FROSTBITE/ or exp HEAT STRESS DISORDERS/ or exp RADIATION INJURIES/ or RETROPNEUMOPERITONEUM/ or SURGICAL WOUND/))
53	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti.
54	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ab. /freq=2
55	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
56	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
57	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (HOSPITALIZATION/ or PATIENT ADMISSION/ or ADOLESCENT, HOSPITALIZED/ or CHILD, HOSPITALIZED/ or exp HOSPITALS/ or exp EMERGENCY SERVICE, HOSPITAL/ or exp INTENSIVE CARE UNITS/ or REHABILITATION CENTERS/)
58	(ACCIDENTS/ or ACCIDENTAL FALLS/ or ACCIDENTS, HOME/ or ACCIDENTS, OCCUPATIONAL/ or ACCIDENTS, TRAFFIC/) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
59	*SPINAL CORD INJURIES/ or *SPINAL CORD COMPRESSION/
60	exp *THORACIC INJURIES/ or *ACUTE LUNG INJURY/

#	Searches
61	*PERIPHERAL NERVE INJURIES/ or exp *CRANIAL NERVE INJURIES/
62	exp *AMPUTATION/ or *AMPUTATION, TRAUMATIC/ or *AMPUTEES/ or *AMPUTATION STUMPS/ or *LIMB SALVAGE/
63	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
64	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
65	((Flail$ or stove in) adj3 chest?).ti.
66	(rib? adj3 fractur$).ti.
67	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
68	(amputat$ or amputee?).ti.
69	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
70	*HEAD INJURIES, CLOSED/ or *HEAD INJURIES, PENETRATING/
71	(head adj3 injur$).ti.
72	or/31-71
73	exp BRAIN INJURIES/
74	(brain adj3 injur$).ti,ab.
75	or/73-74
76	72 not 75
77	COSMETICS/
78	COSMETIC TECHNIQUES/
79	camouflag$.ti,ab.
80	cosmetics.ti,ab.
81	or/77-80
82	(Compassion$ adj3 mind$ adj3 (therap$ or train$)).ti,ab.
83	"ACCEPTANCE AND COMMITMENT THERAPY"/
84	(Accept$ adj3 commit$ adj3 (therap$ or train$)).ti,ab.
85	MINDFULNESS/
86	Mindfulness.ti,ab.
87	(Visuali?ation adj3 (therap$ or train$)).ti,ab.
88	mentali?ation.ti,ab.
89	RELAXATION THERAPY/
90	BREATHING EXERCISES/
91	((Relax$ or progressive$ or breath$) adj3 (therap$ or train$ or exercis$)).ti,ab.
92	COGNITIVE BEHAVIORAL THERAPY/
93	(Cognit$ adj3 behav$ adj3 (therap$ or train$)).ti,ab.
94	CBT.ti,ab.
95	MOTIVATIONAL INTERVIEWING/
96	(motivat$ adj3 interview$).ti,ab.
97	or/82-96
98	(FAMILY/ or SPOUSES/ or GRANDPARENTS/ or exp PARENTS/ or SIBLINGS/ or CAREGIVERS/) and (SOCIAL SUPPORT/ or COUNSELING/ or DIRECTIVE COUNSELING/ or *EDUCATION/ or *HEALTH EDUCATION/ or COMMUNICATION/ or exp CONSUMER HEALTH INFORMATION/)
99	((family or families or spouse? or wife or wives or husband? or parent? or parental or father? or mother? or grandparent? or grandfather? or grandmother? or sibling? or brother? or sister? or carer? or caregiver?) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$ or counsel$ or informat$ or communicat$)).ti.
100	((family or families) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$)).ab.
101	or/98-100
102	SELF-MANAGEMENT/
103	*SELF CARE/
104	*SELF EFFICACY/
105	(self adj1 (manag$ or care or help or responsib$ or efficacy)).ti.
106	(self adj1 manag$).ab.
107	((fatigue? or depress$) adj3 (information or educat$ or communicat$ or advice or advise? or advising or counsel$)).ti,ab.
108	or/102-107
109	GOALS/
110	((patient? or person$ or individual$ or client? or user? or participant?) adj10 goal? adj3 (centre$ or center$ or plan$ or set$ or adjust$ or rehab$)).ti,ab.
111	or/109-110
112	PLAY THERAPY/
113	(play$ adj3 therap$).ti,ab.
114	or/112-113
115	FAMILY THERAPY/
116	(famil$ adj3 therap$).ti,ab.
117	SIBLINGS/ and (SOCIAL SUPPORT/ or COUNSELING/ or DIRECTIVE COUNSELING/ or *EDUCATION/ or *HEALTH EDUCATION/ or COMMUNICATION/ or exp CONSUMER HEALTH INFORMATION/)
118	((sibling? or brother? or sister?) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$ or counsel$ or informat$ or communicat$)).ti,ab.
119	or/115-118
120	PROBLEM BEHAVIOR/

#	Searches
121	((intervention? or therapy or therapies) adj3 (adapt$ or behavio$)).ti,ab.
122	or/120-121
123	76 and 81
124	76 and 97
125	76 and 101
126	76 and 108
127	76 and 111
128	30 and 76 and 114
129	30 and 76 and 119
130	30 and 76 and 122
131	or/123-130
132	limit 131 to english language
133	limit 132 to yr="1995 -Current"
134	LETTER/
135	EDITORIAL/
136	NEWS/
137	exp HISTORICAL ARTICLE/
138	ANECDOTES AS TOPIC/
139	COMMENT/
140	CASE REPORT/
141	(letter or comment*).ti.
142	or/134-141
143	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
144	142 not 143
145	ANIMALS/ not HUMANS/
146	exp ANIMALS, LABORATORY/
147	exp ANIMAL EXPERIMENTATION/
148	exp MODELS, ANIMAL/
149	exp RODENTIA/
150	(rat or rats or mouse or mice).ti.
151	or/144-150
152	133 not 151
153	21 and 152

Databases: Embase; and Embase Classic

Date of last search: 19/08/2019

#	Searches
1	HEALTH ECONOMICS/
2	exp ECONOMIC EVALUATION/
3	exp HEALTH CARE COST/
4	exp FEE/
5	BUDGET/
6	FUNDING/
7	RESOURCE ALLOCATION/
8	budget*.ti,ab.
9	cost*.ti,ab.
10	(economic* or pharmaco?economic*).ti,ab.
11	(price* or pricing*).ti,ab.
12	(financ* or fee or fees or expenditure* or saving*).ti,ab.
13	(value adj2 (money or monetary)).ti,ab.
14	resourc* allocat*.ti,ab.
15	(fund or funds or funding* or funded).ti,ab.
16	(ration or rations or rationing* or rationed).ti,ab.
17	or/1-16
18	exp ADOLESCENT/
19	(adolescen$ or teen$ or youth$ or young or juvenile? or minors or highschool$).ti,ab,jx.
20	exp CHILD/
21	(child$ or schoolchild$ or "school age" or "school aged" or preschool$ or toddler$ or kid? or kindergar$ or boy? or girl?).ti,ab,jx.
22	exp INFANT/
23	(infan$ or neonat$ or newborn$ or baby or babies).ti,ab,jx.
24	exp PEDIATRICS/ or exp PUBERTY/
25	(p?ediatric$ or pubert$ or prepubert$ or pubescen$ or prepubescen$).ti,ab,jx,ec.
26	or/18-25
27	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT

#	Searches
	INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED ADOLESCENT/ or HOSPITALIZED CHILD/ or exp HOSPITAL/ or EMERGENCY HOSPITAL SERVICE/ or exp INTENSIVE CARE UNIT/ or REHABILITATION CENTER/)
28	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
29	((hospitali?ed or hospitali?ation?) adj10 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
30	((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?) adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$ or accident?)).ti,ab.
31	(patient? adj5 trauma$).ti,ab.
32	(patient? adj3 (burn? or burned or fractur$)).ti,ab.
33	wound$ patient?.ti,ab.
34	injur$ patient?.ti,ab.
35	accident$ patient?.ti,ab.
36	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and trauma$.ti.
37	(exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/)) and trauma$.ab. /freq=2
38	MULTIPLE TRAUMA/
39	TRAUMATOLOGY/
40	(trauma$ adj5 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
41	((complex$ or multiple or critical$) adj3 (injur$ or wound$ or burn? or burned or fractur$)).ti,ab.
42	(trauma$ adj3 (severe or severely or major or multiple)).ti,ab.
43	((injur$ or wound$ or burn? or burned or fractur$) adj2 (severe or severely or major or multiple)).ti,ab.
44	((physical$ or body or bodily) adj3 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
45	(acute adj1 (injur$ or trauma$ or wound$ or burn? or burned or fractur$)).ti,ab.
46	(polytrauma? or poly-trauma?).ti,ab.
47	traumatolog$.ti,ab.
48	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (exp INJURY/ not (AUTOMUTILATION/ or BATTERED CHILD SYNDROME/ or BIRTH INJURY/ or exp "BITES AND STINGS"/ or exp DROWNING/ or exp EROSION/ or exp EXPERIMENTAL INJURY/ or exp HEART INJURY/ or IMMUNE INJURY/ or IMMUNE MEDIATED INJURY/ or MEMBRANE DAMAGE/ or PRENATAL INJURY/ or PSYCHOTRAUMA/ or exp RADIATION INJURY/ or exp REPERFUSION INJURY/ or exp RESPIRATORY TRACT INJURY/ or exp RUPTURE/ or STRANGULATION/ or SURGICAL INJURY/ or exp THERMAL INJURY/ or BITE WOUND/ or exp SURGICAL WOUND/))
49	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ti.
50	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (injur$ or wound? or trauma$ or burn? or burned or fractur$).ab. /freq=2
51	(accident? adj5 (injur$ or wound$ or trauma$ or burn? or burned or fractur$)).ti,ab.
52	(accident? adj3 (serious$ or severe or severely or major)).ti,ab.
53	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (HOSPITALIZATION/ or HOSPITAL ADMISSION/ or HOSPITALIZED ADOLESCENT/ or HOSPITALIZED CHILD/ or exp HOSPITAL/ or EMERGENCY HOSPITAL SERVICE/ or exp INTENSIVE CARE UNIT/ or REHABILITATION CENTER/)
54	(ACCIDENT/ or FALLING/ or HOME ACCIDENT/ or exp OCCUPATIONAL ACCIDENT/ or TRAFFIC ACCIDENT/) and (hospitali?ed or hospitali?tion? or ((admi$ or stay? or stayed or treat$ or present$) adj5 (hospital? or unit? or intensive care or ICU? or PICU? or NICU? or department? or centre? or center?))).ti,ab.
55	*SPINAL CORD INJURY/ or *SPINAL CORD COMPRESSION/
56	exp *THORAX INJURY/ or *ACUTE LUNG INJURY/ or exp *RIB FRACTURE/
57	exp *NERVE INJURY/
58	exp *AMPUTATION/ or *AMPUTEE/ or *LIMB SALVAGE/
59	((spinal$ or spine? or chest? or thoracic$ or nerve?) adj3 injur$).ti.
60	((spinal$ or spine?) adj3 cord? adj3 compress$).ti.
61	((Flail$ or stove in) adj3 chest?).ti.
62	(rib? adj3 fractur$).ti.

#	Searches
63	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) adj3 plexus adj3 injur$).ti.
64	(amputat$ or amputee?).ti.
65	(limb? adj3 (loss or losing or lost or salvag$ or re-construct$ or reconstruct$)).ti.
66	*HEAD INJURY/
67	(head adj3 injur$).ti.
68	or/27-67
69	exp BRAIN INJURY/
70	(brain adj3 injur$).ti,ab.
71	or/69-70
72	68 not 71
73	*COSMETIC/
74	*ESTHETIC SURGERY/
75	camouflag$.ti,ab.
76	cosmetics.ti,ab.
77	or/73-76
78	(Compassion$ adj3 mind$ adj3 (therap$ or train$)).ti,ab.
79	*"ACCEPTANCE AND COMMITMENT THERAPY"/
80	(Accept$ adj3 commit$ adj3 (therap$ or train$)).ti,ab.
81	*MINDFULNESS/
82	Mindfulness.ti,ab.
83	(Visuali?ation adj3 (therap$ or train$)).ti,ab.
84	mentali?ation.ti,ab.
85	*RELAXATION TRAINING/
86	*BREATHING EXERCISE/
87	((Relax$ or progressive$ or breath$) adj3 (therap$ or train$ or exercis$)).ti,ab.
88	*COGNITIVE BEHAVIORAL THERAPY/
89	(Cognit$ adj3 behav$ adj3 (therap$ or train$)).ti,ab.
90	CBT.ti,ab.
91	*MOTIVATIONAL INTERVIEWING/
92	(motivat$ adj3 interview$).ti,ab.
93	or/78-92
94	(FAMILY/ or exp SPOUSE/ or exp GRANDPARENT/ or PARENT/ or FATHER/ or MOTHER/ or exp SIBLING/ or CAREGIVER/) and (SOCIAL SUPPORT/ or COUNSELING/ or DIRECTIVE COUNSELING/ or *EDUCATION/ or *HEALTH EDUCATION/ or INTERPERSONAL COMMUNICATION/ or exp CONSUMER HEALTH INFORMATION/)
95	((family or families or spouse? or wife or wives or husband? or parent? or parental or father? or mother? or grandparent? or grandfather? or grandmother? or sibling? or brother? or sister? or carer? or caregiver?) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$ or counsel$ or informat$ or communicat$)).ti.
96	((family or families) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$)).ab.
97	or/94-96
98	*SELF CARE/
99	(self adj1 (manag$ or care or help or responsib$ or efficacy)).ti.
100	(self adj1 manag$).ab.
101	((fatigue? or depress$) adj3 (information or educat$ or communicat$ or advice or advise? or advising or counsel$)).ti,ab.
102	or/98-101
103	*MOTIVATION/
104	GOAL ATTAINMENT/
105	((patient? or person$ or individual$ or client? or user? or participant?) adj10 goal? adj3 (centre$ or center$ or plan$ or set$ or adjust$ or rehab$)).ti,ab.
106	or/103-105
107	PLAY THERAPY/
108	(play$ adj3 therap$).ti,ab.
109	or/107-108
110	FAMILY THERAPY/
111	(famil$ adj3 therap$).ti,ab.
112	exp SIBLING/ and (SOCIAL SUPPORT/ or COUNSELING/ or DIRECTIVE COUNSELING/ or *EDUCATION/ or *HEALTH EDUCATION/ or INTERPERSONAL COMMUNICATION/ or exp CONSUMER HEALTH INFORMATION/)
113	((sibling? or brother? or sister?) adj3 (support$ or educat$ or advice or advise? or advising or signpost$ or sign post$ or counsel$ or informat$ or communicat$)).ti,ab.
114	or/110-113
115	PROBLEM BEHAVIOR/
116	((intervention? or therapy or therapies) adj3 (adapt$ or behavio$)).ti,ab.
117	or/115-116
118	72 and 77
119	72 and 93
120	72 and 97
121	72 and 102
122	72 and 106
123	26 and 72 and 109

#	Searches
124	26 and 72 and 114
125	26 and 72 and 117
126	or/118-125
127	limit 126 to english language
128	limit 127 to yr="1995 -Current"
129	letter.pt. or LETTER/
130	note.pt.
131	editorial.pt.
132	CASE REPORT/ or CASE STUDY/
133	(letter or comment*).ti.
134	or/129-133
135	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
136	134 not 135
137	ANIMAL/ not HUMAN/
138	NONHUMAN/
139	exp ANIMAL EXPERIMENT/
140	exp EXPERIMENTAL ANIMAL/
141	ANIMAL MODEL/
142	exp RODENT/
143	(rat or rats or mouse or mice).ti.
144	or/136-143
145	128 not 144
146	17 and 145

Database: Cochrane Central Register of Controlled Trials

Date of last search: 19/08/2019

#	Searches
#1	MeSH descriptor: [Economics] this term only
#2	MeSH descriptor: [Value of Life] this term only
#3	MeSH descriptor: [Costs and Cost Analysis] explode all trees
#4	MeSH descriptor: [Economics, Hospital] explode all trees
#5	MeSH descriptor: [Economics, Medical] explode all trees
#6	MeSH descriptor: [Resource Allocation] explode all trees
#7	MeSH descriptor: [Economics, Nursing] this term only
#8	MeSH descriptor: [Economics, Pharmaceutical] this term only
#9	MeSH descriptor: [Fees and Charges] explode all trees
#10	MeSH descriptor: [Budgets] explode all trees
#11	budget*:ti,ab
#12	cost*:ti,ab
#13	(economic* or pharmaco?economic*):ti,ab
#14	(price* or pricing*):ti,ab
#15	(financ* or fee or fees or expenditure* or saving*):ti,ab
#16	(value near/2 (money or monetary)):ti,ab
#17	resourc* allocat*:ti,ab
#18	(fund or funds or funding* or funded):ti,ab
#19	(ration or rations or rationing* or rationed) .ti,ab.
#20	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19
#21	[mh ^ADOLESCENT]
#22	[mh ^MINORS]
#23	(adolescen* or teen* or youth* or young or juvenile* or minors or highschool*):ti,ab
#24	[mh CHILD]
#25	(child* or schoolchild* or "school age" or "school aged" or preschool* or toddler* or kid* or kindergar* or boy* or girl*):ti,ab
#26	[mh INFANT]
#27	(infan* or neonat* or newborn* or baby or babies):ti,ab
#28	[mh PEDIATRICS]
#29	[mh PUBERTY]
#30	(pediatric* or paediatric* or pubert* or prepubert* or pubescen* or prepubescen*):ti,ab
#31	#21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30
#32	([mh "WOUNDS AND INJURIES"] not ([mh ^ASPHYXIA] or [mh ^"BATTERED CHILD SYNDROME"] or [mh "BIRTH INJURIES"] or [mh "BITES AND STINGS"] or [mh DROWNING] or [mh ^"EXTRAVASATION OF DIAGNOSTIC AND THERAPEUTIC MATERIALS"] or [mh ^FROSTBITE] or [mh "HEAT STRESS DISORDERS"] or [mh "RADIATION INJURIES"] or [mh ^RETROPNEUMOPERITONEUM] or [mh ^"SURGICAL WOUND"]))
#33	([mh ^HOSPITALIZATION] or [mh ^"PATIENT ADMISSION"] or [mh ^"ADOLESCENT, HOSPITALIZED"] or [mh ^"CHILD, HOSPITALIZED"] or [mh HOSPITALS] or [mh "EMERGENCY SERVICE, HOSPITAL"] or [mh "INTENSIVE CARE UNITS"] or [mh ^"REHABILITATION CENTERS"])
#34	#32 and #33

#	Searches
#35	(hospitalised or hospitalized or hospitalistion* or hospitaliztion* or ((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or "intensive care" or ICU* or PICU* or NICU* or department* or centre* or center*))):ti,ab
#36	#32 and #35
#37	((hospitalised or hospitalized or hospitalistion* or hospitaliztion*) near/10 (injur* or wound* or trauma* or burn* or burned or fractur* or accident*)):ti,ab
#38	((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or "intensive care" or ICU* or PICU* or NICU* or department* or centre* or center*) near/5 (injur* or wound* or trauma* or burn* or burned or fractur* or accident*)):ti,ab
#39	(patient* near/5 trauma*):ti,ab
#40	(patient* near/3 (burn* or burned or fractur*)):ti,ab
#41	"wound* patient*":ti,ab
#42	"injur* patient*":ti,ab
#43	"accident* patient*":ti,ab
#44	trauma*:ti,ab
#45	#32 and #44
#46	[mh "MULTIPLE TRAUMA"]
#47	[mh ^TRAUMATOLOGY]
#48	(trauma* near/5 (injur* or wound* or burn* or burned or fractur*)):ti,ab
#49	((complex* or multiple or critical*) near/3 (injur* or wound* or burn* or burned or fractur*)):ti,ab
#50	(trauma* near/3 (severe or severely or major or multiple)):ti,ab
#51	((injur* or wound* or burn* or burned or fractur*) near/2 (severe or severely or major or multiple)):ti,ab
#52	((physical* or body or bodily) near/3 (injur* or wound* or trauma* or burn* or burned or fractur*)):ti,ab
#53	(acute near/1 (injur* or trauma* or wound* or burn* or burned or fractur*)):ti,ab
#54	(polytrauma* or poly-trauma*):ti,ab
#55	traumatolog*:ti,ab
#56	([mh ^ACCIDENTS] or [mh ^"ACCIDENTAL FALLS"] or [mh ^"ACCIDENTS, HOME"] or [mh ^"ACCIDENTS, OCCUPATIONAL"] or [mh ^"ACCIDENTS, TRAFFIC"])
#57	#32 and #56
#58	(injur* or wound* or trauma* or burn* or burned or fractur*):ti,ab
#59	#56 and #58
#60	(accident* near/5 (injur* or wound* or trauma* or burn* or burned or fractur*)):ti,ab
#61	(accident* near/3 (serious* or severe or severely or major)):ti,ab
#62	#33 and #56
#63	(hospitalised or hospitalized or hospitalistion* or hospitaliztion* or ((admi* or stay* or stayed or treat* or present*) near/5 (hospital* or unit* or intensive care or ICU* or PICU* or NICU* or department* or centre* or center*))):ti,ab
#64	#56 and #63
#65	[mh ^"SPINAL CORD INJURIES"] or [mh ^"SPINAL CORD COMPRESSION"]
#66	[mh "THORACIC INJURIES"] or [mh ^"ACUTE LUNG INJURY"]
#67	[mh ^"PERIPHERAL NERVE INJURIES"] or [mh "CRANIAL NERVE INJURIES"]
#68	[mh AMPUTATION] or [mh ^"AMPUTATION, TRAUMATIC"] or [mh ^AMPUTEES] or [mh ^"AMPUTATION STUMPS"] or [mh ^"LIMB SALVAGE"]
#69	((spinal* or spine* or chest* or thoracic* or nerve*) near/3 injur*):ti
#70	((spinal* or spine*) near/3 cord* near/3 compress*):ti
#71	((Flail* or stove in) near/3 chest*):ti
#72	(rib* near/3 fractur*):ti
#73	((brachial or lumbosacral or lumba or sacral or cervical or coccygeal) near/3 plexus near/3 injur*):ti
#74	(amputat* or amputee*):ti
#75	(limb* near/3 (loss or losing or lost or salvag* or re-construct* or reconstruct*)):ti
#76	[mh ^"HEAD INJURIES, CLOSED"] or [mh ^"HEAD INJURIES, PENETRATING"]
#77	(head near/3 injur*):ti
#78	#34 or #36 or #37 or #38 or #39 or #40 or #41 or #42 or #43 or #45 or #46 or #47 or #48 or #49 or #50 or #51 or #52 or #53 or #54 or #55 or #57 or #59 or #60 or #61 or #62 or #64 or #65 or #66 or #67 or #68 or #69 or #70 or #71 or #72 or #73 or #74 or #75 or #76 or #77
#79	[mh "BRAIN INJURIES"]
#80	(brain near/3 injur*):ti,ab
#81	#79 or #80
#82	#78 not #81
#83	[mh ^COSMETICS]
#84	[mh ^"COSMETIC TECHNIQUES"]
#85	camouflag*:ti,ab
#86	cosmetics:ti,ab
#87	#83 or #84 or #85 or #86
#88	(Compassion* near/3 mind* near/3 (therap* or train*)):ti,ab
#89	[mh ^"ACCEPTANCE AND COMMITMENT THERAPY"]
#90	(Accept* near/3 commit* near/3 (therap* or train*)):ti,ab
#91	[mh ^MINDFULNESS]
#92	Mindfulness:ti,ab
#93	((Visualisation or visualization) near/3 (therap* or train*)):ti,ab
#94	(mentalisation or mentalization):ti,ab
#95	[mh ^"RELAXATION THERAPY"]

#	Searches
#96	[mh ^"BREATHING EXERCISES"]
#97	((Relax* or progressive* or breath*) near/3 (therap* or train* or exercis*)):ti,ab
#98	[mh ^"COGNITIVE THERAPY"]
#99	(Cognit* near/3 behav* near/3 (therap* or train*)):ti,ab
#100	CBT:ti,ab
#101	[mh ^"MOTIVATIONAL INTERVIEWING"]
#102	(motivat* near/3 interview*):ti,ab
#103	#88 or #89 or #90 or #91 or #92 or #93 or #94 or #95 or #96 or #97 or #98 or #99 or #100 or #101 or #102
#104	([mh ^FAMILY] or [mh ^SPOUSES] or [mh ^GRANDPARENTS] or [mh PARENTS] or [mh ^SIBLINGS] or [mh ^CAREGIVERS]) and ([mh ^"SOCIAL SUPPORT"] or [mh ^COUNSELING] or [mh ^"DIRECTIVE COUNSELING"] or [mh ^EDUCATION] or [mh ^"HEALTH EDUCATION"] or [mh ^COMMUNICATION] or [mh "CONSUMER HEALTH INFORMATION"])
#105	((family or families or spouse* or wife or wives or husband* or parent* or parental or father or fathers or mother or mothers or grandparent* or grandfather* or grandmother* or sibling* or brother* or sister* or carer* or caregiver*) near/3 (support* or educat* or advice or advise* or advising or signpost* or sign post* or counsel* or informat* or communicat*)):ti
#106	((family or families) near/3 (support* or educat* or advice or advise* or advising or signpost* or sign post*)):ab
#107	#104 or #105 or #106
#108	[mh ^"SELF-MANAGEMENT"]
#109	[mh ^"SELF CARE"]
#110	[mh ^"SELF EFFICACY"]
#111	(self near/1 (manag* or care or help or responsib* or efficacy)):ti
#112	(self near/1 manag*):ab
#113	((fatigue* or depress*) near/3 (information or educat* or communicat* or advice or advise* or advising or counsel*)):ti,ab
#114	#108 or #109 or #110 or #111 or #112 or #113
#115	[mh ^GOALS]
#116	((patient* or person* or individual* or client* or user* or participant*) near/10 goal* near/3 (centre* or center* or plan* or set* or adjust* or rehab*)):ti,ab
#117	#115 or #116
#118	[mh ^"PLAY THERAPY"]
#119	(play* near/3 therap*):ti,ab
#120	#118 or #119
#121	[mh ^"FAMILY THERAPY"]
#122	(famil* near/3 therap*):ti,ab
#123	[mh ^SIBLINGS] and ([mh ^"SOCIAL SUPPORT"] or [mh ^COUNSELING] or [mh ^"DIRECTIVE COUNSELING"] or [mh ^EDUCATION] or [mh ^"HEALTH EDUCATION"] or [mh ^COMMUNICATION] or [mh "CONSUMER HEALTH INFORMATION"])
#124	((sibling* or brother* or sister*) near/3 (support* or educat* or advice or advise* or advising or signpost* or sign post* or counsel* or informat* or communicat*)):ti,ab
#125	#121 or #122 or #123 or #124
#126	[mh ^"PROBLEM BEHAVIOR"]
#127	((intervention* or therapy or therapies) near/3 (adapt* or behavio*)):ti,ab
#128	#126 or #127
#129	#82 and #87
#130	#82 and #103
#131	#82 and #107
#132	#82 and #114
#133	#82 and #117
#134	#31 and #82 and #120
#135	#31 and #82 and #125
#136	#31 and #82 and #128
#137	#129 or #130 or #131 or #132 or #133 or #134 or #135 or #136
#138	#129 or #130 or #131 or #132 or #133 or #134 or #135 or #136 with Publication Year from 1995 to 2019, in Trials
#139	#20 and #138

Appendix C – Clinical evidence study selection

Clinical study selection for review questions:

B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?)

A combined search was conducted for both review questions

Figure 1: Study selection flow chart: Adults

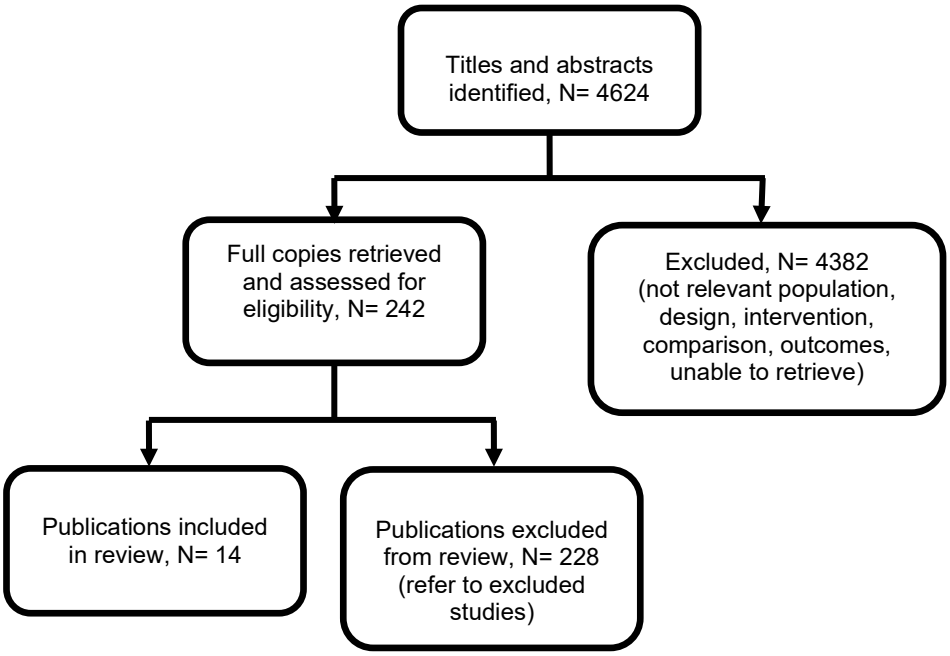
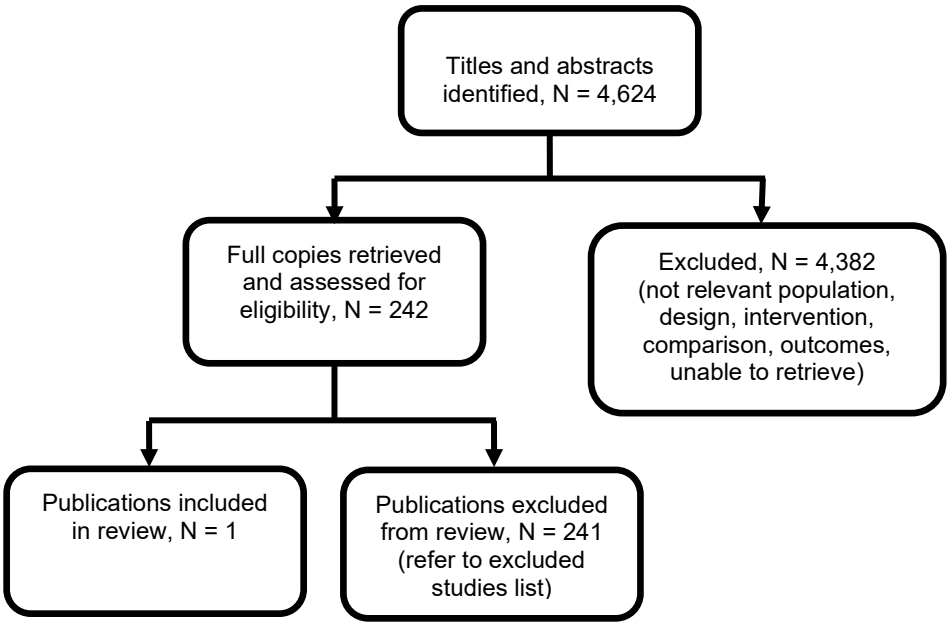


Figure 2: Study selection flow chart: Children and young people



Appendix D – Clinical evidence tables

Clinical evidence tables for review question: B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

Table 7: Clinical evidence tables

Study details	Participants	Interventions	Outcomes and Results	Comments
Full citation Allegrante, J. P., Peterson, M. G., Cornell, C. N., MacKenzie, C. R., Robbins, L., Horton, R., Ganz, S. B., Ruchlin, H. S., Russo, P. W., Paget, S. A., Charlson, M. E., Methodological challenges of multiple-component intervention: lessons learned from a randomized controlled trial of functional recovery after hip fracture, Hss j, 3, 63-70, 2007 **Ref Id** 1118071 **Country/ies where the study was carried out** USA **Study type** RCT	**Sample size** N= 176 (randomised) • Motivation and support: 90 • Standard post-operative care: 86 N= 59 (analysed) • Motivation and support: 32 • Standard post-operative care: 27 **Characteristics** Age in years [Mean (SD)]: • Motivation and support = 78 (7) • Standard post-operative care = 77 (8) Gender (M/F): • Motivation and support (N): 8/24 • Standard post-operative care (N): 6/21	**Interventions** • All eligible participants were recruited either 4th or 5th day after hip surgery. Informed consent was gotten, and baseline assessment taken. • *Control group* Standard post-operative care and rehabilitation services offered by hospital, including weight-bearing on fractured hip along with routine range -of-motion and strengthening exercises. As an attention control measure, control participants received supportive telephone schedule post-discharge very similar to intervention. • *Intervention group* Standard care plus intervention programme consisting of o Post-operative motivational videotape ('Getting Up Again, Getting Better') and corresponding patient information booklet given prior to discharge, primarily addressing fall prevention self-efficacy	**Results** *Quality of life (SF-36 Physical functioning) [mean (SD)]* At 6 months: • Motivation and support: 50 (25) • Standard post-operative care: 45 (29) *Quality of life (SF-36 General health domain) [mean (SD)]* At 6 months: • Motivation and support: 74 (22) • Standard post-operative care: 68 (25) *Quality of life (SF-36 Mental health) [mean (SD)]* At 6 months:	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomisation process 1.1 Was the allocation sequence random? Y – random number tables 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y 1.3 Did baseline differences between intervention groups suggest a problem with the randomisation process? PN *Risk-of-bias judgement:* Low risk Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)

Study details	Participants	Interventions	Outcomes and Results	Comments
Aim of the study To assess the efficacy and safety of a multi-component intervention on functional outcomes following hip surgery. **Study dates** Not reported **Source of funding** This study received funding from the National Institute of Arthritis and Musculoskeletal and Skin Diseases.	Time since injury in years: not reported Type of injury: not reported. Length of hospitalisation in days: not reported **Inclusion criteria** Participants had to: • Be aged 65 years or older • Have a primary unilateral fracture of the hip with a subsequent successful surgical repair **Exclusion criteria** • Patient was unable to give informed consent or unable to give coherent responses to mental state examination • Pathological cause of hip fracture • Non-English speaking • Exercise contra-indicated as determined by physician or diagnosis • No access to telephone or cannot be reached by telephone	○ In-hospital support visit from a peer counsellor, designed to model successful recovery and provide social support ○ 8-week outpatient individually tailored physical therapy programme, consisting of balance re-training, observational gait analysis and strength-training exercise. ○ Post-operation, all patients received weekly support telephone calls until their first post-surgical visit (week 4-5). At this point, they were cleared to participate in physical therapy component of the intervention.	• Motivation and support: 79 (12) • Standard post-operative care: 72 (23) *Pain (SF-36 Bodily pain) [mean (SD)]* At 6 months: • Motivation and support: 71 (23) • Standard post-operative care: 71 (26)	2.1. Were participants aware of their assigned intervention during the trial? PY 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? Y - only 10 participants received all components 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? No 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? PY 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA

Study details	Participants	Interventions	Outcomes and Results	Comments
	• Patient does not live in New York tristate area or were planning to relocate on discharge			*Risk-of-bias judgement:* High risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomised? No – outcome data only available for 32/90 in intervention group and 27/86 in control group. 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? PN - patients completing assessments at 6 months were statistically different. 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN - proportions and reasons similar *Risk-of-bias judgement:* Some concerns <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed

Study details	Participants	Interventions	Outcomes and Results	Comments
				between intervention groups? PN 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? PY - self assessed questionnaire 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Y 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? PY *Risk-of-bias judgement:* High risk Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales,

Study details	Participants	Interventions	Outcomes and Results	Comments
				definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> *Risk-of-bias judgement:* High risk **Other information** None.
Full citation Castillo, R. C., Wegener, S. T., Newell, M. Z., Carlini, A. R., Bradford, A. N., Heins, S. E., Wysocki, E., Pollak, A. N., Teter, H., Mackenzie, E. J., Improving outcomes at Level I trauma centers: An early evaluation of the trauma survivors network, Journal of Trauma and Acute Care Surgery, 74, 1534-1540, 2013 **Ref Id** 1093955 **Country/ies where the study was carried out** USA	**Sample size** N= 251 • Trauma Support Network: 126 • Standard care: 125 **Characteristics** Age in years [Mean (SD)]: • Trauma Support Network = 36.9 (14.1) • Standard care= 38.0 (12.5) Gender (M/F): • Trauma Support Network (N): 95/31 • Standard care (N): 44/81 Time since injury in years: not reported	**Interventions** • Trauma Support Network was implemented throughout the participating trauma centres and effectiveness was measured in a sample of participants meeting the inclusion criteria. Baseline assessments were conducted while participants were inpatients and follow-up via telephone. • *Control group* Standard care from participating rehabilitation centres. No further information reported. • *Intervention group* Standard care plus access to Trauma Support Network (TSN), which integrates 4 supportive platforms that are accessed through a customised information technology. ○ Peer-support - peer visitation with TSN-trained individuals,	**Results** *Quality of life (SF-12 Physical component score) [mean (SD)]* At 6 months from baseline: • Trauma Support Network: 41.4 (11.9) • Standard care: 40.0 (12.9) *Quality of life (SF-12 Mental component score) [mean (SD)]* At 6 months from baseline: • Trauma Support Network group: 52.2 (15.0) • Standard care: 48.8 (15.1)	**Limitations** **Quality assessment:** Risk of bias assessed using Risk Of Bias In Non-randomized Studies of Interventions (ROBINS-I): <u>Domain 1: Bias due to confounding</u> 1.1 Is there potential for confounding of the effect of intervention in this study? Y 1.2. Was the analysis based on splitting participants' follow-up time according to intervention received? N If N/PN, answer questions relating to baseline confounding (1.4 to 1.6) If Y/PY, go to question 1.3. 1.4. Did the authors use an appropriate analysis method that controlled for all the

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type Prospective and retrospective cohort study **Aim of the study** To evaluate the effectiveness of the Trauma Survivors Network, a psychosocial support intervention, on patient reported outcomes in orthopaedic trauma patients. **Study dates** Recruitment: control group 2008 to 2009; intervention group 2009 to 2010. **Source of funding** This study received funding from the Centers for Disease Control.	Injury cause: not reported **Inclusion criteria** Participants had to be: • Aged between 18 to 69 years' old • Discharged alive • Sustained one or more extremity injuries • No serious brain injury (defined as an Abbreviated Injury Scale score of above 3) • English speaking • Not in jail or homeless • Computer literate, with access to a computer at home, work or school **Exclusion criteria** Not reported. See above for inclusion criteria.	trauma support groups and TSN website ○ Self-management - NextSteps is the TSN self-management course, which is focused in engaging participants as active partners in their recovery. This is done through increasing problem-solving skills, forming relationships with healthcare providers and goal setting. ○ Information and resources - accessed through a handbook and TSN website. ○ Provider training - educate healthcare providers on the TSN through staff meetings, hospital in-services and educational presentations.	*Changes in mood (BSI score for anxiety) [mean(SD)]* *At 6 months from baseline* • Trauma Support Network: 4.3 (0.8) • Standard care: 4.3 (0.7) *Changes in mood (PHQ-9 depression score) [mean (SD)]* At 6 months from baseline: • Trauma Support Network: 6.1 (6.0) • Standard care: 8.3 (6.5)	important confounding domains? PY 1.5. If Y/PY to 1.4: Were confounding domains that were controlled for measured validly and reliably by the variables available in this study? PY 1.6. Did the authors control for any post-intervention variables that could have been affected by the intervention? N Questions relating to baseline and time-varying confounding 1.7. Did the authors use an appropriate analysis method that controlled for all the important confounding domains and for time-varying confounding? 1.8. If Y/PY to 1.7: Were confounding domains that were controlled for measured validly and reliably by the variables available in this study? *Risk of bias:* Some concerns <u>Domain 2: Bias in selection of participants into the study</u> 2.1. Was selection of participants into the study (or into the analysis) based on participant characteristics

Study details	Participants	Interventions	Outcomes and Results	Comments
				observed after the start of intervention? N If N/PN to 2.1: go to 2.4: 2 2.4. Do start of follow-up and start of intervention coincide for most participants? PN - evaluation group was enrolled between 2009 and 2010 following the programme start. 2.5. If Y/PY to 2.2 and 2.3, or N/PN to 2.4: Were adjustment techniques used that are likely to correct for the presence of selection biases? N *Risk of bias:* High risk <u>Domain 3: Bias in classification of interventions</u> 3.1 Were intervention groups clearly defined? PN - possibility that some control participants were exposed to intervention 3.2 Was the information used to define intervention groups recorded at the start of the intervention? PY 3.3 Could classification of intervention status have been affected by knowledge of the outcome or risk of the outcome? PN *Risk of bias:* High risk

Study details	Participants	Interventions	Outcomes and Results	Comments
				Domain 4: Bias due to deviations from intended interventions 4.1. Were there deviations from the intended intervention beyond what would be expected in usual practice? Y- use of TSN resource ranged from 3-27%. Additionally, Next Steps only ran once during experimental period and was not well attended. 4.2. If Y/PY to 4.1: Were these deviations from intended intervention unbalanced between groups and likely to have affected the outcome? PY *Risk of bias:* High risk Domain 5: Bias due to missing data 5.1 Were outcome data available for all, or nearly all, participants? No – only 75.5% participants followed up (74% intervention and 77% control) 5.2 Were participants excluded due to missing data on intervention status? PN 5.3 Were participants excluded due to missing data on other variables needed for the analysis? NI

Study details	Participants	Interventions	Outcomes and Results	Comments
				5.4 If PN/N to 5.1, or Y/PY to 5.2 or 5.3: Are the proportion of participants and reasons for missing data similar across interventions? NI - proportions similar but no information on reasons 5.5 If PN/N to 5.1, or Y/PY to 5.2 or 5.3: Is there evidence that results were robust to the presence of missing data? NI *Risk of bias:* High risk Domain 6: Bias in measurement of outcomes 6.1 Could the outcome measure have been influenced by knowledge of the intervention received? PY 6.2 Were outcome assessors aware of the intervention received by study participants? Y - self assessment 6.3 Were the methods of outcome assessment comparable across intervention groups? Y 6.4 Were any systematic errors in measurement of the outcome related to intervention received? PN *Risk of bias:* Some concerns Overall risk of bias *Risk-of-bias judgement:* High risk

Study details	Participants	Interventions	Outcomes and Results	Comments
				Other information None.
Full citation Coker, J., Cuthbert, J., Ketchum, J. M., Holicky, R., Huston, T., Charlifue, S., Re-inventing yourself after spinal cord injury: a site-specific randomized clinical trial, Spinal Cord, 57, 282-292, 2019 **Ref Id** 1021091 **Country/ies where the study was carried out** USA **Study type** RCT **Aim of the study** This RCT aimed to compare the effect of a self-efficacy group treatment programme to no treatment in adults after acute spinal cord injury (SCI). **Study dates** Recruitment: October 2011 to November 2015	**Sample size** N= 81 (randomised) • Therapeutic intervention programme: 41 • Waitlist control: 40 N= 81 (analysed) • Therapeutic intervention programme: 41 • Waitlist control: 40 **Characteristics** Age in years [Mean (SD)]: • Therapeutic intervention programme: = 48.0 (12.8) • Waitlist control = 52.0 (15.3) Gender (M/F): • Therapeutic intervention programme (N): 34/7 • Waitlist control (N): 32/8 Time since injury: Not reported	**Interventions** • *Control Group:* Waitlist control. • *Intervention group:* 'Re-inventing Yourself after SCI' - a manual-based, educationally-based group therapeutic intervention programme consisting of 2 hour weekly sessions for 6 weeks. 8 specific skills were presented over the course, designed to re-frame the way an individual looks at events, build their confidence and developing ways to express positive attitude. These skills were taught in a schedule, designed to progress from introductory concepts to more complex ones. Each session was led by trained group facilitators (including a physical therapist, a nurse, a social worker, and an individual with SCI) and included presentations, goal setting and group discussion. Tasks were also assigned to be completed at home between sessions.	**Results** *Changes in mood (PHQ-9) [mean (SE)]* After intervention completion (week 6): • Therapeutic intervention programme: 7.19 (0.87) • Control (waitlist): 6.83 (0.85) 24 weeks follow-up from baseline (week 30): • Therapeutic intervention programme: 7.18 (0.88) • Control (waitlist): 6.58 (0.85)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) **Domain 1: Risk of bias arising from the randomization process** 1.1 Was the allocation sequence random? Y – group blocked randomisation by statistician in groups of 17 participants 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PN - no statistical analysis presented but visibly appear similar Risk-of-bias judgement Low risk **Domain 2: Risk of bias due to deviations from the intended interventions (*effect of assignment to intervention*)**

Study details	Participants	Interventions	Outcomes and Results	Comments
Source of funding Funded by a grant from National Institute on Disability and Rehabilitation Research/National Institute on Disability, Independent Living, and Rehabilitation Research.	Level of injury (AIS grade A/B/C/D): • Therapeutic intervention programme (N): 19/2/7/13 • Waitlist control (N): 16/3/8/13 Type of SCI (motor complete/incomplete) • Therapeutic intervention programme (N): 19/22 • Waitlist control (N): 16/24 **Inclusion criteria** Participants had to: • be 18 years old or over at enrolment • have a traumatic or non-traumatic SCI at any level • be at least 4 weeks post-discharge from initial inpatient rehabilitation • be English-speaking • provide informed consent to participate **Exclusion criteria** • History of moderate or severe traumatic brain injury • Participant in another RCT, formal clinical			2.1. Were participants aware of their assigned intervention during the trial? Y 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY - not possible to blind due to nature of intervention 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? No – modular approach and strict schedule to intervention. Treatment fidelity monitoring also performed. 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the

Study details	Participants	Interventions	Outcomes and Results	Comments
	group or psychological therapy • Individuals currently experiencing ≥moderately severe levels of depression • Individuals currently self-efficacious • Living beyond a reasonable commuting distance from the study site • Participants unable to verbally communicate			group to which they were randomized? NA Risk-of-bias judgement Low risk **Domain 3: Missing outcome data** 3.1 Were data for this outcome available for all, or nearly all, participants randomized? No – only 4 (5%) lost to follow up/withdrew but all were assigned to the intervention group 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? PY – sensitivity analysis and adjustment for co-variates done 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA Risk-of-bias judgement Low risk **Domain 4: Risk of bias in measurement of the outcome** 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed

Study details	Participants	Interventions	Outcomes and Results	Comments
				between intervention groups? PN 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? No – outcome assessors blinded to intervention group 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA Risk-of-bias judgement Low risk **Domain 5: Risk of bias in selection of the reported result** 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points)

Study details	Participants	Interventions	Outcomes and Results	Comments
				within the outcome domain? PN 5.3 ... multiple analyses of the data? PN Risk-of-bias judgement Some concerns **Overall risk of bias** Risk-of-bias judgement Some concerns **Other information** None
Full citation Elinge, Eva, Löfgren, Britta, Gagerman, Eva, Nyberg, Lars, A Group Learning Programme for Old People with Hip Fracture: A Randomized Study, Scandinavian Journal of Occupational Therapy, 10, 27-33, 2003 **Ref Id** 1118075 **Country/ies where the study was carried out** Sweden **Study type** RCT **Aim of the study** To investigate the effectiveness of a group learning programme on	**Sample size** N= 43 (randomised) • Small group learning: 21 • Standard care and rehab: 22 N= 35 (analysed) • Small group learning: 21 • Standard care and rehab: 14 **Characteristics** Age in years [Mean (SD)]: • Small group learning = 73.1 (7.3) • Standard care and rehab = 73.8 (11.1) Gender (M/F): • Small group learning (N): 5/16 • Standard care and rehab (N): 3/11	**Interventions** • First pre-intervention assessment occurred 3 months after hip or vertebral fracture, post-intervention 2nd assessment, and 3rd assessment 12 months after the intervention. • *Control group* Standard care for hip fractures and rehabilitation as provided by trauma centre. No further information reported. • *Intervention group* Group learning programme consisting of lectures from a multi-disciplinary geriatric team, focusing on the risk factors and effects of osteoporosis, fall prevention and performing activities of daily living safely. Lecturers included a dietician, an occupational therapist, a physician, a physiotherapist, a social worker and a gymnast. Participants were divided into 4 groups, each with 5-8 participants, and started 106-194 days after hip fracture (when enough participants had joined	**Results** *Changes in ADL (Barthel ADL Index) [median (range)]* At intervention completion: • Small group learning: 20 (12-20) • Standard care and rehab: 19 (16-20) 12 months after intervention completion: • Small group learning: 20 (18-20) • Standard care and rehab: 19 (17-20)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomisation process</u> 1.1 Was the allocation sequence random? NI 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? NI 1.3 Did baseline differences between intervention groups suggest a problem with the randomisation process? PY - significantly significant lower ability to perform activities of daily living at baseline in control. *Risk-of-bias judgement:* High risk

Study details	Participants	Interventions	Outcomes and Results	Comments
ability to participate in perceived performance and social activities after hip fracture. **Study dates** Recruitment: October 1996 to February 1998 **Source of funding** This study received funding from the Swedish National Board of Health and Welfare and Geriatric Centre, Um eå University Hospital	Time since injury in years: not reported Injury cause: not reported Length of hospitalisation in days: not reported Fracture type (cervical/trochanteric): • Small group learning (N): 16/5 • Standard care and rehab (N): 10/4 **Inclusion criteria** Patients had to be: • Part of larger group learning programme including patients with hip or vertebral fracture • Admitted to Orthopaedic or Geriatric clinic at Umeå University Hospital with diagnosis of hip fracture or vertebral fracture **Exclusion criteria** • Dementia or other severe cognitive impairment	the study). Each session lasted 2 hours (1 hour of education, 1 hour of weight-bearing exercise), and ran once a week for 10 weeks. Additionally, intervention participants received an individually tailored home-training programme.		<u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? NI 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the

Study details	Participants	Interventions	Outcomes and Results	Comments
	• Psychiatric or other severe illness • Fracture caused by high-energy trauma or pathology • Previous fracture of opposite hip • Inability to walk independently before fracture			group to which they were randomised? NA *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomised? No - large attrition in control arm only. 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? No 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PY - large loss to follow-up in the control group only. Outcome data only available for 14/22 in control group, compared to all 21 participants in intervention group. *Risk-of-bias judgement:* High risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? PN

Study details	Participants	Interventions	Outcomes and Results	Comments
				4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? NI 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? PY 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? PY *Risk-of-bias judgement:* High risk <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalised before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from...

Study details	Participants	Interventions	Outcomes and Results	Comments
				5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> *Risk-of-bias judgement:* High risk **Other information** None.
Full citation Holmes, A., Hodgins, G., Adey, S., Menzel, S., Danne, P., Kossmann, T., Judd, F., Trial of interpersonal counselling after major physical trauma, Australian and New Zealand journal of psychiatry, 41, 926-933, 2007 **Ref Id** 1070729 **Country/ies where the study was carried out** Australia	**Sample size** N= 90 (randomised) • Interpersonal counselling: 51 • Standard care: 39 N= 58 (analysed) • Interpersonal counselling: 27 • Standard care: 31 **Characteristics** Age in years [Mean (SD)]: • Interpersonal counselling = 39.9 (15.8) • Standard care = 36.4 (14.8)	**Interventions** • *Control group* Standard care including non-specific psychological support (physiological and occupational). No further information reported apart from noting that if patients exhibited psychological distress, they were referred to the study co-ordinator or their primary care doctor. • *Intervention group* Interpersonal counselling (IPC) delivered for initial 3 months' post-trauma. Sessions included identifying the impact of trauma on interpersonal issues, both before and after the incident, as well as issues of role transference, grief and loss. Strategies for adaptation were	**Results** *Changes in mood (BDI) [mean (SD)]* At 3 months: • Interpersonal counselling: 13.1 (12.4) • Standard care: 9.8 (7.8) At 6 months: • Interpersonal counselling: 12.3 (11.2) • Standard care: 12.3 (11.5) *Changes in mood (HADS Anxiety score) [mean (SD)]*	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? Y – research officer made blind selection from mixed envelopes. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y 1.3 Did baseline differences between intervention groups

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type RCT **Aim of the study** To measure the effectiveness of an interpersonal counselling intervention on reducing psychological morbidity after major physical trauma. **Study dates** Not reported **Source of funding** This study received funding from the Victorian Trauma Foundation.	Gender (M/F): • Interpersonal counselling (N): 36/15 • Standard care (N): 27/12 Time since injury in years: not reported Injury cause: not reported Length of hospitalisation in days [Mean (SD)]: • Interpersonal counselling: 15.7 (13.3) • Standard care: 13.1 (11.4) % total burn surface area [Mean (SD)]: • Interpersonal counselling: 35.50 (42.91) • Standard care: 38.00 (43.37) **Inclusion criteria** Participants had to: • Aged 18 years or older • Experienced major physical trauma without major head injury	developed during sessions and practiced by participants between therapy. ○ *Therapists* Professional clinical psychologists who had received at least 20 hours IPC seminar training and subject to ongoing peer reviewing of sessions.	At 3 months: • Interpersonal counselling: 4.7 (5.0) • Standard care: 4.1 (3.9) At 6 months: • Interpersonal counselling: 6.9 (5.2) • Standard care: 6.9 (5.2) *Changes in mood (HADS Depression score) [mean (SD)]* At 3 months: • Interpersonal counselling: 5.6 (5.1) • Standard care: 4.3 (3.9) At 6 months: • Interpersonal counselling: 8.9 (6.8) • Standard care: 8.2 (6.4)	suggest a problem with the randomization process? PN *Risk-of-bias judgement*: Low risk <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? NI 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? NI 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? PY - no information given on frequency of intervention, length of session 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? PN 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? PY 2.6 Was an appropriate analysis used to estimate the effect of assignment to

Study details	Participants	Interventions	Outcomes and Results	Comments
	• Injury not due to self-harm • No current psychotic illness **Exclusion criteria** Not reported. See above for inclusion criteria.			intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA *Risk-of-bias judgement:* High risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomised? No – data only available for 27/51 in intervention group and 31/39 in control group. 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? PY 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA *Risk-of-bias judgement:* Low risk <u>Domain 4: Risk of bias in measurement of the outcome</u>

Study details	Participants	Interventions	Outcomes and Results	Comments
				4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? No 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA *Risk-of-bias judgement*: Low risk <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalised before unblinded outcome data were available for analysis? NI

Study details	Participants	Interventions	Outcomes and Results	Comments
				Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Some concerns Overall risk of bias *Risk-of-bias judgement:* High risk **Other information** None.
Full citation Kooijmans, H., Post, M. W. M., Stam, H. J., van der Woude, L. H. V., Spijkerman, D. C. M., Snoek, G. J., Bongers-Janssen, H. M. H., van Koppenhagen, C. F., Twisk, J. W., Bussmann, J. B. J., Effectiveness of a Self-Management Intervention to Promote an Active Lifestyle in Persons With Long-Term Spinal Cord Injury: The HABITS Randomized Clinical Trial,	**Sample size** N= 64 (randomised) • HABITS: 33 • Single meeting control: 31 N= 55 (analysed at 16 weeks) • HABITS: 30 • Control: 25 N= 51 (analysed at 42 weeks) • HABITS: 28	**Interventions** • Assessments occurred at baseline, 16 weeks following baseline and 42 weeks following baseline. Participant assessed outcomes were collected via self-report and an activity monitor while physical tests were carried out at the rehabilitation centre. • *Control group* One group meeting in week 1, giving information on active lifestyle in SCI, and 'How to Stay Fit with SCI' information booklet. This booklet had been published at the start of the study	**Results** *Quality of life (WHOQOL-5) [mean (SD)]* At 16 weeks (following baseline): • HABITS (N=21): 18.5 (3.1) • Single meeting control (N=21): 19.0 (2.7) At 42 weeks (following baseline):	L**imitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomisation process 1.1 Was the allocation sequence random? NI 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y

Study details	Participants	Interventions	Outcomes and Results	Comments
Neurorehabilitation and Neural Repair, 31, 991-1004, 2017 **Ref Id** 1091584 **Country/ies where the study was carried out** The Netherlands **Study type** RCT **Aim of the study** To test the effectiveness of a structured self-management intervention on physical activity, perceived behaviour control, stages of exercise change, and attitude in people with chronic SCI. **Study dates** Recruitment: January 2012 to October 2014 **Source of funding** This study received funding from by ZonMW and Fonds Nutsohra.	• Single meeting control: 23 **Characteristics** Age in years [Mean (SD)]: • HABITS = 48 (10) • Single meeting control = 49 (11) Gender (M/F): • HABITS (N): 21/12 • Single meeting control (N): 24/7 Time since injury in years [Mean (SD)]: • HABITS = 21 (8) • Single meeting control = 23 (10) Injury cause: not reported **Inclusion criteria** Participants had to: • Be aged 28-65 years' old • Be aged 18 years or above at the time of injury, and have at least 10 years since injury • Able to use a hand-rim wheelchair • Physically inactive (defined as Physical Activity Scale for	and contained up-to-date information. • *Intervention group* Healthy Active Behavioural Intervention in SCI (HABITS), which involved 1 home visit and 5 group sessions over 16 weeks. Designed to include elements that can facilitate an active lifestyle and increase self-management mechanisms: counsellor guidance; peer support; information and discussions relating to active lifestyle; action planning and coping strategies; problem solving; and activity monitoring. Participants also received a work book and a 'How to Stay Fit with SCI' information booklet. ○ *HABITS* Combines the Theory of Planned Behaviour and Transtheoretical Model of Behaviour Change in its framework. Targets 2 areas for behaviour change - optimising intentions toward a healthier lifestyle and improving perceived behaviour control (which itself includes self-efficacy and proactive coping). ○ *Counsellors* Professionals currently working in rehabilitation centres, used to working with people with SCI e.g. occupational therapists, who received training in motivational interviewing.	• HABITS (N=17): 19.8 (3.3) • Single meeting control (N=14): 18.7 (2.8) *Overall quality of life (MHI-5) [mean(SD)]* At 16 weeks (following baseline): • HABITS (N=21): 77.5 (11.2) • Single meeting control (N=21): 74.7 (11.2) At 42 weeks (following baseline): • HABITS (N=17): 79.3 (14.1) • Single meeting control (N=14): 78.6 (9.4) *Changes in activity of daily living (SCIM3) [mean (SD)]* At 16 weeks (following baseline): • HABITS (N=25): 58.5 (15.6) • Single meeting control (N=25): 56.6 (15.6) At 42 weeks (following baseline):	1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? N *Risk-of-bias judgement:* Low risk <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? N - researchers blinded until data analysis stage 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? N 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the

Study details	Participants	Interventions	Outcomes and Results	Comments
	Individuals with Physical Disabilities score below 75th percentile of Dutch population) **Exclusion criteria** • No intent to change physical activity behaviour in next 6 months • Progressive disease or severe co-morbidities • Psychiatric issues that might affect study adherence and results • Insufficient knowledge of Dutch language that would preclude participant giving informed consent		• HABITS (N=23): 57.9 (16.3) • Single meeting control (N=20): 57.1 (15.5)	effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N - imputation of values 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PY – intervention group has missing data for 15% (28/33) but 25% (23/31) for control group. *Risk-of-bias judgement:* High risk

Study details	Participants	Interventions	Outcomes and Results	Comments
				Domain 4: Risk of bias in measurement of the outcome 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? No 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? No 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA *Risk-of-bias judgement:* Low risk Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalised before unblinded outcome data

Study details	Participants	Interventions	Outcomes and Results	Comments
				were available for analysis? Y Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Low risk <u>Overall risk of bias</u> *Risk-of-bias judgement:* High risk **Other information** None.
Full citation Mercier, H. W., Ni, P., Houlihan, B. V., Jette, A. M., Differential Impact and Use of a Telehealth Intervention by Persons with MS or SCI, Am J Phys Med Rehabil, 94, 987-99, 2015 **Ref Id** 1118078	**Sample size** N= 142 (randomised) • CareCall (MS): 18 • CareCall (SCI): 53 • Standard care and resource book: 71 (18 MS + 53 SCI) N= 106 (analysed) • CareCall (SCI): 53 • Standard care and resource book: 53	**Interventions** • Assessment was done in participant homes, by blinded assessors, at baseline and 6months follow-up. • *Control group* Standard care plus CareCall resource book. No further information reported. • *Intervention group* CareCall. 6 months of scheduled automated telephone calls to deliver educational content, peer support and clinical expertise relating to depression, skin care, wellness	**Results** *Changes in activity of daily living (CHART-SF Physical independence) [mean (SD)]* at 6 months: • CareCall: 72.4 (34.5) • Standard care and resource book: 70.4 (32.2)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? NI 1.2 Was the allocation sequence concealed until participants were enrolled

Study details	Participants	Interventions	Outcomes and Results	Comments
Country/ies where the study was carried out USA **Study type** RCT **Aim of the study** To measure the effect of CareCall, a telehealth intervention, in adult wheelchair users with severe mobility limitations and spinal cord injury. NOTE: Study includes participants with MS and SCI. However, results are reported separately for these conditions and only SCI has been extracted. **Study dates** Not reported **Source of funding** This study received funding from the Centers for Disease Control and Prevention, the Department of Health and Human Services, and the National Institute	**Characteristics** Age in years [Mean (SD)]: • CareCall = 45.8 (12.1) • Standard care and resource book = 45.0 (14.0) Gender (M/F): • CareCall (N): 42/11 • Standard care and resource book (N): 34/19 Time since injury in years [Mean (SD)]: • CareCall: 11.5 (11.7) • Standard care and resource book: 12.1 (9.7) Injury cause: not reported Length of hospitalisation in days: not reported SCI level (cervical/thoracic/lumbar): • CareCall (N): 23/25/2 • Standard care and resource book (N): 28/21/4 **Inclusion criteria** Participants had to:	and health care utilisation. Calls were delivered weekly for initial 3 months and every 2 weeks for the last 3 months. These calls were pre-programmed to be automatically made to participants at on their preferred schedule. If needed, participants could call into the CareCall system to access that week's content, report a healthcare issue or leave a message for a nurse tele-rehabilitation co-ordinator. Participants also received a resource book that reinforced diagnosis-specific and general information provided during Carecall telephone calls, as well as additional information on community resources. ○ *Nurse telerehabilitation co-ordinators* Alerted when a clinically significant event was reported to CareCall, and called participants back 48-72 hours later (depending on severity of alert). Nurses were then able to provide appropriate referral, resources and action. A tracking system was utilised to inform future CareCall information.	*Changes in mood (PHQ-9 depression score) [mean (SD)]* at 6 months: • CareCall: 3.0 (3.5) • Standard care and resource book: 4.0 (5.0) NB. Satisfaction is measured and reported but only in intervention group so no comparison data.	and assigned to interventions? NI 1.3 Did baseline differences between intervention groups suggest a problem with the randomisation process? PN <u>Risk-of-bias judgement:</u> Some concerns <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? NI 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? NI 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the

Study details	Participants	Interventions	Outcomes and Results	Comments
of Disability and Rehabilitation Research.	• Community-residing adults with spinal cord dysfunction (either multiple sclerosis or spinal cord injury) • Use a wheelchair at least 6 hours per day • Sufficient cognitive ability to use CareCall intervention **Exclusion criteria** • Participants at risk for self-harm. • Stage III pressure ulcer. • Participants with a scheduled surgery • Severe psychiatric illness e.g. bipolar or severe depression that could affect the reliability of outcome data. • Non-traumatic spinal cord dysfunction diagnosis with fast progression			effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA *Risk-of-bias judgement:* Some concerns <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomised? Y 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NA 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA *Risk-of-bias judgement:* Low risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? PN

Study details	Participants	Interventions	Outcomes and Results	Comments
				4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? No - blinded assessors 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA *Risk-of-bias judgement:* Low risk <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalised before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been

Study details	Participants	Interventions	Outcomes and Results	Comments
				selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Some concerns Overall risk of bias *Risk-of-bias judgement:* Some concerns **Other information** None.
Full citation Migliorini, C., Sinclair, A., Brown, D., Tonge, B., New, P., A randomised control trial of an Internet-based cognitive behaviour treatment for mood disorder in adults with chronic spinal cord injury, Spinal Cord, 54, 695-701, 2016 **Ref Id** 1022802 **Country/ies where the study was carried out** Australia	**Sample size** N= 59 (randomised) • Psycho-educational programme: 34 • Waitlist control: 25 N= 48 (analysed) • Psycho-educational programme: 23 • Waitlist control: 25 **Characteristics** Age in years [Mean (SD)]: • Psycho-educational programme = 47.5 (12.2) • Waitlist control Control= 52.8 (12.9)	**Interventions** • *Intervention:* ePACT, a weekly modular skills and psycho-educational programme based on cognitive behavioural therapy for 10 sessions (between 10 mins and 1 hour). Work was assigned outside of class to continue development and it was recommended to have clinician support by telephone and/or e-mail. • *Control:* Waitlist control	**Results** *Changes in mood (DASS-21: Depression) [mean (SD)]* At intervention completion (10-12 weeks from baseline): • Psycho-educational programme: 12.3 (12.2) • Control (waitlist): 15.0 (10.8) *Changes in mood (DASS-21: Anxiety) [mean (SD)]*	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) **Domain 1: Risk of bias arising from the randomization process** 1.1 Was the allocation sequence random? Y - block allocation (groups of 10) 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? PN – 1:1 block randomisation (groups of 10) changed to 3:2 (groups of 10) as study

Study details	Participants	Interventions	Outcomes and Results	Comments
Study type RCT **Aim of the study** This RCT aimed to compare a skills and psycho-education programme intervention to waitlist controls in adults after spinal cord injury (SCI). **Study dates** Recruitment: 15 month period from 2012 to 2013 **Source of funding** Supported by beyondblue, Victorian Centre of Excellence 2011 Research Grant.	Gender (M/F): • Psycho-educational programme (N): 25/9 • Waitlist control Control (N): 17/8 Time since injury in months (Mean [SD]): • Psycho-educational programme: 11.4 (11.9) • Waitlist control Control: 19.8 (14.0) Level of injury: Not reported Type of SCI: Not reported **Inclusion criteria** Participants had to: • be aged between 18 and 70 years old • have chronic (more than 6 months) SCI • scored above normative threshold on Depression, Anxiety and Stress Scale-Short Form • be living in the community **Exclusion criteria** Not reported.		At intervention completion (10-12 weeks from baseline): • Psycho-educational programme: 7.0 (7.9) • Control (waitlist): 7.2 (8.2)	progressed due to large drop out in one arm 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PY – comparative analysis performed. Some discrepancies in time since and level of injury. Risk-of-bias judgement High risk **Domain 2: Risk of bias due to deviations from the intended interventions (*effect of assignment to intervention*)** 2.1. Were participants aware of their assigned intervention during the trial? Y – allocation concealed from participants until baseline interview completed 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY – not possible to blind due to nature of intervention 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? PN – modular approach and strict schedule to intervention. 2.4. If Y/PY to 2.3: Were these deviations from

Study details	Participants	Interventions	Outcomes and Results	Comments
				intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA Risk-of-bias judgement Low risk **Domain 3: Missing outcome data** 3.1 Were data for this outcome available for all, or nearly all, participants randomized? No - roughly 18.5% dropout. 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? No 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY – documented several reasons but not for all 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the

Study details	Participants	Interventions	Outcomes and Results	Comments
				outcome depended on its true value? PY – all drop-out occurred in intervention group, some reasons due to intervention itself *Risk-of-bias judgement* High risk **Domain 4: Risk of bias in measurement of the outcome** 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? PY – majority self-reported (unblended study), not mention of professional study assessors 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? y - self reported measures used 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? PN

Study details	Participants	Interventions	Outcomes and Results	Comments
				Risk-of-bias judgement Some concerns **Domain 5: Risk of bias in selection of the reported result** 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? NI 5.3 ... multiple analyses of the data? NI Risk-of-bias judgement Some concerns **Overall risk of bias** ***Risk-of-bias judgement*** High risk **Other information** None.
Full citation Mohaddes Ardebili, Fatemeh, Najafi Ghezeljeh, Tahereh, Bozorgnejad, Mehri, Zarei, Mohammadreza, Ghorbani, Hooman,	**Sample size** N= 100 (randomised) • Multi-media self-care education: 50 • Self-care recommendation: 50	**Interventions** • Assessment occurred at discharge (basline) and at 3 months follow-up, via telephone. • *Control group* Face-to-face delivered suggested self-care	**Results** *Quality of life (Brief BSHQ) [mean (SD)]* 3 months after intervention:	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2)

Study details	Participants	Interventions	Outcomes and Results	Comments
Manafi, Farzad, Effect of Multimedia Self-Care Education on Quality of Life in Burn Patients, World journal of plastic surgery, 6, 292-297, 2017 **Ref Id** 1091623 **Country/ies where the study was carried out** Iran **Study type** RCT **Aim of the study** To investigate the effect of a multi-media self-education package on quality of life in burn patients. **Study dates** Investigation: November 2015 to December 2016 **Source of funding** Not reported.	N= 100 (analysed) • Multi-media self-care education: 50 • Self-care recommendation: 50 **Characteristics** Age in years (18-28/29-38/39-48/49-58): • Multi-media self-care education (N) = 11/15/17/7 • Self-care recommendation (N) = 10/22/14/6 Gender (M/F): • Multi-media self-care education (N): 23/28 *Adds up to 51, double checked reported figures. • Self-care recommendation (N): 22/28 Time since injury in years: not reported Injury cause (Gas/Natural gas/Flame/Liquids/Kerosine/Food/Other)	routine. No further information reported. • *Intervention group* Face-to-face suggested self-care routine plus a burn patient self-care CD, educational books and information resources. Information on self-care included activities of daily living, care of repaired burn areas and skin grafts, nutrition, compression clothing, mental health education, sleep improvement, and pharmacological care. Participants also received a briefing session prior to discharge to ask any questions the educational material may have raised.	• Multi-media self-care education: 3.37 (0.93) • Self-care recommendation: 2.24 (0.37)	<u>Domain 1: Risk of bias arising from the randomisation process</u> 1.1 Was the allocation sequence random? NI 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? NI 1.3 Did baseline differences between intervention groups suggest a problem with the randomisation process? PY - significant differences found in baseline occupation and marital status. *Risk-of-bias judgement:* High risk <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? NI 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? NI 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? NI

Study details	Participants	Interventions	Outcomes and Results	Comments
	• Multi-media self-care education (N): 3/8/18/13/1/4/3 • Self-care recommendation (N): 2/14/17/12/2/1/2 **Inclusion criteria** • Not reported. **Exclusion criteria** • Not reported.			2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA *Risk-of-bias judgement:* Some concerns <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomised? Y 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NA 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA

Study details	Participants	Interventions	Outcomes and Results	Comments
				3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA *Risk-of-bias judgement:* Low risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PY - no blinding and self-report outcomes 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? NA 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA *Risk-of-bias judgement:* High risk

Study details	Participants	Interventions	Outcomes and Results	Comments
				Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalised before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Some concerns Overall risk of bias *Risk-of-bias judgement:* High risk **Other information** None.
Full citation Nooijen, C. F., Stam, H. J., Bergen, M. P., Bongers-Janssen, H. M., Valent, L., van	**Sample size** N= 45 (randomised) • Motivational interviewing: 23 • Standard care: 22	**Interventions** • Assessment occurred 2 months before inpatient rehabilitation discharge (baseline), inpatient rehabilitation discharge, 6 months	**Results** *Changes in ADL (min/day wheeled physical activity) [mean (SD)]*	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2)

Study details	Participants	Interventions	Outcomes and Results	Comments
Langeveld, S., Twisk, J., van den Berg-Emons, R. J., A behavioural intervention increases physical activity in people with subacute spinal cord injury: a randomised trial, Journal of physiotherapy, 62, 35-41, 2016 **Ref Id** 1091349 **Country/ies where the study was carried out** The Netherlands **Study type** RCT **Aim of the study** To test the effect of standard rehabilitation including a behavioural intervention promoting physical activity on physical activity in people with subacute spinal cord injury. **Study dates** Recruitment: January 2011 to August 2013. **Source of funding**	N= 30 (analysed at discharge [2 months after baseline]) • Motivational interviewing: 16 • Standard care: 14 N= 27 (analysed at 6 months after discharge) • Motivational interviewing: 13 • Standard care: 14 N= 20 (analysed at 12 months after discharge) • Motivational interviewing: 10 • Standard care: 10 **Characteristics** Age in years [Mean (SD)]: • Motivational interviewing = 44 (15) • Standard care = 44 (15) Gender (M/F): • Motivational interviewing (N): 17/3 • Standard care (N): 16/3 Time since injury in days [Mean (SD)]:	post-dsischare (within 4 weeks of intervention completion), and 12 months post-discharge. Measurements were a mixture of physical activity monitiors, physical tests and self-reported outcomes. • *Control group* Standard care, including a handcycle training programme and advice on physical activity post-discharge. The handcycling programme consisted of a structured interval training protocol, 3 times per week for last 8 weeks of inpatient rehabilitation. Physical activity advice was mainly sports-related rather than activities of daily living and was unstructured. All participants continued rehabilitation after discharge. • *Intervention group* Behavioural intervention aimed at increasing the amount of physical activity performed every day during outpatient rehabilitation, plus standard care. The intervention was given during 13 individual sessions (maximum 60 minutes each), either given face-to-face or via telephone, if more practical. As of 2 months prior to discharge, sessions were scheduled twice per month until 3 months after discharge. After these 10 sessions, the remaining sessions were scheduled one every three months.	At discharge (2 months after baseline): • Motivational interviewing: 72 (14) • Standard care: 61 (21) At 6 months after discharge: • Motivational interviewing: 68 (30) • Standard care: 40 (31) At 12 months after discharge: • Motivational interviewing: 73 (40) • Standard care: 50 (39) *Changes in activity of daily living (PASIPD, (MET hour/day)) [mean(SD)]* At 6 months after discharge • Motivational interviewing: 32 (34) • Standard care: 10 (8) At 12 months after discharge: • Motivational interviewing: 26 (11) • Standard care: 11 (12)	<u>Domain 1: Risk of bias arising from the randomisation process</u> 1.1 Was the allocation sequence random? Y – block randomisation by computer-genrated random number list. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y 1.3 Did baseline differences between intervention groups suggest a problem with the randomisation process? PN *Risk-of-bias judgement:* Low risk <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? PN

Study details	Participants	Interventions	Outcomes and Results	Comments
This study received funding from Children's Fund Adriaanstichting and Johanna Children's Fund.	• Motivational interviewing = 139 (67) • Standard care = 161 (81) Traumatic injury cause [N (%)] • Motivational interviewing: 14 (70) • Standard care: 12 (63) Motor complete injury [N (%)] • Motivational interviewing: 13 (65) • Standard care: 11 (58) **Inclusion criteria** Participants had to: • be aged 18-65 years old • have been diagnosed with SCI • have undergone initial inpatient rehabilitation • be dependent on a manual wheelchair and able to handcycle **Exclusion criteria** • Insufficient comprehension of the Dutch language which affects an individual's ability to understand study participation	○ *Coaches* Professional occupational therapists or physiotherapists trained in motivational interviewing (based on transtheoretical model). ○ *Motivational interviewing* Each session began with participants proposing topics of conversation. The intervention itself had 4 main components: 1. feedback on daily wheelchair activity using bicycle odometers. Each participant was supposed to keep track of the distance travelled each day, and set goals to increase this range; 2. planning of how and when to be physically active and coping strategies for potential barriers; 3. home visit from the coach in the first month post-discharge in which coach aimed to optimise the home and environment for physical activity; and 4. provision of relevant information if requested.		2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N - large attrition (lost more than 50% over 12 months) 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N

Study details	Participants	Interventions	Outcomes and Results	Comments
	• A progressive disease or psychiatric condition that could impact participation in trial			3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN - similar proportions and reasons between groups *Risk-of-bias judgement:* High risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? N 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? N 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA

Study details	Participants	Interventions	Outcomes and Results	Comments
				Risk-of-bias judgement: Low risk <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalised before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> *Risk-of-bias judgement:* High risk **Other information** None.
Full citation Nooijen, C. F., Stam, H. J., Schoenmakers, I.,	Same study as Nooijen, C. F., Stam, H. J., Bergen, M. P., Bongers-Janssen, H.	Same study as Nooijen, C. F., Stam, H. J., Bergen, M. P., Bongers-Janssen, H. M., Valent, L.,	**Results**	**Limitations** **Quality assessment:** Risk of bias assessed using

Study details	Participants	Interventions	Outcomes and Results	Comments
Sluis, T. A., Post, M. W., Twisk, J. W., van den Berg-Emons, R. J., Working mechanisms of a behavioural intervention promoting physical activity in persons with subacute spinal cord injury, Journal of Rehabilitation Medicine, 48, 583-588, 2016 **Ref Id** 1091350	M., Valent, L., van Langeveld, S., Twisk, J., van den Berg-Emons, R. J., A behavioural intervention increases physical activity in people with subacute spinal cord injury: a randomised trial, Journal of physiotherapy, 62, 35-41, 2016. See that entry for full details.	van Langeveld, S., Twisk, J., van den Berg-Emons, R. J., A behavioural intervention increases physical activity in people with subacute spinal cord injury: a randomised trial, Journal of physiotherapy, 62, 35-41, 2016. See that entry for full details.	*Changes in mood (CES-D depression score) [mean (SD)]* At discharge (2 months after baseline): • Motivational interviewing: 14.94 (10.28) • Standard care: 12.00 (7.30) 6 months after discharge: • Motivational interviewing: 15.93 (14.36) • Standard care: 16.62 (9.73) 12 months after discharge: • Motivational interviewing: 11.91 (12.16) • Standard care: 13.30 (8.60) *Pain (Chronic Pain Grade pain intensity) [mean (SD)]* At discharge (2 months after baseline): • Motivational interviewing: 50.74 (25.32) • Standard care: 47.78 (30.69) 6 months after discharge:	revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomisation process</u> 1.1 Was the allocation sequence random? Y – block randomisation by computer-genrated random number list. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y 1.3 Did baseline differences between intervention groups suggest a problem with the randomisation process? PN *Risk-of-bias judgement:* Low risk <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that

Study details	Participants	Interventions	Outcomes and Results	Comments
			• Motivational interviewing: 50.72 (24.98) • Standard care: 49.49 (29.72) 12 months after discharge: • Motivational interviewing: 45.76 (32.25) • Standard care: 49.67 (26.36) *Pain (Chronic Pain Grade disability score) [mean (SD)]* 6 months after discharge: • Motivational interviewing: 0.86 (1.46) • Standard care: 0.92 (1.66) 12 months after discharge: • Motivational interviewing: 1.55 (1.57) • Standard care: 0.40 (0.70)	arose because of the experimental context? PN 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N - large attrition (lost more than 50% over 12 months) 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N

Study details	Participants	Interventions	Outcomes and Results	Comments
				3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN - similar proportions and reasons between groups *Risk-of-bias judgement:* High risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? N 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? N 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA

Study details	Participants	Interventions	Outcomes and Results	Comments
				Risk-of-bias judgement: Low risk <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalised before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> *Risk-of-bias judgement:* High risk **Other information** None.
Full citation Nooijen, C. F., Stam, H. J., Sluis, T., Valent, L.,	Same study as Nooijen, C. F., Stam, H. J., Bergen, M. P., Bongers-Janssen, H.	Same study as Nooijen, C. F., Stam, H. J., Bergen, M. P., Bongers-Janssen, H. M., Valent, L.,	**Results**	**Limitations** **Quality assessment:** Risk of bias assessed using

Study details	Participants	Interventions	Outcomes and Results	Comments
Twisk, J., van den Berg-Emons, R. J., A behavioral intervention promoting physical activity in people with subacute spinal cord injury: secondary effects on health, social participation and quality of life, Clinical Rehabilitation, 31, 772-780, 2017 **Ref Id** 1091648	M., Valent, L., van Langeveld, S., Twisk, J., van den Berg-Emons, R. J., A behavioural intervention increases physical activity in people with subacute spinal cord injury: a randomised trial, Journal of physiotherapy, 62, 35-41, 2016. See that entry for full details.	van Langeveld, S., Twisk, J., van den Berg-Emons, R. J., A behavioural intervention increases physical activity in people with subacute spinal cord injury: a randomised trial, Journal of physiotherapy, 62, 35-41, 2016. See that entry for full details.	*Quality of life (SF-36 General health) [mean (SD)]* At discharge (2 months after baseline): • Motivational interviewing: 54.12 (21.38) • Standard care: 54.58 (20.05) At month 6 after discharge: • Motivational interviewing: 55.00 (23.86) • Standard care: 53.85 (15.70) At month 12 after discharge: • Motivational interviewing: 53.50 (25.83) • Standard care: 54.50 (21.66) *Quality of life (SF-36 Mental health) [mean (SD)]* At discharge (2 months after baseline): • Motivational interviewing: 75.33 (18.88) • Standard care: 69.33 (19.32)	revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomisation process</u> 1.1 Was the allocation sequence random? Y – block randomisation by computer-genrated random number list. 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y 1.3 Did baseline differences between intervention groups suggest a problem with the randomisation process? PN *Risk-of-bias judgement:* Low risk <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that

Study details	Participants	Interventions	Outcomes and Results	Comments
			At month 6 after discharge: • Motivational interviewing: 73.14 (23.03) • Standard care: 62.77 (21.06) At month 12 after discharge: • Motivational interviewing: 73.45 (23.14) • Standard care: 68.80 (16.31) *Quality of life (IMPACT-S participation score) [mean (SD)]* At discharge (2 months after baseline): • Motivational interviewing: 65.04 (13.37) • Standard care: 73.96 (13.56) At month 6 after discharge: • Motivational interviewing: 66.67 (11.37) • Standard care: 67.63 (15.60) At month 12 after discharge: • Motivational interviewing: 71.02 (15.14)	arose because of the experimental context? PN 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N - large attrition (lost more than 50% over 12 months) 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N

Study details	Participants	Interventions	Outcomes and Results	Comments
			• Standard care: 66.25 (13.04)	3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN - similar proportions and reasons between groups *Risk-of-bias judgement:* High risk Domain 4: Risk of bias in measurement of the outcome 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? N 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? N 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA

Study details	Participants	Interventions	Outcomes and Results	Comments
				Risk-of-bias judgement: Low risk Domain 5: Risk of bias in selection of the reported result 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalised before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Some concerns Overall risk of bias *Risk-of-bias judgement:* High risk **Other information** None.
Full citation Pirente, N., Blum, C., Wortberg, S., Bostanci,	**Sample size** N= 171 (randomised) • Intervention: 83	**Interventions** • Assesments were carried out at discharge from hospital	**Results**	**Limitations** **Quality assessment:** Risk of bias assessed using

Study details	Participants	Interventions	Outcomes and Results	Comments
S., Berger, E., Lefering, R., Bouillon, B., Rehm, K. E., Neugebauer, E. A., Quality of life after multiple trauma: the effect of early onset psychotherapy on quality of life in trauma patients, Langenbeck's archives of surgery / Deutsche Gesellschaft fur Chirurgie, 392, 739-745, 2007 **Ref Id** 1092985 **Country/ies where the study was carried out** Germany **Study type** RCT **Aim of the study** To test the effect of an early onset CBT intervention on health-related quality of life in severely injured patients. **Study dates** Recruitment: July 1996 to July 2001. **Source of funding**	• Standard care: 88 N= 92 (analysed) • CBT-based psychotherapy: 45 • Standard care: 47 **Characteristics** Age in years [Mean (range)]: • CBT-based psychotherapy = 39 (18-69) • Standard care = 38 (21-65) Gender (M/F): • CBT-based psychotherapy (N): 28/17 • Standard care (N): 37/10 Total time in hospital in days [Mean (range)]: • CBT-based psychotherapy = 57 (13-192) • Standard care = 53 (16-187) Injury cause (motor vehicle accident/bicycle/collapse/pedestrian/sporting accident/truck accident)	(baseline), 6 months post trauma and 12 months post trauma. • *Control group* Standard care described as psychological and medical diagnostics. No further information reported. • *Intervention group* Standard care plus a standardised psychotherapy programme. Participants received a maximum of 8 sessions over the course of the intervention, at a maximum of 3 times per week. ○ Delivered by professional research psychologists, trained in CBT and subject to regular supervision from external psychotrauma supervisors. Sessions were documented, including topics of conversation and therapy progress. • All patients were able to contact research psychologists for further information throughout the study.	*Quality of life (HR-QoL) [mean (SD)]* At 6 months post trauma: • CBT-based psychotherapy: 0.46 (0.18) • Standard care: 0.52 (0.23) *Changes in mood (BDI) [mean(SD)]* At 6 months post trauma: • CBT-based psychotherapy: 9.0 (7.9) • Standard care: 8.3 (10.4) At 12 months post trauma: • CBT-based psychotherapy: 9.3 (9.0) • Standard care: 7.5 (7.7) *Changes in mood (STAI score) [mean(SD)]* At 6 months post trauma: • CBT-based psychotherapy: 40.56 (11.6) • Standard care: 37.6 (11.0) At 12 months post trauma:	revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomisation process 1.1 Was the allocation sequence random? Y – computer-generated random allocation sequence 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y 1.3 Did baseline differences between intervention groups suggest a problem with the randomisation process? PY - differences in baseline quality of life, depression and anxiety *Risk-of-bias judgement:* Some concerns Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention) 2.1. Were participants aware of their assigned intervention during the trial? Y 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? PY

Study details	Participants	Interventions	Outcomes and Results	Comments
This study received funding from the Federal Ministry of Education and Research, the German Research Foundation and the Köln-Fortune Programme, Medical Faculty, University of Cologne.	• CBT-based psychotherapy (N): 16/15/1/1/7/3/2 • Standard care (N): 19/20/3/2/1/1/1 **Inclusion criteria** Participants had to: • Be aged 18 to 70 years old • Have at least 2 injuries with a combined abbreviated injury scale (AIS) severity index ≥ 6 • Mentally orientated at the time of initial contact **Exclusion criteria** • Severe traumatic brain injury (defined as AIS ≥ 3 for head trauma and initial Glasgow Coma Scale ≤ 8) • Attempted suicide • Attended psychotherapy prior to trauma • Injuries due to criminal behaviour • Problems with the German language • Informed consent not obtained		• CBT-based psychotherapy: 40.20 (12.0) • Standard care: 36.51 (10.6) *Changes in mood (SCL-4 Symptom Checklist Subscale 5 anxiety score) [mean(SD)]* At 6 months post trauma: • CBT-based psychotherapy: 54.2 (32.4) • Standard care: 41.1 (31.1) At 12 months post trauma: • CBT-based psychotherapy: 55.9 (33.0) • Standard care: 42.1 (32.8)	2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? PN 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomised? No – outcome data only available for 45/83 in intervention group and 47/88 in control group.

Study details	Participants	Interventions	Outcomes and Results	Comments
				3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NI 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN - similar proportions and reasons *Risk-of-bias judgement:* Some concerns <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? Y - self report and participants unblinded 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Y

Study details	Participants	Interventions	Outcomes and Results	Comments
				4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? PY *Risk-of-bias judgement:* High risk <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalised before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> *Risk-of-bias judgement:* High risk **Other information**

Study details	Participants	Interventions	Outcomes and Results	Comments
				None.
Full citation Schulz, Richard, Czaja, Sara J., Lustig, Amy, Zdaniuk, Bozena, Martire, Lynn M., Perdomo, Dolores, Improving the quality of life of caregivers of persons with spinal cord injury: a randomized controlled trial, Rehabilitation Psychology, 54, 1-15, 2009 **Ref Id** 1093266 **Country/ies where the study was carried out** USA **Study type** RCT **Aim of the study** To investigate the effectiveness of individualised multi-component psychosocial intervention targeted at both carers and their older care recipients with SCI. This was compared with the same	**Sample size** N= 173 caregivers/173 care recipients (randomised) • Dual target: 57 caregivers/57 care recipients • Caregiver only: 56 caregivers/56 care recipients • Written information control: 60 caregivers/60 care recipients N= 148 caregivers/151 care recipients (analysed) • Dual target: 49 caregivers/50 care recipients • Caregiver only: 44 caregivers/45 care recipients • Written information control: 55 caregivers/56 care recipients **Characteristics** *Caregivers* Age in years [Mean (SD)]: • Dual target = 50.7 (14.3) • Caregiver only = 53.7 (14.3)	**Interventions** • Baseline assessments were carried out in-home by certified assessors, as well as 6 months and 12 months follow-up. • *Control group* Received a standard written pack containing information on SCI, ageing and caregiving, as well as information community resources and programmes. Also had 3 telephone contacts at months 3, 5 and 9 after randomisation. • *Intervention group* Education for caregivers on SCI and increased access to support resources, as well as cognitive and behavioural skills to reduce stress, improve health (mental and physical). Delivered over 6 months via 7 individual training sessions, 5 at home and 2 by telephone, each lasting 60-90 minutes. 5 additional structured telephone-based support group sessions, consisting of up to 6 caregivers, were interspersed throughout study period. Caregivers were also given a smart phone and notebook, containing information on SCI, ageing and caregiving, as well as information community resources and programmes. This phone was also used for the telephone support groups.	**Results** *Changes in mood (CES-D depression score) [mean (SD)]* At 12 months follow-up: • Dual target (N=50): 9.35 (6.07) • Caregiver only (N=45): 9.55 (6.63) • Written information control (N=56): 10.28 (6.19) *Health symptoms [mean (SD)]* At 12 months follow-up: • Dual target (N=50): 3.84 (1.97) • Caregiver only (N=45): 4.32 (1.96) • Written information control (N=56): 4.82 (1.71) *Social integration [mean (SD)]* At 12 months follow-up:	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomisation process</u> 1.1 Was the allocation sequence random? Y – computer generated randomisation sequence 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? PY 1.3 Did baseline differences between intervention groups suggest a problem with the randomisation process? N *Risk-of-bias judgement:* Low risk <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PN 2.2. Were carers and people delivering the interventions aware of participants'

Study details	Participants	Interventions	Outcomes and Results	Comments
individualised psychosocial intervention targeted solely at carers, or with an information only control. **Study dates** Not reported **Source of funding** This study received funding from the National Institute of Nursing Research, National Institute on Aging, National Institute of Mental Health, National Institute on Minority Health and Health Disparities, National Heart, Lungs, and Blood Institute and National Science Foundation.	• Written information control = 53.4 (15.8) Gender (M/F): • Dual target (N): 9/48 • Caregiver only (N): 14/42 • Written information control (N): 19/41 Time in caregiving role in years [Mean (SD)]: • Dual target = 8.4 (8.4) • Caregiver only = 7.7 (7.8) • Written information control = 9.0 (10.6) *Care recipients* Age in years [Mean (SD)]: • Dual target = 53.4 (12.7) • Caregiver only = 57.7 (12.5) • Written information control = 54.4 (13.2) Gender (M/F): • Dual target (N): 41/16 • Caregiver only (N): 18/38 • Written information control (N): 27/33 Time since injury in years: not reported	○ *Sessions* Targeted 5 areas of caregiver risk: lack of knowledge regarding caregiving and caregiver burden; social support; emotional well-being; communication; and physical health. However, the intervention was designed to be flexible and tailored towards the needs of individual carers, based on risk profiles from baseline assessment. These areas of concentration for following sessions were negotiated between facilitator and caregiver during the 2nd session, as well as issues of health and well-being in the care dyad. Each subsequent home visits focused on communication problems and coping strategies, emotional well-being and managing stress, and social support respectively. The final intervention session was a review of the major topics and coping mechanisms learnt. ○ *Education facilitators* Professionals in psychology or social care disciplines, who received session training. This included reading materials, structured role play and practice opportunities, and 3 cross-site training calls on the intervention. Counsellors were	• Dual target (N=50): 8.51 (3.62) • Caregiver only (N=45): 9.38 (2.91) • Written information control (N=56): 10.02 (2.75)	assigned intervention during the trial? PY 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? PN 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or nearly all, participants randomised? Y

Study details	Participants	Interventions	Outcomes and Results	Comments
	Injury cause: not reported Location of SCI (lumbar/thoracic/cervical) • Dual target (N): 3/14/29 • Caregiver only (N): 2/16/30 • Written information control (N): 4/21/29 **Inclusion criteria** Caregivers had to: • Be aged 18 years or above • Provide instrumental or emotional support for a significant other with SCI for ≥ preceding 6 months • Have regular contact with individual with SCI (defined as at least 1 face-to-face meeting per month, and 1 telephone contact per week) • Living with or near individual with SCI • Competent in English language • Have a telephone • Be planning on remaining in the geographical area for the next 6 months Care recipients had to:	certified by principal investigators, reviewed at 6months and received weekly supervision from investigators. An assessment form was completed after each contact with a caregiver to ensure continuity. • *Dual target intervention* Caregiver component as described above. Care recipient portion designed to educate care recipient in SCIs, stress management, self-care and emotional well-being, as well as increasing access to both formal and informal support. Also provided information on the emotional and physical impact of caring on caregivers. Received a screen phone if participants lived separately to their caregiver, and a written information pack on SCI, ageing and local resources. ○ *Sessions* Delivered over 7 individual intervention sessions - 5 at home and 2 via telephone, following the same schedule as caregiver only group. Five group support sessions were also held over the telephone, with other SCI care recipients.		3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NI 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PY 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? PN - proportions and reasons similar *Risk-of-bias judgement:* Low risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? No 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? NA

Study details	Participants	Interventions	Outcomes and Results	Comments
	• Be aged 35 years or older • Have an SCI through either injury or disease • Complete or incomplete lesion as defined by American Spinal Cord Injury Association • Have impaired mobility due to the SCI • Living in the community (non-group setting) for at least 1 year after SCI • Competent in English language • Have a telephone • Be planning on remaining in the geographical area for the next 6 months **Exclusion criteria** Either caregiver or care recipient: • Terminal illness with a life expectancy of < 6months • In active treatment for cancer (excluding maintenance tamoxifen or lupron treatment) • Blind or deaf • Cognitive impairment (defined as ≥ 4 errors on			4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? NA *Risk-of-bias judgement:* Low risk <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> *Risk-of-bias judgement:* Some concerns **Other information**

Study details	Participants	Interventions	Outcomes and Results	Comments
	Short Portable Mental Status Questionnaire)			None.
Full citation Wiechman, S. A., Carrougher, G. J., Esselman, P. C., Klein, M. B., Martinez, E. M., Engrav, L. H., Gibran, N. S., An expanded delivery model for outpatient burn rehabilitation, Journal of burn care & research, 36, 14-22, 2015 **Ref Id** 1036605 **Country/ies where the study was carried out** USA **Study type** RCT **Aim of the study** To test the efficacy of an outpatient expanded care co-coordinator to assist with management of burn issues, provide motivational interviewing, and facilitate coping with social and community issues.	**Sample size** N= 81 (randomised) • Motivational interviewing: 40 • Standard care: 41 N= 81 (analysed) • Motivational interviewing: 40 • Standard care: 41 NOTE Mentions that 3 participants dropped out but doesn't mention at what part of the study. **Characteristics** Age in years [Mean (SD)]: • Motivational interviewing = 43.23 (16.92) • Standard care = 43.68 (17.13) Gender (M/F): • Motivational interviewing (N): 25/15 • Standard care (N): 29/12 Time since injury in years: not reported	**Interventions** • Once participants were enrolled in the study, they completed a goal attainment scale (before randomisation). Follow-up assessments were scheduled at 6 months and 12 months from baseline. • *Control group* Received standard outpatient care from clinic. This included discharge education prior to discharge and a 24-hour post-discharge follow-up telephone call from the primary care nurse to ensure a smooth transition. Outpatient clinic visits were initially scheduled every 2 weeks as needed and then every 1-2 months until no longer necessary. Outpatient appointments included a multidisciplinary team i.e. nurse, surgeon, physical and occupational therapist, vocational counsellor and psychologist. The control group also received an introductory letter describing contact times at 6 and 12 months post-discharge, to collect outcome measurements. • *Intervention group* Motivational interviewing plus standard outpatient care from clinic and welcome letter as described above. The introductory	**Results** *Quality of life (SF-12 Mental component score) [mean (SD)]* At 6 months: • Motivational interviewing: 51.1 (8.6) • Standard care: 49.2 (11.5) At 12 months: • Motivational interviewing: 51.2 (10.0) • Standard care: 46.8 (12.5) *Quality of life (SF-12 Physical component score) [mean (SD)]* At 6 months: • Motivational interviewing: 48.8 (8.0) • Standard care: 44.1 (11.9) At 12 months: • Motivational interviewing: 50.1 (11.8)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomisation process 1.1 Was the allocation sequence random? NI 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? NI 1.3 Did baseline differences between intervention groups suggest a problem with the randomisation process? PN *Risk-of-bias judgement:* Some concerns Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention) 2.1. Were participants aware of their assigned intervention during the trial? NI - described as single-blind but not description of who was blinded. 2.2. Were carers and people delivering the interventions

Study details	Participants	Interventions	Outcomes and Results	Comments
Study dates Not reported **Source of funding** This study received funding from the National Institute on Disability and Rehabilitation Research in the U.S. Department of Education.	Injury cause: not reported Length of hospitalisation in days [Mean (SD)]: • Motivational interviewing: 19.15 (19.28) • Standard care: 18.42 (18.54) % total burn surface area [Mean (SD)]: • Motivational interviewing: 35.50 (42.91) • Standard care: 38.00 (43.37) **Inclusion criteria** Participants had to: • 18 years old or above • Burn size: ○ Greater than 15% ○ Less than 15% and requiring surgical closure ○ Less than 15% and located on face, hand, or over the joint • Informed written consent for study participation **Exclusion criteria** Not reported. See above for inclusion criteria.	letter also contained details of a telephone call schedule with an expanded care coordinator (ECC). Intervention group participants were contacted by the ECC at 24-48 hours post-discharge, at weeks 2, 4, 8 and 12, and months 5, 7 and 9. Conversations were semi-structured for consistency, with the first bit of the call devoted to medical and psychological issues that participants may have encountered. The second part of each call utilised motivational interviewing and was focused on the reviewing participant goals and any progress made towards them. Additionally, the ECC could identify local support resources for participants, accompany them to clinic visits, and help with compensation. ○ *Motivational interviewing* A patient-centred, directive method aimed at enhancing a person's desire to change. The content of this intervention was based on a biopsychosocial model of burn recovery, which premises that the outcomes of bun injury are reliant on a combination of pre-injury physical and emotional states, characteristics of the injury, hospitalisation experience and healthcare experiences.	• Standard care: 53.7 (15.3) *Patient satisfaction (Satisfaction with social support) [mean (SD)]* At 6 months: • Motivational interviewing: 8.9 (1.6) • Standard care: 8.4 (2.1) At 12 months: • Motivational interviewing: 9.0 (1.3) • Standard care: 7.5 (3.0) *Changes in activity of daily living (GAS) [mean (SD)]* at 6 months: • Motivational interviewing: 55.5 (13.5) • Standard care: 58.1 (14.8) at 12 months: • Motivational interviewing: 59.0 (14.2) • Standard care: 57.9 (13.6)	aware of participants' assigned intervention during the trial? NI - described as single-blind but not description of who was blinded. 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? PN - semi-structured telephone calls 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u>

Study details	Participants	Interventions	Outcomes and Results	Comments
		○ *ECC professional* Received several months of training and close supervision from primary investigator. Training included an introduction to the burn team, overview of the pathophysiology of burns and treatment, training in motivational interviewing, counselling and crisis intervention. Assistance was available from an experienced multi-disciplinary team, should the EEC have any issues during the calls. • Supplementary support services such as burn support groups and burn advocacy services were also available to the control group but this was advertised through brochures or posters in the hospital waiting area.		3.1 Were data for this outcome available for all, or nearly all, participants randomised? Y 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NA 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA *Risk-of-bias judgement:* Low risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? NI - described as single-blind but not description of who was blinded.

Study details	Participants	Interventions	Outcomes and Results	Comments
				4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Y 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? PN *Risk-of-bias judgement:* Some concerns <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalised before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? Y - RTW recorded but not reported. 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* High risk

Study details	Participants	Interventions	Outcomes and Results	Comments
				Overall risk of bias *Risk-of-bias judgement:* High risk **Other information** None.
Full citation Zidén, L., Frändin, K., Kreuter, M., Home rehabilitation after hip fracture. A randomized controlled study on balance confidence, physical function and everyday activities, Clinical Rehabilitation, 22, 1019-1033, 2008 **Ref Id** 1093137 **Country/ies where the study was carried out** Sweden **Study type** RCT **Aim of the study** To investigate the effect of a home-based rehabilitation programme emphasising self-efficacy and physical activity on	**Sample size** N= 212 (randomised) • Supported discharge: 105 • Standard care and rehab: 107 N= 102 (analysed) • Supported discharge: 48 • Standard care and rehab: 54 **Characteristics** Age in years [Mean (SD)]: • Supported discharge = 81.2 (5.9) • Standard care and rehab = 82.5 (7.6) Gender (M/F): • Supported discharge (N): 19/29 • Control (N): 12/42 Time since injury in years: not reported	**Interventions** • Self-report and clinical data were collected at baseline and 1 month follow-up. • *Control group* Standard care and rehabilitation. This included early mobilisation of patients, preferably within 48 hours, as well as information on their surgical treatment, prognosis and the important of physical activity. The standard rehabilitation programme consisted of individual daily training to include everyday tasks, transfer techniques, training with technical aids and stair walking. Group-based physiotherapy and occupational therapy training sessions were also provided. Rehabilitation measures were adapted to individual needs and personal goals. • *Intervention group* Standard care and rehabilitation, plus supported discharge for home rehabilitation. While in hospital, patients were offered an individually tailored rehabilitation programme with increased support from a multi-	Results *Changes in ADL (Instrumental Activity Measure) [mean (SD)]* At 1 month follow-up: • Supported discharge: 52.2 (9.5) • Standard care and rehab: 33.5 (16.7)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) Domain 1: Risk of bias arising from the randomisation process 1.1 Was the allocation sequence random? NI 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PN Risk-of-bias judgement: Some concerns Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention) 2.1. Were participants aware of their assigned intervention during the trial? PY

Study details	Participants	Interventions	Outcomes and Results	Comments
balance confidence, physical function and physical activity in early hip fracture, when compared to standard care. **Study dates** Recruitment: November 2004 to February 2006. **Source of funding** This study received funding from the Vårdal Institute, the Hjalmar Svensson's Foundation and the Geriatric Section of the Swedish Association of Registered Physiotherapists.	Injury cause: not reported **Inclusion criteria** Participants had to: • Be aged 65 years or older • Have had acute hip fracture surgery • Be medically approved by responsible geriatric doctors as being in need of geriatric care and rehabilitation • Be able to communicate in Swedish **Exclusion criteria** • Severe medical illness with an anticipated survival of less than one year • Severe drug or alcohol abuse • Mental illness or severe cognitive impairment	disciplinary team (including occupational therapist and physiotherapist). Prior planning and close contact with social home service and a family support network was utilised for a smooth discharge and initial period (maximum 3 weeks) at home. Where possible, the same occupational therapist and physiotherapist attended participants during home visits for continuity. ○ *Motivational interviewing* An initial meeting between the participant was used to provide programme information and establish personal goals. The home rehabilitation included multi-disciplinary efforts to increase a patient's motivation and self-efficacy. Physiotherapy concentrated on confidence in locomotion and physical activity, with an emphasis was placed on outdoor ambulation. Occupational therapy concentrated on safety and independence in activities of daily life. ○ Depending on the needs of the participant, assistant nurses or assistant physiotherapists could make home visits to assist with home training.		2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? Y 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? PN 2.4. If Y/PY to 2.3: Were these deviations from intended intervention balanced between groups? NA 2.5 If No/PN/NI to 2.4: Were these deviations likely to have affected the outcome? NA 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomised? NA *Risk-of-bias judgement:* Low risk <u>Domain 3: Missing outcome data</u> 3.1 Were data for this outcome available for all, or

Study details	Participants	Interventions	Outcomes and Results	Comments
				nearly all, participants randomised? Y 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? NA 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? NA 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA *Risk-of-bias judgement:* Low risk <u>Domain 4: Risk of bias in measurement of the outcome</u> 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PN 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? Y 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? Y

Study details	Participants	Interventions	Outcomes and Results	Comments
				4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? PN *Risk-of-bias judgement:* Some concerns <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalised before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN 5.3 ... multiple analyses of the data? PN *Risk-of-bias judgement:* Some concerns <u>Overall risk of bias</u> *Risk-of-bias judgement:* Some concerns **Other information**

Study details	Participants	Interventions	Outcomes and Results	Comments
				None.

ADL: Activities of daily living; AIS: American Spinal Injury Association Impairment Scale; BDI: Beck Depression Inventory; BSHQ: Burn Specific Health Questionnaire; BSI: Brief Symptom Index; CBT: Cognitive behavioural therapy; CHART-SF; Short-form Craig Handicap Assesment and Reporting Technique; CES-D: Center for Epidemiologic Studies depression scale; CI: Confidence interval; F: Female; GAS: Goal Attainment Score; HABITS: Healthy Active Behavioural Intervention in SCI; HADS: Hospital Anxiety and Depression scale; HR-QoL: Health-related quality yof life; IMPACT-S; ICF Measure of Participation and Activities questionnaire – screening; ITT: Intention to treat; IQR: Interquartile range; M: Male; MET: Metabolic equivalent; MHI-5; 5-item Mental Health Inventory; min: Minute; MS: Multiple sclerosis; N: Number [or No if answering a risk of bias checklist question]; NA: Not applicable; NI: No information; PASIPD; Physical Activity Scale for Individuals with Physical Disabilities; PHQ-9: 9-item Patient Health Questionnaire; PN: Probably not; PY: Probably yes; QoL: Quality of life; RCT: Randomised controlled trial; RoB2: Revised Cochrane risk of bias tool; SCI: Spinal cord injury; SCIM3: Spinal Cord Independence Measurement III; SD: Standard deviation; SF-12; 12-item short form health survey; SF-36; 36-item short form health survey; STAI: State Trait Anxiety Inventory; WHOQOL-5: 5-item World Health Organization quality of life questionnaire; Y: Yes

Clinical evidence tables for review question: B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?

Table 8: Clinical evidence tables

Study details	Participants	Interventions	Outcomes and Results	Comments
Full citation Maskell, J., Newcombe, P., Martin, G., Kimble, R., Psychological and psychosocial functioning of children with burn scarring using cosmetic camouflage: A multi-centre prospective randomised controlled trial, Burns, 40, 135-149, 2014 **Ref Id** 1094340	**Sample size** N= 63 (randomised) • Skin camouflage: 35 • Wait-list: 28 N= 41 (analysed) • Skin camouflage: 24 • Wait-list: 17 **Characteristics** Age in years [Mean (SD)]: • Skin camouflage = 12.23 (1.97) • Wait-list = 13.31 (2.22) Gender (M/F):	**Interventions** • Baseline questionnaires were administered 2 weeks before the start of the study, and follow-up questionnaires 2 weeks before the end of the study. Child versions and adult versions were provided. • *Control group* Wait-list control • *Intervention group* Participants and caregivers attended a 1.5 day Microskin™ training before being provided with the relevant equipment to begin using the product at home. A booster training was provided 2 weeks prior to the end of the intervention (week 8). ○ *Microskin*™ Liquidised simulated skin camouflage that binds to the epidermis. Digital photography and computer colour-matching is used	*Overall quality of life (measured using PedsQL4.0 Total score) [Mean (SD)]* At 8 weeks follow-up (from baseline): • Skin camouflage: 83.57 (10.03) • Wait-list control: 79.93 (15.16)	**Limitations** **Quality assessment:** Risk of bias assessed using revised Cochrane risk of bias tool (RoB 2) <u>Domain 1: Risk of bias arising from the randomization process</u> 1.1 Was the allocation sequence random? Y – computer-generated random numbers 1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions? Y 1.3 Did baseline differences between intervention groups suggest a problem with the randomization process? PN

Study details	Participants	Interventions	Outcomes and Results	Comments
Country/ies where the study was carried out Australia and New Zealand **Study type** RCT **Aim of the study** To determine the impact of a cosmetic camouflage intervention (Microskin™) on the perceived scar appearance and overall psychosocial functioning in children with burn injury. **Study dates** Recruitment: December 2009 to October 2010. **Source of funding** This study received funding from University of Queensland (Queensland Children's Medical Research Institute PhD Scholarship programme), Royal Children's Hospital,	• Skin camouflage (N): 11/24 • Wait-list (N): 4/24 Time since injury in years [Mean (SD)]: • Skin camouflage = 6.46 (4.55) • Wait-list = 8.39 (4.67) Injury cause (scald/contact/flame/friction/chemical/thermal): • Skin camouflage (N): 16/1/16/0/1/1 • Wait-list (N): 13/4/9/2/0/0 Length of hospitalisation in days: not reported % total burn surface area [Mean (SD)]: • Skin camouflage: 23.53 (19.48) • Wait-list: 21.19 (19.52) **Inclusion criteria** Participants had to: • Be aged 8 to 16 years old • Have a burn past the acute stage of healing,	to replicate an individual skin colour, although it does not affect the texture of the burn area. The camouflage can last for several days, and is water and sun resistant. Application is via a sponge or roller for smaller burns, or by an air brush for larger surface areas. **Follow-up** 8 weeks after baseline **Setting** 6 paediatric burn centres in Australia and New Zealand.		*Risk-of-bias judgement: Low risk* <u>Domain 2: Risk of bias due to deviations from the intended interventions (effect of assignment to intervention)</u> 2.1. Were participants aware of their assigned intervention during the trial? PY 2.2. Were carers and people delivering the interventions aware of participants' assigned intervention during the trial? NI 2.3. If Y/PY/NI to 2.1 or 2.2: Were there deviations from the intended intervention that arose because of the experimental context? PY - no information taken on frequency of intervention utilisation 2.4. If No/PN/NI to 2.3: Were these deviations likely to have affected the outcome? PY 2.5 If Y/PY to 2.4: Were these deviations from intended intervention balanced between groups? N 2.6 Was an appropriate analysis used to estimate the effect of assignment to intervention? Y - ITT analysis 2.7 If No/PN/NI to 2.6: Was there potential for a substantial impact (on the result) of the failure to analyse participants in the group to which they were randomized? NA

Study details	Participants	Interventions	Outcomes and Results	Comments
Queensland Health and Microskin™ International (researcher travel costs and supply of skin camouflage).	with mature scarring on a visible body area. **Exclusion criteria** • Cognitive impairment that may affect the use of self-reported outcome measurement or intervention • Limited English language proficiency • Psychological difficulties or co-morbidity that may confound findings			*Risk-of-bias judgement: High risk* Domain 3: Missing outcome data 3.1 Were data for this outcome available for all, or nearly all, participants randomized? N - high attrition rate. Data only available for 24/35 in skin camouflage group and 17/28 for wait-list group. 3.2 If No/PN/NI to 3.1: Is there evidence that the result was not biased by missing outcome data? N - no information provided of analysis methods correcting for bias or sensitivity analysis 3.3 If No/PN to 3.2: Could missingness in the outcome depend on its true value? PN 3.4 If Y/PY/NI to 3.3: Is it likely that missingness in the outcome depended on its true value? NA *Risk-of-bias judgement: Low risk* Domain 4: Risk of bias in measurement of the outcome 4.1 Was the method of measuring the outcome inappropriate? PN 4.2 Could measurement or ascertainment of the outcome have differed between intervention groups? PY - once wait-list participants and

Study details	Participants	Interventions	Outcomes and Results	Comments
				caregivers were aware of the intervention available, may have lead to more optimistic self-report outcomes. 4.3 If No/PN/NI to 4.1 and 4.2: Were outcome assessors aware of the intervention received by study participants? PY - self report questionnaires 4.4 If Y/PY/NI to 4.3: Could assessment of the outcome have been influenced by knowledge of intervention received? PY - self report questionnaires 4.5 If Y/PY/NI to 4.4: Is it likely that assessment of the outcome was influenced by knowledge of intervention received? PY *Risk-of-bias judgement: High risk* <u>Domain 5: Risk of bias in selection of the reported result</u> 5.1 Were the data that produced this result analysed in accordance with a pre-specified analysis plan that was finalized before unblinded outcome data were available for analysis? NI Is the numerical result being assessed likely to have been selected, on the basis of the results, from... 5.2. ... multiple outcome measurements (e.g. scales, definitions, time points) within the outcome domain? PN -

Study details	Participants	Interventions	Outcomes and Results	Comments
				multiple outcome measurements but all reported in paper 5.3 ... multiple analyses of the data? PN - multiple analyses but all reported in paper *Risk-of-bias judgement Some concerns* Overall risk of bias *Risk-of-bias judgement: High risk* **Other information** None.

F: Female; ITT: Intent to treat; M: Male; N: Number [or No if answering a risk of bias checklist question); NA: Not applicable; NI: No information; PedsQL 4.0; Pediatric Quality of Life Index (4th version); PN: Probably not; PY: Probably yes; SD: Standard deviation; TM: Trademark; Y: Yes

Appendix E – Forest plots

Forest plots for review question: B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

No meta-analyses were performed as the interventions or outcomes were either not sufficiently similar to allow them to be combined or they were not reported by more than one study.

Forest plots for review question: B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?

No meta-analyses were performed as the interventions or outcomes were either not sufficiently similar to allow them to be combined or they were not reported by more than one study.

Appendix F – GRADE tables

GRADE tables for review question: B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

Table 9: Clinical evidence profile for psychological therapies for adjustment and engagement: motivation intervention versus standard post-operative care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Motivation intervention	Standard post-operative care	Relative (95% CI)	Absolute		
Overall quality of life: Physical functioning (SF-36; scale not reported; better indicated by higher values) [at 6 months]												
1 (Allegrante 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	32	27	-	MD 5 higher (8.95 lower to 18.95 higher)	LOW	CRITICAL
Overall quality of life: General health (SF-36; scale not reported; better indicated by higher values) [at 6 months]												
1 (Allegrante 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	32	27	-	MD 6 higher (6.13 lower to 18.13 higher)	VERY LOW	CRITICAL
Overall quality of life: Mental health (SF-36; scale not reported; better indicated by higher values) [at 6 months]												
1 (Allgrante 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	32	27	-	MD 7 higher (2.62 lower to 16.62 higher)	VERY LOW	CRITICAL
Pain: Bodily pain (SF-36; scale not reported; better indicated by higher values) [at 6 months]												
1 (Allegrante 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	32	27	-	MD 0 higher (12.64 lower to 12.64 higher)	VERY LOW	IMPORTANT

CI: confidence interval; MD: mean difference; SF-36: 36 item short-form survey
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for SF-36 general health +/-13.0; for SF-36 mental health +/-10.0)
3 95% CI crosses 2 MIDs (for SF-36 bodily pain +/-12.0)

Table 10: Clinical evidence profile for psychological therapies for adjustment and engagement: interpersonal counselling versus standard care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interpersonal counselling	Standard care	Relative (95% CI)	Absolute		
Changes in mood: Depression (BDI; range 0-63; better indicated by lower values) - at 3 months												
1 (Holmes 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	27	31	-	MD 3.3 higher (2.12 lower to 8.72 higher)	VERY LOW	CRITICAL
Changes in mood: Depression (BDI; range 0-63; better indicated by lower values) - at 6 months												
1 (Holmes 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	27	31	-	MD 0 higher (5.85 lower to 5.85 higher)	VERY LOW	CRITICAL
Changes in mood: Depression (HADS; range 0-21; better indicated by lower values) - at 3 months												
1 (Holmes 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	27	31	-	MD 1.3 higher (1.06 lower to 3.66 higher)	VERY LOW	CRITICAL
Changes in mood: Depression (HADS; range 0-21; better indicated by lower values) - at 6 months												
1 (Holmes 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	27	31	-	MD 0.7 higher (2.71 lower to 4.11 higher)	VERY LOW	CRITICAL
Changes in mood: Anxiety (HADS; range 0-21; better indicated by lower values) - at 3 months												
1 (Holmes 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	27	31	-	MD 0.6 higher (1.73 lower to 2.93 higher)	VERY LOW	CRITICAL
Changes in mood: Anxiety (HADS; range 0-21; better indicated by lower values) - at 6 months												
1 (Holmes 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	27	31	-	MD 1.3 lower (4.29 lower to 1.69 higher)	VERY LOW	CRITICAL

BDI: Beck depression inventory; CI: confidence interval; HADS: Hospital anxiety and depression scale; MD: mean difference
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for BDI +/-4.8; for HADS Depression +/-2.25; for HADS Anxiety +/-2.5)
3 95% CI crosses 2 MIDs (for BSI +/-4.8; for HADS Depression +/-2.25)

Table 11: Clinical evidence profile for psychological therapies for adjustment and engagement: peer support telephone call service versus standard care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Peer support telephone call service	Standard care	Relative (95% CI)	Absolute		
Changes in mood: Depression (PHQ-9; range 0-27; better indicated by lower values) [at 6 months follow-up]												
1 (Mercier 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	53	53	-	MD 1 lower (2.64 lower to 0.64 higher)	LOW	CRITICAL
Changes in activity of daily living: Physical independence scale (CHART-SF; range 0-100; better indicated by higher values) [at 6 months follow-up]												
1 (Mercier 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	53	53	-	MD 2 higher (10.71 lower to 14.71 higher)	MODERATE	IMPORTANT

CHART-SF: Short form Craig handicap assessment and reporting technique; CI: confidence interval; PHQ-9: 9 item patient health questionnaire MD: mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for PHQ-9 +/-2.3)

Table 12: Clinical evidence profile for psychological therapies for adjustment and engagement: on-line based cognitive behavioural therapy (CBT) versus waitlist control

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	On-line based CBT	Waitlist control	Relative (95% CI)	Absolute		
Changes in mood – depression: Depression, Anxiety and Stress Scale (DASS21; range 0-42; better indicated by lower values) [after intervention completion (10-12 weeks from baseline)]												

1 (Migliorini 2016)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	23	25	-	MD 2.7 lower (9.24 lower to 3.84 higher)	VERY LOW	IMPORTANT
Changes in mood – anxiety: Depression, Anxiety and Stress Scale (DASS21; range 0-42; better indicated by lower values) [after intervention completion (10-12 weeks from baseline)]												
1 (Migliorini 2016)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[4]	none	23	25	-	MD 0.2 lower (4.76 lower to 4.36 higher)	VERY LOW	IMPORTANT

CI: Confidence interval; MD: Mean difference
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Population is indirect: mix of traumatic and non-traumatic patients (exact numbers were not reported)
3 95% CI crosses 1 MID (for DASS21: Depression +/- 5.40)
4 95% CI crosses 2 MID (for DASS21: Anxiety +/- 4.20)

Table 13: Clinical evidence profile for psychological therapies for adjustment and engagement: CBT-based psychotherapy versus standard care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**CBT-based psychotherapy**	**Standard care**	**Relative (95% CI)**	**Absolute**		
Overall quality of life: Health-related Quality of Life (HR-QoL; scale not reported; better indicated by higher values) [at 6 months post trauma]												
1 (Pirente 2007)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	45	47	-	MD 0.06 lower (0.14 lower to 0.02 higher)	VERY LOW	CRITICAL
Changes in mood: Depression (BDI; range 0-63; better indicated by lower values) - at 6 months post trauma												
1 (Pirente 2007)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	no serious imprecision	none	45	47	-	MD 0.7 higher (3.06 lower to 4.46 higher)	VERY LOW	CRITICAL
Changes in mood: Depression (BDI; range 0-63; better indicated by lower values) - at 12 months post trauma												
1 (Pirente 2007)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	no serious imprecision	none	45	47	-	MD 1.8 higher (1.63 lower to 5.23 higher)	VERY LOW	CRITICAL
Changes in mood: Anxiety (STAI ; scale not reported; better indicated by lower values) - at 6 months post trauma												
1 (Pirente 2007)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	45	47	-	MD 2.96 higher (1.66 lower to 7.58 higher)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CBT-based psychotherapy	Standard care	Relative (95% CI)	Absolute		
Changes in mood: Anxiety (STAI ; scale not reported; better indicated by lower values) - at 12 months post trauma												
1 (Pirente 2007)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	45	47	-	MD 3.69 higher (0.94 lower to 8.32 higher)	VERY LOW	CRITICAL
Changes in mood: Anxiety (SSCS5 SCL-4 Symptom Checklist Subscale 5 anxiety score) - at 6 months post trauma												
1 (Pirente 2007)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	45	47	-	MD 13.1 higher (0.11 to 26.09 higher)	VERY LOW	CRITICAL
Changes in mood: Anxiety (SSCS5 SCL-4 Symptom Checklist Subscale 5 anxiety score) - at 12 months post trauma												
1 (Pirente 2007)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	45	47	-	MD 13.8 higher (0.35 to 27.25 higher)	VERY LOW	CRITICAL

BDI: Beck depression inventory; CBT: Cognitive behavioural therapy; CI: confidence interval; HRQoL: Health-related quality of life; MD: mean difference; SSCS5: Subscale 5 (anxiety) of symptoms checklist 90-R; STAI: State subscale from stair-anxiety anxiety inventory
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Population is indirect (includes moderate traumatic brain injury)
3 95% CI crosses 1 MID (for HR-QoL +/-0.1; for STAI +/-5.65, for SSCS5 +/-15.225)

Table 14: Clinical evidence profile for family support: caregiver education and support versus written information pack

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Caregiver education and support	Written information pack	Relative (95% CI)	Absolute		
Overall quality of life: Health symptoms (range 0-8; better indicated by lower values) [at 12 months follow-up]												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Caregiver education and support	Written information pack	Relative (95% CI)	Absolute		
1 (Schulz 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	56	-	MD 0.5 lower (1.23 lower to 0.23 higher)	LOW	CRITICAL
Overall quality of life: Social integration (range 0-15; better indicated by higher values) [at 12 months follow-up]												
1 (Schulz 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	56	-	MD 0.64 lower (1.77 lower to 0.49 higher)	LOW	CRITICAL
Changes in mood: Depression (CES-D; range 0-30; better indicated by lower vales) [at 12 months follow-up]												
1 (Schulz 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	56	-	MD 0.73 lower (3.26 lower to 1.8 higher)	LOW	CRITICAL

CES-D: Center for epidemiologic studies depression scale; CI: confidence interval; MD: mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for Health symptoms +/-0.99; for Social Integration +/-1.485; for CES-D +/-2.955)

Table 15: Clinical evidence profile for family support: dual target caregiver and care recipient education and support versus written information pack

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Dual target	Written information pack	Relative (95% CI)	Absolute		
Overall quality of life: Health symptoms (range 0-8; better indicated by lower values) [at 12 months follow-up]												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Dual target	Written information pack	Relative (95% CI)	Absolute		
1 (Schulz 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	50	56	-	MD 0.98 lower (1.69 to 0.27 lower)	LOW	CRITICAL
Overall quality of life: Social integration (range 0-15; better indicated by higher values) [at 12 months follow-up]												
1 (Schulz 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	50	56	-	MD 1.51 lower (2.75 to 0.27 lower)	LOW	CRITICAL
Changes in mood: Depression (CES-D; range 0-30; better indicated by lower vales)) [at 12 months follow-up]												
1 (Schulz 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	50	56	-	MD 0.93 lower (3.27 lower to 1.41 higher)	LOW	CRITICAL

CES-D: Center for epidemiologic studies depression scale; CI: confidence interval; MD: mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for Health symptoms +/-0.99; for Social Integration +/-1.485; CES-D +/-2.955)

Table 16: Clinical evidence profile for self-management interventions: Trauma Support Network versus standard care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma Support Network	Standard care	Relative (95% CI)	Absolute		
Overall quality of life: mental component score (SF-12; scale not reported; better indicated by higher values) [at 6 months (from baseline)]												
1 (Castillo 2013)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	126	125	-	MD 3.4 higher (0.32 lower to 7.12 higher)	LOW	CRITICAL
Overall quality of life: physical component score (SF-12; scale not reported; better indicated by higher values) [at 6 months (from baseline)]												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma Support Network	Standard care	Relative (95% CI)	Absolute		
1 (Castillo 2013)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	126	125	-	MD 1.4 higher (1.67 lower to 4.47 higher)	LOW	CRITICAL
Changes in mood: Depression (PHQ-9; range 0-27; better indicated by lower values) [at 6 months (from baseline)]												
1 (Castillo 2013)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	serious imprecision[2]	none	126	125	-	MD 2.2 lower (3.75 to 0.65 lower)	VERY LOW	CRITICAL
Changes in mood: Anxiety (BSI; scale not reported; better indicated by lower values) [at 6 months (from baseline)]												
1 (Castillo 2013)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	126	125	-	MD 0 higher (0.19 lower to 0.19 higher)	LOW	CRITICAL

BSI: Brief symptom inventory; CI: confidence interval; MD: mean difference; PHQ-9: 9 item patient health questionnaire; SF-12: 12 item short-form survey
1 Very serious risk of bias in the evidence contributing to the outcomes as per ROBINS-I
2 95% CI crosses 1 MID (for PHQ-9 +/-3.25)

Table 17: Clinical evidence profile for self-management interventions: educationally based group therapeutic programme versus waitlist control

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group therapeutic programme	Waitlist control	Relative (95% CI)	Absolute		
Changes in mood: Patient Health Questionnaire 9-Item (PHQ-9; range 0-27; better indicated by lower values) - at 6 weeks from baseline (after intervention completion)												
1 (Coker 2019)	randomised trials	serious[1]	no serious inconsistency	serious[2]	serious[3]	none	41	40	-	MD 0.36 higher (1.96 lower to 2.68 higher)	VERY LOW	IMPORTANT

Changes in mood: Patient Health Questionnaire 9-Item (PHQ-9; range 0-27; better indicated by lower values) - at 24 weeks after intervention completion (Better indicated by lower values)												
1 (Coker 2019)	randomised trials	serious[1]	no serious inconsistency	serious[2]	serious[3]	none	41	40	-	MD 0.6 higher (1.80 lower to 3.00 higher)	VERY LOW	IMPORTANT

CI: Confidence interval; MD: Mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Population is indirect: mix of traumatic and non-traumatic patients (exact numbers were not reported)
3 95% CI crosses 1 MID: (for PHQ-9 +/-2.53)

Table 18: Clinical evidence profile for self-management interventions: group learning programme versus standard care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Group learning programme**	**Standard care**	**Relative (95% CI)**	**Absolute**		
Changes in activities of daily living: Barthel ADL Index (range 0-20; better indicated by higher values) [at intervention completion]												
1 (Elinge 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious imprecision[2]	none	21	14	Median (IQR): 20 (12-20)[3]	Median (IQR): 19 (16-20)[3]	VERY LOW	IMPORTANT
Changes in activities of daily living: Barthel ADL Index (range 0-20; better indicated by higher values) [at 12 months after intervention completion]												
1 (Elinge 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious imprecision[2]	none	18	12	Median (IQR): 20 (18-20)[3]	Median (IQR): 19 (17-20)[3]	VERY LOW	IMPORTANT

ADL: Activities of daily living; CI: confidence interval; IQR: interquartile range
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to no reporting of SD and no published MIDs so was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels. Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
3 According to the statistical analyses performed by the author, the median difference was not statistically significant

Table 19: Clinical evidence profile for self-management interventions: Health Active Behavioural intervention in SCI (HABITS) programme versus single information meeting

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	HABITS	Information meeting	Relative (95% CI)	Absolute		
Overall quality of life (WHOQoL-5; scale not reported; better indicated by higher values) - at 16 weeks (following baseline)												
1 (Kooijmans 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	21	21	-	MD 0.5 lower (2.26 lower to 1.26 higher)	VERY LOW	CRITICAL
Overall quality of life (WHOQoL-5; scale not reported; better indicated by higher values) - at 42 weeks (following baseline)												
1 (Kooijmans 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	17	14	-	MD 1.1 higher (1.05 lower to 3.25 higher)	VERY LOW	CRITICAL
Overall quality of life (MHI-5; scale not reported; better indicated by higher values) - at 16 weeks (following baseline)												
1 (Kooijmans 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	21	21	-	MD 2.8 higher (3.97 lower to 9.57 higher)	VERY LOW	CRITICAL
Overall quality of life (MHI-5; scale not reported; better indicated by higher values) - at 42 weeks (following baseline)												
1 (Kooijmans 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	17	14	-	MD 0.7 higher (7.62 lower to 9.02 higher)	VERY LOW	CRITICAL
Changes in activity of daily living (SCIM3; range 0-100; better indicated by higher values) - at 16 weeks (following baseline) (Better indicated by higher values)												
1 (Kooijmans 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	25	-	MD 1.9 higher (6.75 lower to 10.55 higher)	VERY LOW	IMPORTANT
Changes in activity of daily living (SCIM3; range 0-100; better indicated by higher values) - at 42 weeks (following baseline) (Better indicated by higher values)												
1 (Kooijmans 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	23	20	-	MD 0.8 higher (8.71 lower to 10.31 higher)	VERY LOW	IMPORTANT

CI: confidence interval; MD: mean difference; MHI-5: 5 item Mental health inventory; SCIM3: Spinal cord independence measure III: WHOQoL-5: 5 item World Health Organization quality of life
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for WHOQoL-5 +/-2.05; for MHI-5 +/-7.5 to 7.5, for SCIM3 +/-7.5)
3 95% CI crosses 2 MIDs (for MHI-5 +/-7.5 to 7.5, for SCIM3 +/-7.5)

Table 20: Clinical evidence profile for self-management interventions: multimedia self-care education and information versus self-care information

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multimedia self-care education and information	Self-care information	Relative (95% CI)	Absolute		
Overall quality of life (Brief burn specific health scale; range 0-40; better indicated by higher values) [3 months (after intervention completion)]												
1 (Mohaddes Ardebili 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	50	50	-	MD 1.13 higher (0.85 to 1.41 higher)	LOW	CRITICAL

CI: confidence interval; MD: mean difference
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2

Table 21: Clinical evidence table for person-centred goal setting: motivational interviewing versus standard care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Motivational interviewing	Standard care	Relative (95% CI)	Absolute		
Overall quality of life: General health score (SF-36; scale not reported; better indicated by higher values) [at discharge (2 months after baseline)]												
1 (Nooijen 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	20	19	-	MD 0.46 lower (13.46	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Motivational interviewing	Standard care	Relative (95% CI)	Absolute		
										lower to 12.54 higher)		
Overall quality of life: General health score (SF-36; scale not reported; better indicated by higher values) [at 6 months after discharge]												
1 (Nooijen 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	15	16	-	MD 1.15 higher (13.17 lower to 15.47 higher)	VERY LOW	CRITICAL
Overall quality of life: General health score (SF-36; scale not reported; better indicated by higher values) [at 12 months after discharge]												
1 (Nooijen 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	11	11	-	MD 1 lower (20.92 lower to 18.92 higher)	VERY LOW	CRITICAL
Overall quality of life: Physical component score (SF-12; scale not reported; better indicated by higher values) [at 6 months]												
1 (Wiechman 2015)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	40	41	-	MD 4.7 higher (0.29 lower to 9.11 higher)	MODERATE	CRITICAL
Overall quality of life: Physical component score (SF-12; scale not reported; better indicated by higher values) [at 12 months]												
1 (Wiechman 2015)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[4]	none	40	41	-	MD 3.6 lower (9.54 lower to 2.34 higher)	LOW	CRITICAL
Overall quality of life: Mental health score (SF-36; scale not reported; better indicated by higher values) [at discharge (2 months after baseline)]												
1 (Nooijen 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	20	19	-	MD 6 higher (6 lower to 18 higher)	VERY LOW	CRITICAL
Overall quality of life: Mental health score (SF-36; scale not reported; better indicated by higher values) [at 6 months after discharge]												
1 (Nooijen 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	15	16	-	MD 10.37 higher (5.2 lower to 25.94 higher)	VERY LOW	CRITICAL
Overall quality of life: Mental health score (SF-36; scale not reported; better indicated by higher values) [at 12 months after discharge]												
1 (Nooijen 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	11	11	-	MD 4.65 higher (12.08	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Motivational interviewing	Standard care	Relative (95% CI)	Absolute		
										lower to 21.38 higher)		
Overall quality of life: Mental component score (SF-12; scale not reported; better indicated by higher values) [at 6 month												
1 (Wiechman 2015)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[4]	none	40	41	-	MD 1.9 higher (2.52 lower to 6.32 higher)	LOW	CRITICAL
Overall quality of life: Mental component score (SF-12; scale not reported; better indicated by higher values) [at 12 months]												
1 (Wiechman 2015)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[4]	none	40	41	-	MD 7.1 higher (2.32 to 11.88 higher)	LOW	CRITICAL
Overall quality of life: Participation (IMPACT-S; scale not reported; better indicated by higher values) [at discharge (2 months after baseline)]												
1 (Nooijen 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	20	19	-	MD 8.92 lower (17.38 to 0.46 lower)	VERY LOW	CRITICAL
Overall quality of life: Participation (IMPACT-S; scale not reported; better indicated by higher values) [at 6 months after discharge]												
1 (Nooijen 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	15	16	-	MD 0.96 lower (10.53 lower to 8.61 higher)	VERY LOW	CRITICAL
Overall quality of life: Participation (IMPACT-S; scale not reported; better indicated by higher values) [at 12 months after discharge]												
1 (Nooijen 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	11	11	-	MD 4.77 higher (7.04 lower to 16.58 higher)	VERY LOW	CRITICAL
Patient Satisfaction: Satisfaction with Social Support (scale not reported; better indicated by higher values) [at 6 months]												
1 (Wiechman 2015)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[4]	none	40	41	-	MD 0.5 higher (0.31 lower to 1.31 higher)	LOW	CRITICAL
Patient Satisfaction: Satisfaction with Social Support (scale not reported; better indicated by higher values) [at 12 months]												
1 (Wiechman 2015)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[4]	none	40	41	-	MD 1.5 higher (0.5 to 2.5 higher)	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Motivational interviewing	Standard care	Relative (95% CI)	Absolute		
Changes in mood: Depression (CES-D; range 0-30; better indicated by lower values) [at discharge (2 months after baseline)]												
1 (Nooijen 2016b)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	20	19	-	MD 2.94 higher (2.63 lower to 8.51 higher)	VERY LOW	CRITICAL
Changes in mood: Depression (CES-D; range 0-30; better indicated by lower values) [at 6 months after discharge]												
1 (Nooijen 2016b)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	15	16	-	MD 0.69 lower (9.38 lower to 8 higher)	VERY LOW	CRITICAL
Changes in mood: Depression (CES-D; range 0-30; better indicated by lower values) [at 12 months after discharge]												
1 (Nooijen 2016b)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	11	11	-	MD 1.39 lower (10.19 lower to 7.41 higher)	VERY LOW	CRITICAL
Changes in activity of daily living (min/day wheeled physical activity; better indicated by higher values) [at discharge (2 months after baseline)]												
1 (Nooijen 2016a)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	16	14	-	MD 11 higher (1.96 lower to 23.96 higher)	VERY LOW	IMPORTANT
Changes in activity of daily living (Wheeled physical activity min/day; better indicated by higher values) [at 6 months]												
1 (Nooijen 2016a)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	13	14	-	MD 28 higher (4.99 to 51.01 higher)	VERY LOW	IMPORTANT
Changes in activity of daily living (Wheeled physical activity min/day; better indicated by higher values) [at 12 months]												
1 (Nooijen 2016a)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	10	10	-	MD 23 higher (11.63 lower to 57.63 higher)	VERY LOW	IMPORTANT
Changes in activity of daily living (Physical Activity Scale for Individuals with Physical Disabilities; scale not reported; better indicated by higher values) [at 6 months]												
1 (Nooijen 2016a)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	20	19	-	MD 22 higher (6.67 to 37.33 higher)	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Motivational interviewing	Standard care	Relative (95% CI)	Absolute		
Changes in activity of daily living (Physical Activity Scale for Individuals with Physical Disabilities; scale not reported; better indicated by higher values) [at 12 months]												
1 (Nooijen 2016a)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	20	19	-	MD 15 higher (7.76 to 22.24 higher)	LOW	IMPORTANT
Changes in activity of daily living (GAS; scale not reported; better indicated by higher values) [at 6 months]												
1 (Wiechman 2015)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	serious[4]	none	40	41	-	MD 2.6 lower (8.77 lower to 3.57 higher)	LOW	IMPORTANT
Changes in activity of daily living (GAS; scale not reported; better indicated by higher values) [at 12 months]												
1 (Wiechman 2015)	randomised trials	serious[3]	no serious inconsistency	no serious indirectness	no serious imprecision	none	40	41	-	MD 1.1 higher (4.96 lower to 7.16 higher)	MODERATE	IMPORTANT
Pain: Pain intensity (Chronic Pain Grade; scale not reported; better indicated by lower values) [at discharge (2 months after baseline)]												
1 (Nooijen 2016b)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	20	19	-	MD 2.96 higher (14.75 lower to 20.67 higher)	VERY LOW	IMPORTANT
Pain: Pain intensity (Chronic Pain Grade; scale not reported; better indicated by lower values) [at 6 months after discharge]												
1 (Nooijen 2016b)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	15	16	-	MD 1.23 higher (18.05 lower to 20.51 higher)	VERY LOW	IMPORTANT
Pain: Pain intensity (Chronic Pain Grade; scale not reported; better indicated by lower values) [at 12 months after discharge]												
1 (Nooijen 2016b)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	11	11	-	MD 3.91 lower (28.52 lower to 20.7 higher)	VERY LOW	IMPORTANT
Pain: Pain disability (Chronic Pain Grade; scale not reported; better indicated by lower values) [at 6 months after discharge]												
1 (Nooijen 2016b)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	15	16	-	MD 0.06 lower (1.16 lower to 1.04 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Motivational interviewing	Standard care	Relative (95% CI)	Absolute		
Pain: Pain disability (Chronic Pain Grade; scale not reported; better indicated by lower values) [at 12 months after discharge]												
1 (Nooijen 2016b)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	11	11	-	MD 1.15 higher (0.13 to 2.17 higher)	VERY LOW	IMPORTANT

CES-D: Center for Epidemiologic Studies Depression Scale; CI: confidence interval; GAS: Goal attainment scaling; IMPACT-S: ICF-Measure of Participation and Activities Screener; MD: mean difference; SF-12: 12 item short-form survey; SF-36: 36 item short-form survey
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
3 95% CI crosses 2 MIDs (for SF-36 General Health +/-11.83; for IMPACT-S Participation +/-8.54; for CES-D +/-4.585; for SF-36 Mental health +/-9.63; for pain intensity +/-10.92, for pain disability +/-0.83)
4 95% CI crosses 1 MID (for SF-12 physical component score +/-5.95; for IMPACT-S Participation +/-8.54; for Satisfaction with Social Support +/-1.05;, for CES-D +/-4.585; ; for SF-26 mental health score +/-9.63; for SF-12 mental component score +/-5.75; for wheeled physical activity +/-17.5 to 17.5; for Goal Attainment Score +/-7.4; for Pain disability +/-0.83)

Table 22: Clinical evidence table for person-centred goal setting: supported discharge with motivational interviewing versus standard care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Supported discharge with motivational interviewing	Standard care and rehabilitation	Relative (95% CI)	Absolute		
Changes in activity of daily living (Instrumental Activities of Daily Living; range 0-56; better indicated by higher values) [at 1 month follow-up]												
1 (Zidén 2008)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	48	54	-	MD 18.7 higher (13.5 to 23.9 higher)	MODERATE	IMPORTANT

CI: confidence interval; MD: mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2

GRADE tables for review question: B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?

Table 23: Clinical evidence profile for Microskin™ camouflage versus wait-list control

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Microskin™ camouflage	Wait-list control	Relative (95% CI)	Absolute		
Overall quality of life: PedsQL 4.0 (scale not reported; better indicated by higher values) [at 8 weeks follow-up from baseline]												
1 (Maskell 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	17	-	MD 3.64 higher (4.61 lower to 11.89 higher)	VERY LOW	CRITICAL

CI: confidence interval; MD: Mean difference; PEDsQL 4.0: Pediatric quality of life inventory version 4.0; TM: Trademark
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for PedsQL 4.0 +/- 7.83)

Appendix G – Economic evidence study selection

Economic study selection for review questions:

B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?)

A combined search was conducted for both review questions.

Figure 3: Study selection flow chart: Adults

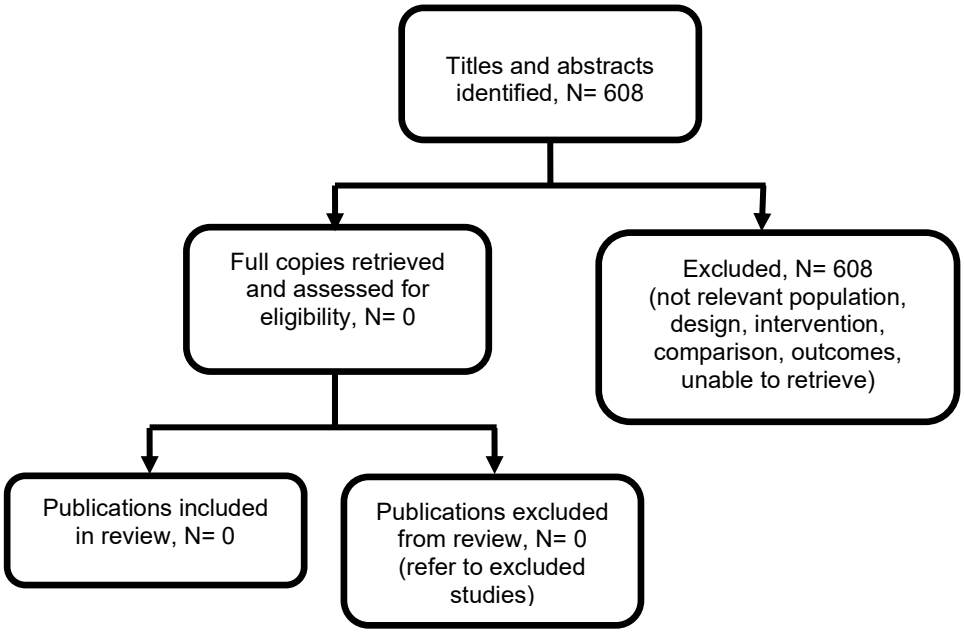
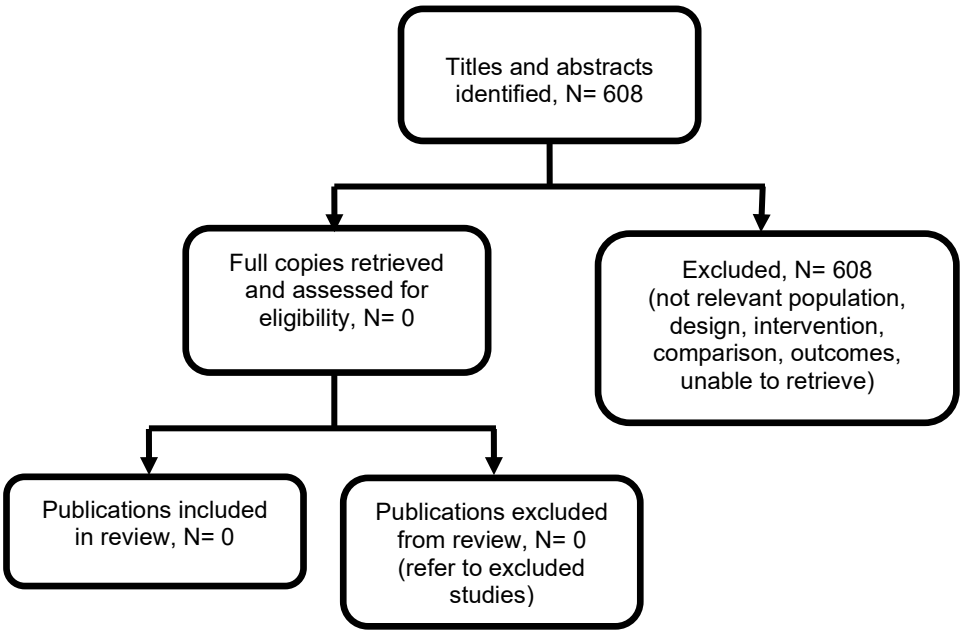


Figure 4: Study selection flow chart: Children and young people



Appendix H – Economic evidence tables

Economic evidence tables for review question: B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

No economic studies were identified which were applicable to this review question.

Economic evidence tables for review question: B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?

No economic studies were identified which were applicable to this review question.

Appendix I – Economic evidence profiles

Economic evidence profiles for review question: B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

No economic studies were identified which were applicable to this review question.

Economic evidence profiles for review question: B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?

No economic studies were identified which were applicable to this review question.

Appendix J – Economic analysis

Economic evidence analysis for review question: B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

No economic analysis was conducted for this review question.

Economic evidence analysis for review question: B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?

No economic analysis was conducted for this review question.

Appendix K – Excluded studies

Excluded clinical and economic studies for review question: B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

Clinical studies

Table 24: Excluded studies and reasons for their exclusion

Study	Reason for Exclusion
Abou-Setta, A. M., Beaupre, L. A., Rashiq, S., Dryden, D. M., Hamm, M. P., Sadowski, C. A., Menon, M. R. G., Majumdar, S. R., Wilson, D. M., Karkhaneh, M., Mousavi, S. S., Wong, K., Tjosvold, L., Jones, C. A., Comparative effectiveness of pain management interventions for hip fracture: A systematic review, Annals of Internal Medicine, 155, 234-245, 2011	Systematic review included studies checked for relevance. None were found.
Arbour-Nicitopoulos, K. P., Ginis, K. A., Latimer, A. E., Planning, leisure-time physical activity, and coping self-efficacy in persons with spinal cord injury: a randomized controlled trial, Archives of Physical Medicine and Rehabilitation, 90, 2003-2011, 2009	Outcomes not in PICO - intentions and self-efficacy
Arefnasab, Z., Babamahmoodi, A., Babamahmoodi, F., Noorbala, A. A., Alipour, A., Panahi, Y., Shams, J., Rad, F. R., Khaze, V., Ghanei, M., Mindfulness-based Stress Reduction (MBSfR) and its effects on psychoimmunological factors of chemically pulmonary injured veterans, Iranian Journal of Allergy, Asthma and Immunology, 15, 476-486, 2016	Population not in PICO - veterans exposed to mustard gas and complications of Iran-Iraq war.
Arefnasab, Zahra, Babamahmoodi, Abdolreza, Babamahmoodi, Farhang, Noorbala, Ahmad Ali, Alipour, Ahmad, Panahi, Yunes, Shams, Jamal, Riazi Rad, Farhad, Khaze, Vahid, Ghanei, Mostafa, Mindfulness-based Stress Reduction (MBSR) and Its Effects on Psychoimmunological Factors of Chemically Pulmonary Injured Veterans, Iranian journal of allergy, asthma, and immunology, 15, 476-486, 2016	Population not in PICO - veterans exposed to mustard gas and complications of Iran-Iraq war.
Arrieta, H., Rezola-Pardo, C., Gil, S. M., Virgala, J., Iturburu, M., Anton, I., Gonzalez-Templado, V., Irazusta, J., Rodriguez-Larrad, A., Effects of Multicomponent Exercise on Frailty in Long-Term Nursing Homes: A Randomized Controlled Trial, Journal of the American Geriatrics Society, 67, 1145-1151, 2019	Population not in PICO: Residents at a longterm nursing home
Baker, Virginia B., Eliasen, Kathryn M., Hack, Nawaz K., Lifestyle modifications as therapy for medication refractory post-traumatic headache (PTHA) in the military population of Okinawa, The journal of headache and pain, 19, 113, 2018	Non-comparative study

Study	Reason for Exclusion
Bakker, R., Elderdesign: Home modifications for enhanced safety and self-care, Care Management Journals, 1, 47-54, 1999	Narrative review
Baron, J. S., Sullivan, K. J., Swaine, J. M., Aspinall, A., Jaglal, S., Presseau, J., White, B., Wolfe, D., Grimshaw, J. M., Self-management interventions for skin care in people with a spinal cord injury: part 1-a systematic review of intervention content and effectiveness, Spinal Cord, 56, 823-836, 2018	Systematic review - studies checked for possible inclusion. 8 were identified.
Basilici Zannetti, Emanuela, D'Agostino, Fabio, Cittadini, Noemi, Feola, Maurizio, Pennini, Annalisa, Rao, Cecilia, Vellone, Ercole, Tarantino, Umberto, Alvaro, Rosaria, Effect of tailored educational intervention to improve self-care maintenance and quality of life in postmenopausal osteoporotic women after a fragility fracture: the Guardian Angel® study, Igiene e sanita pubblica, 73, 65-76, 2017	Full text in Italian
Berube, M., Gelinas, C., Feeley, N., Martorella, G., Cote, J., Laflamme, G. Y., Rouleau, D. M., Choiniere, M., Feasibility of a Hybrid Web-Based and In-Person Self-management Intervention Aimed at Preventing Acute to Chronic Pain Transition After Major Lower Extremity Trauma (iPACT-E-Trauma): A Pilot Randomized Controlled Trial, Pain medicine (Malden, Mass.), 2019	Intervention not in PICO - specific pain management interventions
Berube, M., Gelinas, C., Martorella, G., Feeley, N., Cote, J., Laflamme, G. Y., Rouleau, D. M., Choiniere, M., Development and Acceptability Assessment of a Self-Management Intervention to Prevent Acute to Chronic Pain Transition after Major Lower Extremity Trauma, Pain management nursing : official journal of the American Society of Pain Management Nurses, 19, 671-692, 2018	Non-randomised study, n<100 per treatment arm.
Berube, Melanie, Gelinas, Celine, Feeley, Nancy, Martorella, Geraldine, Cote, Jose, Laflamme, G. Yves, Rouleau, Dominique M., Choiniere, Manon, A Hybrid Web-Based and In-Person Self-Management Intervention Aimed at Preventing Acute to Chronic Pain Transition After Major Lower Extremity Trauma: Feasibility and Acceptability of iPACT-E-Trauma, JMIR formative research, 2, e10323, 2018	Intervention not in PICO - specific pain management interventions
Best, K. L., Miller, W. C., Huston, G., Routhier, F., Eng, J. J., Pilot Study of a Peer-Led Wheelchair Training Program to Improve Self-Efficacy Using a Manual Wheelchair: A Randomized Controlled Trial, Arch Phys Med Rehabil, 97, 37-44, 2016	Population not in PICO - wheelchair users only.
Black, O., Keegel, T., Sim, M. R., Collie, A., Smith, P., The Effect of Self-Efficacy on Return-to-Work Outcomes for Workers with Psychological or Upper-Body Musculoskeletal	Systematic review, included studies checked for relevance

Study	Reason for Exclusion
Injuries: A Review of the Literature, Journal of Occupational Rehabilitation, 28, 16-27, 2018	
Black, O., Keegel, T., Sim, M., Collie, A., Smith, P., The effect of self-efficacy on return-to-work outcomes for workers with psychological or upper-body musculoskeletal injuries: A review of the literature, Occupational and Environmental Medicine, 73, A207, 2016	Duplicate paper
Block, P., Vanner, E. A., Keys, C. B., Rimmer, J. H., Skeels, S. E., Project Shake-It-Up: using health promotion, capacity building and a disability studies framework to increase self efficacy, Disability and Rehabilitation, 32, 741-754, 2010	Non-randomised study, n<100 per treatment arm.
Bombardier, C., Fann, J. R., Ehde, D., Reyes, M. R., Hoffman, J. M., Collaborative care for pain, depression and physical inactivity in an outpatient SCI clinic: The sci-care study, Archives of Physical Medicine and Rehabilitation, 97, e78-e79, 2016	Conference abstract
Brunelli, S., Morone, G., Iosa, M., Ciotti, C., De Giorgi, R., Foti, C., Traballesi, M., Efficacy of progressive muscle relaxation, mental imagery, and phantom exercise training on phantom limb: a randomized controlled trial, Archives of Physical Medicine and Rehabilitation, 96, 181-187, 2015	Population not in PICO - 28/40 had amputation for dysvascular causes.
Burns, A., Banerjee, S., Morris, J., Woodward, Y., Baldwin, R., Proctor, R., Tarrier, N., Pendleton, N., Sutherland, D., Andrew, G., Horan, M., Treatment and prevention of depression after surgery for hip fracture in older people: randomized, controlled trials, J Am Geriatr Soc, 55, 75-80, 2007	Intervention not in PICO - treatment and prevention of depression in hip fracture patients.
Carrougher, G. J., Brych, S. B., Pham, T. N., Mandell, S. P., Gibran, N. S., An Intervention Bundle to Facilitate Return to Work for Burn-Injured Workers: Report from a Burn Model System Investigation, Journal of Burn Care and Research, 38, e70-e78, 2017	Intervention not in PICO: Return to work interventions (covered by NICE guideline on return to work)
Chertok, N. V., Dolgova, V. I., Mamylina, N. V., Bajguzhin, P. A., Kryzhanovskaya, N. V., The effect of rehabilitation technology on quality of life of middle-age women afterupper limb trauma, International Journal of Pharmacy and Technology, 8, 27186-27195, 2016	Intervention not in PICO - rehabilitation course
Chin, O. Y., Tollefson, T. T., Role of Camouflage in Management of Facial Trauma Deformities, Facial plastic surgery : FPS, 33, 643-652, 2017	Narrative review with case reports
Cogan, L., Mc Gurk, S., Cannon, J., Romero-Ortuno, R., Frawley, N., The activity and outcomes of an off-site geriatric rehabilitation unit: A 1-year study, Irish Journal of Medical Science, 182, S243, 2013	Conference abstract
Craig, A. R., Hancock, K., Dickson, H., Chang, E., Long-term psychological outcomes in spinal	Non-randomised study, n<100 per treatment arm.

Study	Reason for Exclusion
cord injured persons: results of a controlled trial using cognitive behavior therapy, Archives of Physical Medicine and Rehabilitation, 78, 33-8, 1997	
Crotty, M., Unroe, K., Cameron, I. D., Miller, M., Ramirez, G., Couzner, L., Rehabilitation interventions for improving physical and psychosocial functioning after hip fracture in older people, Cochrane Database of Systematic Reviews, 2010	Systematic review. References checked for possible studies - 5 were identified.
Curtis, K., Hitzig, S. L., Bechsgaard, G., Stoliker, C., Alton, C., Saunders, N., Leong, N., Katz, J., Evaluation of a specialized yoga program for persons with a spinal cord injury: A pilot randomized controlled trial, Journal of Pain Research, 10, 999-1017, 2017	Intervention not in PICO - physical yoga programme
Daneshpajooh, L., Najafi Ghezeljeh, T., Haghani, H., Comparison of the effects of inhalation aromatherapy using Damask Rose aroma and the Benson relaxation technique in burn patients: A randomized clinical trial, Burns, 45, 1205-1214, 2019	Outcome not in PICO - pain anxiety
De Silva, Mary, Maclachlan, Malcolm, Devane, Declan, Desmond, Deirdre, Gallagher, Pamela, Schnyder, Ulrich, Brennan, Muireann, Patel, Vikram, Psychosocial interventions for the prevention of disability following traumatic physical injury, The Cochrane database of systematic reviews, CD006422, 2009	Systematic review, included studies checked for relevance and added to review individually when relevant
Dennis, B. M., Nolan, T. L., Brown, C. E., Vogel, R. L., Flowers, K. A., Ashley, D. W., Nakayama, D. K., Using a checklist to improve family communication in trauma care, American Surgeon, 82, 59-64, 2016	Paper unavailable.
Dorsey, L., Spinal cord injury interdisciplinary education, Journal for specialists in pediatric nursing : JSPN, 10, 86-89, 2005	Narrative review
Dorstyn, D., Mathias, J., Denson, L., Efficacy of cognitive behavior therapy for the management of psychological outcomes following spinal cord injury: a meta-analysis, Journal of health psychology, 16, 374-391, 2011	Systematic review. References checked for possible studies - 1 was identified.
Dorstyn, D., Roberts, R., Murphy, G., Craig, A., Kneebone, I., Stewart, P., Chur-Hansen, A., Marshall, R., Clark, J., Migliorini, C., Work and SCI: a pilot randomized controlled study of an online resource for job-seekers with spinal cord dysfunction, Spinal Cord, 57, 221â□□228, 2019	Intervention not in PICO - online resource targeted to job seekers with spinal cord injury or disorder
Duchnick, J. J., Letsch, E. A., Curtiss, G., Coping effectiveness training during acute rehabilitation of spinal cord injury/dysfunction: a randomized clinical trial, Rehabil Psychol, 54, 123-32, 2009	Comparison not in PICO - coping effectiveness training versus supportive group therapy. Historical non-randomised study used for secondary analysis, N >100 per arm.
Dyck, D. G., Weeks, D. L., Gross, S., Lederhos Smith, C., Lott, H. A., Wallace, A. J., Wood, S. M., Comparison of two psycho-educational	Study protocol

Study	Reason for Exclusion
family group interventions for improving psycho-social outcomes in persons with spinal cord injury and their caregivers: a randomized-controlled trial of multi-family group intervention versus an active education control condition, BMC psychology, 4, 40, 2016	
Elbers, N. A., Akkermans, A. J., Cuijpers, P., Bruinvels, D. J., Empowerment of personal injury victims through the internet: design of a randomized controlled trial, Trials, 12, 29, 2011	Study protocol
Elbers, N. A., Akkermans, A. J., Cuijpers, P., Bruinvels, D. J., Effectiveness of a web-based intervention for injured claimants: a randomized controlled trial, Trials, 14, 227, 2013	Population not in PICO - 42% were hospitalised (after traffic accident).
Ferguson, S. L., Voll, K. V., Burn Pain and Anxiety: The Use of Music Relaxation during Rehabilitation, Journal of Burn Care and Rehabilitation, 25, 8-14, 2004	Outcome not in PICO - change in pain and anxiety during relaxation intervention
Finn, Sacha B., Perry, Briana N., Clasing, Jay E., Walters, Lisa S., Jarzombek, Sandra L., Curran, Sean, Rouhanian, Minoo, Keszler, Mary S., Hussey-Andersen, Lindsay K., Weeks, Sharon R., Pasquina, Paul F., Tsao, Jack W., A Randomized, Controlled Trial of Mirror Therapy for Upper Extremity Phantom Limb Pain in Male Amputees, Frontiers in neurology, 8, 267, 2017	Intervention not in PICO – mirror therapy
Flinn, N., Storm, K., Lower-extremity dressing for persons with quadriplegia: What are the long-term outcomes?, Archives of Physical Medicine and Rehabilitation, 91, e28, 2010	Conference abstract
Fonte, N., Urological care of the spinal cord-injured patient, Journal of wound, ostomy, and continence nursing : official publication of The Wound, Ostomy and Continence Nurses Society / WOCN, 35, 2008	Narrative review
Forchheimer, Martin, Tate, Denise G., Enhancing community re-integration following spinal cord injury, NeuroRehabilitation, 19, 103-13, 2004	Non-randomised study, n<100 per treatment arm.
Foy, T., Perritt, G., Thimmaiah, D., Heisler, L., Offutt, J. L., Cantoni, K., Hseih, C. H., Gassaway, J., Ozelie, R., Backus, D., Occupational therapy treatment time during inpatient spinal cord injury rehabilitation, Journal of Spinal Cord Medicine, 34, 162-175, 2011	Comparison not in PICO - different levels of SCI injury
Foy, Teresa, Perritt, Ginger, Thimmaiah, Deepa, Heisler, Lauren, Offutt, Jennifer Lookingbill, Cantoni, Kara, Hseih, Ching-Hui, Gassaway, Julie, Ozelie, Rebecca, Backus, Deborah, The SCIRehab project: treatment time spent in SCI rehabilitation. Occupational therapy treatment time during inpatient spinal cord injury rehabilitation, The journal of spinal cord medicine, 34, 162-75, 2011	Comparison not in PICO - different levels of SCI injury

Study	Reason for Exclusion
Frenkel, L., A support group for parents of burned children: A South African Children's Hospital Burns Unit, Burns, 34, 565-569, 2008	Qualitative study
Frisbee, Kathleen L., Variations in the Use of mHealth Tools: The VA Mobile Health Study, JMIR mHealth and uHealth, 4, e89, 2016	Population not in PICO - mixture of mental and physical trauma with no way of differentiating in analysis
Frosch, E., Lewandowski, L., Psychological issues associated with acute physical injury: After the pediatric emergency department, International Review of Psychiatry, 10, 216-223, 1998	Narrative review
Galea, M. P., Levinger, P., Lythgo, N., Cimoli, C., Weller, R., Tully, E., McMeeken, J., Westh, R., A targeted home- and center-based exercise program for people after total hip replacement: a randomized clinical trial, Archives of Physical Medicine and Rehabilitation, 89, 1442â□□1447, 2008	Intervention not in PICO - physical exercise intervention
Gargaro, J., Warren, C., Boschen, K., Perceived barriers and facilitators to community reintegration after spinal cord injury: A critical review of the literature, Critical Reviews in Physical and Rehabilitation Medicine, 25, 101-141, 2013	Narrative review
Gassaway, J., Anziano, P., Peer-supported self-directed care optimizes successful community transition after catastrophic injury, Journal of Spinal Cord Medicine, 39, 562, 2016	Conference abstract
Gassaway, J., Jones, M. L., Sweatman, W. M., Young, T., Peer-led, transformative learning approaches increase classroom engagement in care self-management classes during inpatient rehabilitation of individuals with spinal cord injury, Journal of Spinal Cord Medicine, 42, 338-346, 2019	Non-randomised study, n<100 per treatment arm.
Gassner, K., Einsiedel, T., Linke, M., Görlich, P., Mayer, J., Does mental training improve learning to walk with an above-knee prosthesis?, Der Orthopade, 36, 673â□□678, 2007	German language paper
Gernigon, C., Pereira Dias, C., Riou, F., Briki, W., Ninot, G., Reference system of competence and engagement in adapted physical activities of people with recent spinal cord injury, Disability and Rehabilitation, 37, 2192-2196, 2015	Non-randomised study, n<100 per treatment arm.
Ghazi, C., Nyland, J., Whaley, R., Rogers, T., Wera, J., Henzman, C., Social cognitive or learning theory use to improve self-efficacy in musculoskeletal rehabilitation: A systematic review and meta-analysis, Physiotherapy Theory and Practice, 34, 495-504, 2018	Systematic review - studies check for possible inclusions. None were identified.
Gill, M., Psychosocial implications of spinal cord injury, Critical care nursing quarterly, 22, 1-7, 1999	Narrative reveiw
Giummarra, M. J., Lennox, A., Dali, G., Costa, B., Gabbe, B. J., Early psychological interventions for posttraumatic stress,	Systematic review - studies checked for possible inclusion. None were identified.

Study	Reason for Exclusion
depression and anxiety after traumatic injury: A systematic review and meta-analysis, Clinical Psychology Review, 62, 11-36, 2018	
Goodwin-Wilson, C., Watkins, M., Gardner-Elahi, C., Developing evidence-based process maps for spinal cord injury rehabilitation, Spinal Cord, 48, 122-127, 2010	No comparative data
Goudie, S., Dixon, D., McMillan, G., Ring, D., McQueen, M., Is use of a psychological workbook associated with improved disabilities of the arm, shoulder and hand scores in patients with distal radius fracture?, Clinical Orthopaedics and Related Research, 476, 832-845, 2018	Population not in PICO - isolated distal radial fracture, not complex rehabilitation needs
Griffin, Leah, Sifuentes, Mikaela M., Retrospective Payor Claims Analysis of Patients Receiving Outpatient Negative Pressure Wound Therapy With Remote Therapy Monitoring, Wounds : a compendium of clinical research and practice, 31, E9-E11, 2019	Paper unavailable.
Gual, N., Calle, A., Casino, J., Lusilla, P., Gual, A., Inzitari, M., Feasibility study of motivational interviewing to improve rehabilitation in an intermediate care hospital, European Geriatric Medicine, 6, S107, 2015	Conference abstract
Guest, R., Tran, Y., Gopinath, B., Cameron, I. D., Craig, A., Psychological distress following a motor vehicle crash: Preliminary results of a randomised controlled trial investigating brief psychological interventions, Trials, 19, 343, 2018	Population not included in PICO - exclusion criteria includes presence of severe injuries
Guihan, M., Holmes, S. A., Bombardier, C. H., Ehde, D. M., Rapacki, L. M., Self-management to prevent ulcers in spinal cord injury, Journal of Spinal Cord Medicine, 36, 520, 2013	Conference abstract
Gursky, Barbara, Kestler, Lisa P., Lewis, Michael, Psychosocial intervention on procedure-related distress in children being treated for laceration repair, Journal of developmental and behavioral pediatrics : JDBP, 31, 217-22, 2010	Non-randomised study, n<100 per treatment arm.
Haik, J., Tessone, A., Nota, A., Mendes, D., Raz, L., Goldan, O., Regev, E., Winkler, E., Mor, E., Orenstein, A., Hollombe, I., The use of video capture virtual reality in burn rehabilitation: The possibilities, Journal of Burn Care and Research, 27, 195-197, 2006	Narrative description of intervention development
Hall, A. B., Englert, Z., Hanseman, D., Klein, A., Self-efficacy improvement for performance of trauma-related skills due to a military-civilian partnership, American Surgeon, 84, E505-E507, 2018	Paper unavailable.
Handoll, H. H. G., Brorson, S., Interventions for treating proximal humeral fractures in adults, Cochrane Database of Systematic Reviews, 2015	Systematic review - studies checked for possible inclusion. None were identified.

Study	Reason for Exclusion
Harris, S. R., Psychogenic movement disorders in children and adolescents: an update, European Journal of Pediatrics, 178, 581-585, 2019	Narrative review
Harvey, C., Dixon, M., Padberg, N., Support group for families of trauma patients: a unique approach, Critical care nurse, 15, 59-63, 1995	Narrative review
Hashemi, Fatemeh, Rahimi Dolatabad, Fatemeh, Yektatalab, Shahrzad, Ayaz, Mehdi, Zare, Najaf, Mansouri, Parisa, Effect of Orem Self-Care Program on the Life Quality of Burn Patients Referred to Ghotb-al-Din-e-Shirazi Burn Center, Shiraz, Iran: A Randomized Controlled Trial, International journal of community based nursing and midwifery, 2, 40-50, 2014	Comparison not in PICO - no intervention rather than standard rehabilitation care.
Hearn, J. H., Finlay, K. A., Internet-delivered mindfulness for people with depression and chronic pain following spinal cord injury: a randomized, controlled feasibility trial, Spinal Cord, 56, 750-761, 2018	Population not in PICO - depression and chronic pain
Highsmith, M. Jason, Kahle, Jason T., Knight, Molly, Olk-Szost, Ayla, Boyd, Melinda, Miro, Rebecca M., Delivery of cosmetic covers to persons with transtibial and transfemoral amputations in an outpatient prosthetic practice, Prosthetics and Orthotics International, 40, 343-9, 2016	No comparative data
Hill, Keith D., Hunter, Susan W., Batchelor, Frances A., Cavalheri, Vinicius, Burton, Elissa, Individualized home-based exercise programs for older people to reduce falls and improve physical performance: A systematic review and meta-analysis, Maturitas, 82, 72-84, 2015	Systematic review - studies checked for possible inclusion. None were identified.
Hocaloski, S., Elliott, S., Brotto, L., Breckon, E., McBride, K., A mindfulness psychoeducational group intervention targeting sexual adjustment for women with multiple sclerosis or spinal cord injury: A pilot study, Journal of Spinal Cord Medicine, 39, 583, 2016	Conference abstract
Holstege, M. S., Caljouw, M. A. A., Van Balen, R., Gussekloo, J., Achterberg, W. P., Effectiveness of innovations in geriatric rehabilitation. The SINGER Study, European Geriatric Medicine, 4, S109-S110, 2013	Conference abstract
Hossain, M. S., Harvey, L. A., Rahman, M. A., Muldoon, S., Bowden, J. L., Islam, M. S., Jan, S., Taylor, V., Cameron, I. D., Chhabra, H. S., Lindley, R. I., Biering-Sorensen, F., Li, Q., Dhakshinamurthy, M., Herbert, R. D., Community-based InterVentions to prevent serIous Complications (CIVIC) following spinal cord injury in Bangladesh: protocol of a randomised controlled trial, BMJ Open, 6, e010350, 2016	Published protocol, recruitment still ongoing.
Houlihan, B. V., Brody, M., Everhart-Skeels, S., Pernigotti, D., Burnett, S., Zazula, J., Green, C.,	Analyses and outcomes not in PICO - change in Patient Activation Measure. Quality of life and

Study	Reason for Exclusion
Hasiotis, S., Belliveau, T., Seetharama, S., Rosenblum, D., Jette, A., Randomized Trial of a Peer-Led, Telephone-Based Empowerment Intervention for Persons With Chronic Spinal Cord Injury Improves Health Self-Management, Archives of Physical Medicine and Rehabilitation, 98, 1067, 2017	patient satisfaction reported only as difference in change scores between groups.
Houlihan, B. V., Jette, A., Friedman, R. H., Paasche-Orlow, M., Ni, P., Wierbicky, J., Williams, K., Ducharme, S., Zazula, J., Cuevas, P., et al.,, A pilot study of a telehealth intervention for persons with spinal cord dysfunction, Spinal Cord, 51, 715â□□720, 2013	Intervention not in PICO - telehealth intervention targeted towards pressure ulcers, depression and healthcare utilisation.
Houlihan, B., Brody, M., Everhart-Skeels, S., Pernigotti, D., Sam, J. Z., Hasiotis, B. S., Green, C., Seetharama, S., Belliveau, T., Rosenblum, D., Jette, A., "my care my call," a peer-led, telephone-based intervention for persons with spinal cord injury improves self-management behaviors, Archives of Physical Medicine and Rehabilitation, 97, e23, 2016	Conference abstract
Houlihan, B., Brody, M., Plant, A., Skeels, S. E., Zazula, J., Pernigotti, D., Green, C., Hasiotis, S., Jette, A., Health care self-advocacy strategies for negotiating health care environments: Analysis of recommendations by satisfed consumers with SCI and SCI practitioners, Topics in Spinal Cord Injury Rehabilitation, 22, 13-26, 2016	Qualitative study
Houlihan, B., Brody, M., Skeels, S., Pernigotti, D., Zazula, J., Burnett, S., Green, C., Seetharama, S., Hasiotis, S., Belliveau, T., Rosenblum, D., Jette, A., RCT of peer-led phone-based empowerment intervention for persons with chronic spinal cord injury improves health self-management, Archives of Physical Medicine and Rehabilitation, 98, e152, 2017	Conference abstract
Huang, T. T., Liang, S. H., A randomized clinical trial of the effectiveness of a discharge planning intervention in hospitalized elders with hip fracture due to falling, J Clin Nurs, 14, 1193-201, 2005	Intervention not in PICO - discharge planning programme.
Hughes, R. B., Robinson-Whelen, S., Taylor, H. B., Hall, J. W., Stress self-management: an intervention for women with physical disabilities, Women's health issues, 16, 389-99, 2006	Population mixed between trauma and non-trauma with no way of determining
Huston, T., Hollicky, R., Chase, T., Cuthbert, J., Charlifue, S., Enhancing self-efficacy: The re-inventing yourself after SCI project, Journal of Spinal Cord Medicine, 36, 520-521, 2013	Conference abstract
Isaacson, B. M., Weeks, S. R., Pasquina, P. F., Webster, J. B., Beck, J. P., Bloebaum, R. D., The road to recovery and rehabilitation for injured service members with limb loss: a focus on Iraq and Afghanistan, U.S. Army Medical Department journal, 31-36, 2010	Paper unavailable.

Study	Reason for Exclusion
Jayasinghe, N., Moallem, I., Wyka, K., Bruce, M., Difede, J. A., Addressing anxiety with exposure-based cognitive-behavioral therapy and relaxation training in older adults after medical falls, American Journal of Geriatric Psychiatry, 23, S152, 2015	Conference abstract
Jensen, M. P., Barber, J., Romano, J. M., Hanley, M. A., Raichle, K. A., Molton, I. R., Engel, J. M., Osborne, T. L., Stoelb, B. L., Cardenas, D. D., Patterson, D. R., Effects of self-hypnosis training and EMG biofeedback relaxation training on chronic pain in persons with spinal-cord injury, International Journal of Clinical and Experimental Hypnosis, 57, 239-268, 2009	Specific pain management interventions
Johnson, K. A., Klaas, S. J., The changing nature of play: Implications for pediatric spinal cord injury, Journal of Spinal Cord Medicine, 30, S71-S75, 2007	Narrative review
Johnson, S., Increase burn patient and family satisfaction with simple diagram, Journal of Burn Care and Research, 36, S229, 2015	Conference abstract
Jones, C., Perry, L., Bennett, B., Wickremasinghe, I. M., Addressing elevated blood pressures in spinal cord injury using mindfulness-based exercises, Journal of Spinal Cord Medicine, 37, 442-443, 2014	Conference abstract
Kamal, A. M., Fathy, H., Psychiatric assessment of disfigured burn patients following cognitive behavioral therapy program, Egyptian Journal of Neurology, Psychiatry and Neurosurgery, 50, 19-24, 2013	Paper unavailable.
Kane, F. M., Brodie, E. E., Coull, A., Coyne, L., Howd, A., Milne, A., Niven, C. C., Robbins, R., The analgesic effect of odour and music upon dressing change, British journal of nursing (Mark Allen Publishing), 13, S4â□□12, 2004	Specific pain management interventions
Kellezi, B., Beckett, K., Earthy, S., Barnes, J., Sleney, J., Clarkson, J., Regel, S., Jones, T., Kendrick, D., Understanding and meeting information needs following unintentional injury: comparing the accounts of patients, carers and service providers, Injury, 46, 564-71, 2015	Qualitative study
Khanjari, Sedigheh, Tajik, Zahra, Haghani, Hamid, The effect of family-centered education on the quality of life of adolescents with spinal cord injuries, Journal of family medicine and primary care, 8, 711-716, 2019	Non-randomised study, n<100 per treatment arm.
King, C., Kennedy, P., Coping effectiveness training for people with spinal cord injury: preliminary results of a controlled trial, The British journal of clinical psychology, 38 (Pt 1), 5-14, 1999	Non-randomised study, n<100 per treatment arm.
Kono, Taro, Groff, William Frederick, Sakurai, Hiroyuki, Yamaki, Takashi, Soejima, Kazukata, Nozaki, Motohiro, Treatment of traumatic scars	No comparative data

Study	Reason for Exclusion
using plasma skin regeneration (PSR) system, Lasers in Surgery and Medicine, 41, 128-30, 2009	
Konstantatos, A. H., Angliss, M., Costello, V., Cleland, H., Stafrace, S., Predicting the effectiveness of virtual reality relaxation on pain and anxiety when added to PCA morphine in patients having burns dressings changes, Burns, 35, 491-499, 2009	Specific pain management interventions
Kooijmans, H., Post, M. W., van der Woude, L. H., de Groot, S., Stam, H. J., Bussmann, J. B., Randomized controlled trial of a self-management intervention in persons with spinal cord injury: design of the HABITS (Healthy Active Behavioural Intervention in SCI) study, Disability and Rehabilitation, 35, 1111-1118, 2013	Published protocol for included study (Kooijmans 2017)
Kramer, Didier N., Landolt, Markus A., Early psychological intervention in accidentally injured children ages 2-16: a randomized controlled trial, European Journal of Psychotraumatology, 5, 2014	Population not in PICO - individuals at risk for development of PTSD
Krichbaum, K., GAPN postacute care coordination improves hip fracture outcomes, West J Nurs Res, 29, 523-44, 2007	Population not in PICO - acute hip fracture patients without chronic rehabilitation needs.
Larroque, C. M., Abrams, A. N., Psychotherapy techniques for treating the medically ill or injured child, Journal of the American Academy of Child and Adolescent Psychiatry, 56, S117, 2017	Conference abstract
Lebon, Florent, Guillot, Aymeric, Collet, Christian, Badia, Binkley Bodian Christakou Christakou Cohen Cramer Cupal Decety Derscheid Dowling Drechsler Driediger Ekblom Evans Green Guillot Hale Heil Hermens Hoher Holmes Hortobagyi Hakkinen Ievleva Jeannerod Kaneko Kosslyn Law Liepert Lotze Louis Milne Mizner Moseley Moseley Newsom Ranganathan Ranganathan Richardson Roos Rushall Sordoni Sordoni Stinear Taylor Watson Yeung Yue Zijdewind, Increased muscle activation following motor imagery during the rehabilitation of the anterior cruciate ligament, Applied Psychophysiology and Biofeedback, 37, 45-51, 2012	Population not in PICO - do not get admitted to hospital with ligament tear.
Li, E. J. Q., Li-Tsang, C. W. P., Lam, C. S., Hui, K. Y. L., Chan, C. C. H., The effect of a "training on work readiness" program for workers with musculoskeletal injuries: A randomized control trial (RCT) study, Journal of Occupational Rehabilitation, 16, 529-541, 2006	Intervention not in PICO - 'Return to Work' intervention, crosses over with RTW NICE guideline.
Li, Yan, Bressington, Daniel, Chien, Wai Tong, Systematic Review of Psychosocial Interventions for People With Spinal Cord Injury During Inpatient Rehabilitation: Implications for Evidence-Based Practice, Worldviews on evidence-based nursing, 14, 499-506, 2017	Systematic review - studies checked for possible inclusion. One was identified.

Study	Reason for Exclusion
Li, Yan, Bressington, Daniel, Chien, Wai-Tong, Pilot evaluation of a coping-oriented supportive program for people with spinal cord injury during inpatient rehabilitation, Disability and Rehabilitation, 41, 182-190, 2019	Non-randomised study, n<100 per treatment arm.
Lin, Pi-Chu, Wang, Ching-Hui, Chen, Chyang-Shiong, Liao, Li-Ping, Kao, Shu-Fen, Wu, Heng-Fei, To evaluate the effectiveness of a discharge-planning programme for hip fracture patients, Journal of Clinical Nursing, 18, 1632-1639, 2009	Intervention not in PICO - discharge-planning programme
Littleton, S. M., Hughes, D. C., Gopinath, B., Robinson, B. J., Poustie, S. J., Smith, P. N., Cameron, I. D., The health status of people claiming compensation for musculoskeletal injuries following road traffic crashes is not altered by an early intervention programme: A comparative study, Injury, 45, 1493-1499, 2014	Non-randomised study, n<100 per treatment arm.
London, M., Motivating the back injury patient, Rehab management, 12, 46-81, 1999	Narrative review
Longabaugh, R., Woolard, R. F., Nirenberg, T. D., Minugh, A. P., Becker, B., Clifford, P. R., Carty, K., Sparadeo, F., Gogineni, A., Evaluating the effects of a brief motivational intervention for injured drinkers in the emergency department, Journal of Studies on Alcohol, 62, 806-816, 2001	Population not in PICO - hazardous or harmful drinkers
MacGillivray, M. K., Mortenson, W. B., Sadeghi, M., Mills, P. B., Adams, J., Sawatzky, B. J., Implementing a self-management mobile app for spinal cord injury during inpatient rehabilitation and following community discharge: A feasibility study, Journal of Spinal Cord Medicine, 2019	No comparative data
Mackay, J., Charles, S. T., Kemp, B., Heckhausen, J., Goal striving and maladaptive coping in adults living with spinal cord injury: associations with affective well-being, Journal of aging and health, 23, 158-176, 2011	No comparative data
Maddern, L. H., Cadogan, J. C., Emerson, M. P., 'Outlook': A psychological service for children with a different appearance, Clinical Child Psychology and Psychiatry, 11, 431-443, 2006	No comparative data
Magia, F., Bhise, A., Prabhakar, M., Shukla, Y., Effect of pranayama (yogic breathing) on lung function in traumatic thoracic spinal cord injury patients: An interventional study, Physiotherapy (United Kingdom), 101, eS927, 2015	Conference abstract
Magill, M., Apodaca, T., The route to change: Within-session predictors of Change Plan completion in a motivational interview, Alcoholism: Clinical and Experimental Research, 33, 112A, 2009	Conference abstract
Magill, M., Apodaca, T. R., An exploratory principal component analysis of the Motivational Interviewing Skill code: What do therapists and	Conference abstract

Study	Reason for Exclusion
clients do in mi sessions?, Alcoholism: Clinical and Experimental Research, 34, 229A, 2010	
Mamashli, Leila, Mohaddes Ardebili, Fatemeh, Bozorgnejad, Mehri, Najafi Ghezeljeh, Tahereh, Manafi, Farzad, The Effect of Self-Care Compact Disk-Based Instruction Program on Physical Performance and Quality of Life of Patients with Burn At-Dismissal, World journal of plastic surgery, 8, 25-32, 2019	Comparison not in PICO - standard discharge instructions
Manzone, M. G., Mastronardi, L., Aleotti, S., Pontini, I., Massazza, G., Integration of psychological intervention to trauma patients and their family in medical care, Early Intervention in Psychiatry, 10, 216, 2016	Conference abstract
Marsac, M. L., Kassam-Adams, N., Hildenbrand, A. K., Kohser, K. L., Winston, F. K., After the injury: initial evaluation of a web-based intervention for parents of injured children, Health Education Research, 26, 1-12, 2011	Non-randomised study, n<100 per treatment arm.
Martin, G., Swannell, S., Mill, J., Mott, J., Evans, J., Frederiksen, N., Hilder, M., Kimble, R., Spray on skin improves psychosocial functioning in pediatric burns patients: A randomized controlled trial, Burns, 34, 498-504, 2008	Analyses and outcomes not in PICO - family and behavioural functioning. Satisfaction measured but not reported by intervention/control.
Martin-Herz, S. P., Thurber, C. A., Patterson, D. R., Psychological principles of burn wound pain in children. II: Treatment applications, The Journal of burn care & rehabilitation, 21, 458-457, 2000	Narrative review
Maskell, J., Newcombe, P., Martin, G., Kimble, R., Psychological and psychosocial functioning of children with burn scarring using cosmetic camouflage: A multi-centre prospective randomised controlled trial, Burns, 40, 135-149, 2014	Population not in PICO - under 18 years old
McGilton, K. S., Davis, A. M., Naglie, G., Mahomed, N., Flannery, J., Jaglal, S., Cott, C., Stewart, S., Evaluation of patient-centered rehabilitation model targeting older persons with a hip fracture, including those with cognitive impairment, BMC geriatrics, 13, 136, 2013	Non-randomised study, n<100 per treatment arm.
Meade, M. A., Trumpower, B., Forchheimer, M., Diponio, L., Development and feasibility of health mechanics: A self-management program for individuals with spinal cord injury, Topics in Spinal Cord Injury Rehabilitation, 22, 121-134, 2016	Intervention and comparison not included in PICO - not standard rehabilitation care
Meade, M. A., Wilson, C., Issues of implementation and feasibility of an in-person, individually administered self-management intervention for adults with spinal cord injury, Journal of Spinal Cord Medicine, 36, 514-515, 2013	Conference abstract
Mello, M. J., Baird, J., Lee, C., Strezsak, V., French, M. T., Longabaugh, R., A Randomized Controlled Trial of a Telephone Intervention for	Outcomes not in PICO - past 30-day alcohol use at 12 months, injuries and alcohol-related

Study	Reason for Exclusion
Alcohol Misuse with Injured Emergency Department Patients, Annals of Emergency Medicine, 67, 263-275, 2016	injuries, alcohol-related negative consequences, and impaired driving frequency.
Mello, M. J., Baird, J., Strezsak, V., Lee, C., Longabaugh, R., A telephone intervention for risky alcohol use with injured emergency department patients, Annals of Emergency Medicine, 66, S104-S105, 2015	Conference abstract
Millikan, J. S., On the other side of the door, The Journal of trauma, 55, 1007-1013, 2003	Editorial
Mohammadi Fakhar, F., Rafii, F., Jamshidi Orak, R., The effect of jaw relaxation on pain anxiety during burn dressings: Randomised clinical trial, Burns, 39, 61-67, 2013	Outcome not in PICO - pain anxiety
Morlett-Paredes, A., Perrin, P. B., Olivera, S. L., Rogers, H. L., Perdomo, J. L., Arango, J. A., Arango-Lasprilla, J. C., With a little help from my friends: social support and mental health in SCI caregivers from Neiva, Colombia, Neurorehabilitation, 35, 841-9, 2014	Non-comparative study
Moseley, G. Lorimer, Gallace, Alberto, Spence, Charles, Is mirror therapy all it is cracked up to be? Current evidence and future directions, Pain, 138, 7-10, 2008	Narrative review
Mullen, J., McKechnie, K., Niedzwecki, C., Baize, C., Gammon, S., Giovannetti, B., Lathem, P., Leger, K. L., Vakharia, M., Wirt, Z., Young, A., Stoplight mobility alert system (SMAS): Communication of mobility status for falls prevention, Archives of Physical Medicine and Rehabilitation, 96, e34, 2015	Conference abstract
Murray, K., Corney, J., Moore-Millar, K., Cairns, N., Extending the life and improving the appearance of cosmetic foam covers for people with trans-femoral amputations, Prosthetics and Orthotics International, 39, 198, 2015	Conference abstract
Naglie, G., Tansey, C., Kirkland, J. L., Ogilvie-Harris, D. J., Detsky, A. S., Etchells, E., Tomlinson, G., O'Rourke, K., Goldlist, B., Interdisciplinary inpatient care for elderly people with hip fracture: A randomized controlled trial, CMAJ, 167, 25-32, 2002	Intervention not in PICO - interdisciplinary care
Najafi Ghezeljeh, T., Mohades Ardebili, F., Rafii, F., The effects of massage and music on pain, anxiety and relaxation in burn patients: Randomized controlled clinical trial, Burns : journal of the International Society for Burn Injuries, 43, 1034-1043, 2017	Outcomes not in PICO - very short term effects (immediately after intervention)
Nanney, John T., Conrad, Erich J., Reuther, Erin T., Wamser-Nanney, Rachel A., McCloskey, Michael, Constans, Joseph I., Motivational Interviewing for Victims of Armed Community Violence: A Nonexperimental Pilot Feasibility Study, Psychology of violence, 8, 259-268, 2018	Non-randomised study, n<100 per treatment arm.
Newman, S. D., Andrews, J. O., Toatley, S. L., Rodgers, M. D., Epperly, D., Gillenwater, G., A	Conference abstract

Study	Reason for Exclusion
peer navigation intervention for individuals with spinal cord injury, Journal of Spinal Cord Medicine, 37, 439-440, 2014	
Noroozi, S., Mokhtariaraghi, H., Barzoki, M. H., The effectiveness of trauma-focused cognitive-behavioural therapy in the treatment of depression of divorced women in Tehran, Australasian Medical Journal, 11, 245-252, 2018	Population not in PICO - divorced women
Ogawa, Tatsuya, Omon, Kyohei, Yuda, Tomohisa, Ishigaki, Tomoya, Imai, Ryota, Ohmatsu, Satoko, Morioka, Shu, Short-term effects of goal-setting focusing on the life goal concept on subjective well-being and treatment engagement in subacute inpatients: a quasi-randomized controlled trial, Clinical Rehabilitation, 30, 909-20, 2016	Non-randomised study, n<100 per treatment arm.
Ormhaug, S. M., Jensen, T. K., Wentzel-Larsen, T., Shirk, S. R., The therapeutic alliance in treatment of traumatized youths: Relation to outcome in a randomized clinical trial, Journal of Consulting and Clinical Psychology, 82, 52-64, 2014	Population not in PICO - traumatised youth
Oshvandi, K., Fallahinia, G. H., Azami, H., Tapak, L., The effect of music with relaxation on the patients' pain intensity due to burn dressing, Journal of Chemical and Pharmaceutical Sciences, 2016, 57-60, 2016	Intervention not in PICO - burn care, not rehabilitation.
Oude Voshaar, Richard C., Banerjee, Sube, Horan, Mike, Baldwin, Robert, Pendleton, Neil, Proctor, Rebekah, Tarrier, Nicholas, Woodward, Yvonne, Burns, Alistair, Fear of falling more important than pain and depression for functional recovery after surgery for hip fracture in older people, Psychological Medicine, 36, 1635-45, 2006	Intervention not in PICO - cognitive behavioural therapy designed to treat depression in geriatric hip fracture patients.
Ozturk, A., Ucsular, F. D., Effectiveness of a wheelchair skills training programme for community-living users of manual wheelchairs in Turkey: a randomized controlled trial, Clin Rehabil, 25, 416-24, 2011	Population not in PICO - manual wheelchair users, not traumatic injury.
Pantera, E., Fages, P., Cristina, M. C., Coudeyre, E., Therapeutic education after amputation: Literature's review, Annals of Physical and Rehabilitation Medicine, 56, e145-e146, 2013	Conference abstract
Pantera, E., Pourtier-Piotte, C., Bensoussan, L., Coudeyre, E., Patient education after amputation: Systematic review and experts' opinions, Annals of Physical and Rehabilitation Medicine, 57, 143-158, 2014	Systematic review - studies checked for possible inclusion. None were identified.
Patterson, R. W., Bushnik, T., Burdsall, D., Wright, J., Considerations of peer support for persons with high tetraplegia, Topics in Spinal Cord Injury Rehabilitation, 10, 30-37, 2005	Narrative decription of intervention
Perkes, S. J., Bowman, J., Penkala, S., Psychological therapies for the management of	Systematic review - references checked for possible studies. None were identified.

Study	Reason for Exclusion
co-morbid depression following a spinal cord injury: a systematic review, Journal of health psychology, 19, 1597-1612, 2014	
Peterson, Margaret G. E., Ganz, Sandy B., Allegrante, John P., Cornell, Charles N., High-Intensity Exercise Training Following Hip Fracture, Topics in Geriatric Rehabilitation, 20, 273-284, 2004	Intervention not in PICO - high intensity exercise.
Pham, C. H., Fang, M., Nager, J., Matsushima, K., Inaba, K., Kuza, C. M., The Role of Psychological Support Interventions in Trauma Patients on Mental Health Outcomes: A Systematic Review and Meta-Analysis, The journal of trauma and acute care surgery, 2019	Systematic review - studies checked for possible inclusion. None were identified.
Phillips, V. L., Vesmarovich, S., Hauber, R., Wiggers, E., Egner, A., Telehealth: reaching out to newly injured spinal cord patients, Public health reports (Washington, D.C. : 1974), 116 Suppl 1, 94-102, 2001	Intervention not in PICO – Individual telephone and video rehabilitation education sessions
Pisconti, F., Santos, S. M. S., Lopes, J., Cardoso, J. R., Lavado, E. L., Cross-cultural and psychometric properties assessment of the exercise self-efficacy scale in individuals with spinal cord injury, Acta Medica Portuguesa, 30, 783-789, 2017	No comparative data
Pjanic, I., Messerli-Burgy, N., Bachmann, M. S., Siegenthaler, F., Hoffmann-Richter, U., Znoj, H., Predictors of depressed mood 12 months after injury. Contribution of self-efficacy and social support, Disability and Rehabilitation, 36, 1258-1263, 2014	No comparative data
Plaza, A., Paratz, J., Stockton, K., Muller, M., Hoskin, B., Exercise programmes are effective and safe in a burns population: A controlled trial, Journal of Burn Care and Research, 32, S117, 2011	Conference abstract
Pol, M. C., Ter Riet, G., van Hartingsveldt, M., Krose, B., Buurman, B. M., Effectiveness of sensor monitoring in a rehabilitation programme for older patients after hip fracture: a three-arm stepped wedge randomised trial, Age and Ageing, 2019	Analyses and outcomes not in PICO
Postma, K., Haisma, J. A., Hopman, M. T., Bergen, M. P., Stam, H. J., Bussmann, J. B., Resistive inspiratory muscle training in people with spinal cord injury during inpatient rehabilitation: a randomized controlled trial, Physical Therapy, 94, 1709-1719, 2014	Intervention not in PICO - resistive inspiratory muscle training
Pourmand, Ali, Davis, Steven, Lee, Danny, Barber, Scott, Sikka, Neal, Emerging Utility of Virtual Reality as a Multidisciplinary Tool in Clinical Medicine, Games for health journal, 6, 263-270, 2017	Systematic review - included studies searched for possible inclusions. None were identified.
Prang, K. H., Berecki-Gisolf, J., Newnam, S., The influence of social support on healthcare service use following transport-related	No comparative data

Study	Reason for Exclusion
musculoskeletal injury, BMC health services research, 16, 310, 2016	
Prang, K. H., Berecki-Gisolf, J., Newnam, S., Recovery from musculoskeletal injury: The role of social support following a transport accident, Health and Quality of Life Outcomes, 13, 97, 2015	No comparative data
Prensner, J. D., Yowler, C. J., Smith, L. F., Steele, A. L., Fratianne, R. B., Music therapy for assistance with pain and anxiety management in burn treatment, Journal of Burn Care and Rehabilitation, 22, 83-88, 2001	Case series
Purdue, G. F., Hunt, J. L., Burns and trauma, Problems in General Surgery, 20, 106-111, 2003	Narrative review
Quan, Judy, Managing the occupational injury case: do you manage or monitor?, Professional case management, 13, 116-7, 2008	Editorial
Rajanna, V., Vo, P., Barth, J., Mjelde, M., Grey, T., Oduola, C., Hammond, T., KinoHaptics: An Automated, Wearable, Haptic Assisted, Physio-therapeutic System for Post-surgery Rehabilitation and Self-care, Journal of Medical Systems, 40, 1-12, 2016	Non-randomised study, n<100 per treatment arm.
Ramirez, M., Toussaint, M., Woods-Jaeger, B., Harland, K., Wetjen, K., Wilgenbusch, T., Pitcher, G., Jennissen, C., Link for Injured Kids: A Patient-Centered Program of Psychological First Aid after Trauma, Pediatric Emergency Care, 33, 532-537, 2017	Qualitative study
Rintala, D. H., Garber, S. L., Friedman, J. D., Holmes, S. A., Preventing recurrent pressure ulcers in veterans with spinal cord injury: impact of a structured education and follow-up intervention, Arch Phys Med Rehabil, 89, 1429-41, 2008	Outcomes not in PICO - pressure ulcer recurrence.
Robb, Sheri L., Nichols, Ray J., Rutan, Randi L., Bishop, Bonnie L., Parker, Jayne C., The effects of music assisted relaxation on preoperative anxiety, Journal of Music Therapy, 32, 2-21, 1995	Outcome not in PICO - operative anxiety
Roberts, J. L., Pritchard, A. W., Williams, M., Totton, N., Morrison, V., D. In N.U, Williams, N. H., Mixed methods process evaluation of an enhanced community-based rehabilitation intervention for elderly patients with hip fracture, BMJ Open, 8 (8) (no pagination), 2018	No quantitative data presented
Roosink, Meyke, Robitaille, Nicolas, Jackson, Philip L., Bouyer, Laurent J., Mercier, Catherine, Baumbauer, Beaumont Betker Boudreau Bouffard Bowering Decety Di Rienzo Donnelly Gustin Jackson Jeannerod Kizony Kumru Lamothe Longo Malouin Malouin Malouin Mercier Mercier Moseley Moseley Moseley Moseley Mulder Raffin Roosink Sayenko Sharp Siddall Soler Sumitani Tawashy Turner Villiger Villiger Widerstrom-Noga Witmer Zigmond	Non-randomised study, n<100 per treatment arm.

Study	Reason for Exclusion
Zimmerli, Interactive virtual feedback improves gait motor imagery after spinal cord injury: An exploratory study, Restorative Neurology and Neuroscience, 34, 227-235, 2016	
Rottkamp, B. C., An experimental nursing study: a behavior modification approach to nursing therapeutics in body positioning of spinal cord-injured patients, Nurs Res, 25, 181-6, 1976	Date restriction, pre-1995.
Rowland, Jennifer L., White, Glen W., Wyatt, David A., Analysis of An Intervention to Reduce or Prevent Secondary Conditions for People with Spinal Cord Injuries, Journal of Clinical Psychology in Medical Settings, 13, 263-271, 2006	Outcomes not in PICO - development of secondary conditions.
Rubin, E., Ostrowsky, L., Janopaul-Naylor, E., Sehgal, P., Cama, S., Tanski, E., Curtin, C., The sibling support demonstration project: A pilot study assessing feasibility, preliminary effectiveness, and participant satisfaction, Adolescent Psychiatry, 8, 48-60, 2018	Population not in PICO - psychiatric inpatients.
Ruchlin, H. S., Elkin, E. B., Allegrante, J. P., The economic impact of a multifactorial intervention to improve postoperative rehabilitation of hip fracture patients, 45, 446-52, 2001	Outcomes not in PICO - health economic outcomes only.
Rutherford, L. G., von Wenckstern, T., Trauma Information Group: A Level I Trauma Center's Integrated Approach to Family Support, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 23, 357-360, 2016	No comparative data
Ryan, C. M., Lee, A. F., Kazis, L. E., Schneider, J. C., Palmieri, T. L., Pidcock, F., Reilly, D. A., Meyer, Iii W. J., Sheridan, R. L., Tompkins, R. G., The impact of facial burns on patient reported health outcomes following burn injuries in young adults: A five year study, Journal of Burn Care and Research, 36, S94, 2015	Conference abstract
Sabino, J., Polfer, E., Tintle, S., Jessie, E., Fleming, M., Martin, B., Shashikant, M., Valerio, I. L., A decade of conflict: flap coverage options and outcomes in traumatic war-related extremity reconstruction, Plastic and Reconstructive Surgery, 135, 895-902, 2015	Intervention not in PICO - surgical reconstruction
Sathiya, K., Effect of Progressive Relaxation Therapy among Orthopaedic Trauma Patients, The Nursing journal of India, 106, 186-189, 2015	Outcome not in PICO - post traumatic stress disorder
Saw, A., Chan, C. K., Penafort, R., Sengupta, S., A simple practical protocol for care of metal-skin interface of external fixation, Medical Journal of Malaysia, 61, 2006	Paper unavailable.
Seehausen, A., Ripper, S., Germann, G., Hartmann, B., Wind, G., Renneberg, B., Efficacy of a burn-specific cognitive-behavioral group training, Burns, 41, 308-316, 2015	Non-randomised study, n<100 per treatment arm.
Seel, R. T., Douglas, J., Dennison, A. C., Heaner, S., Farris, K., Rogers, C., Specialized early treatment for persons with disorders of	No comparative data

Study	Reason for Exclusion
consciousness: program components and outcomes, Archives of Physical Medicine & RehabilitationArch Phys Med Rehabil, 94, 1908-23, 2013	
Shamout, S., Biardeau, X., Corcos, J., Campeau, L., Outcome comparison of different approaches to self-intermittent catheterization in neurogenic patients: a systematic review, Spinal Cord, 55, 629-643, 2017	Systematic review - studies checked for possible inclusion. None were identified.
Shepherd-Banigan, Megan E., Shapiro, Abigail, McDuffie, Jennifer R., Brancu, Mira, Sperber, Nina R., Van Houtven, Courtney H., Kosinski, Andrzej S., Mehta, Neha N., Nagi, Avishek, Williams, John W., Jr., Interventions That Support or Involve Caregivers or Families of Patients with Traumatic Injury: a Systematic Review, Journal of General Internal Medicine, 33, 1177-1186, 2018	Systematic review - studies checked for possible inclusion. None were identified.
Shields, B. A., Brown, J. N., Aden, J. K., Salgueiro, M., Mann-Salinas, E. A., Chung, K. K., A pilot review of gradual versus goal re-initiation of enteral nutrition after burn surgery in the hemodynamically stable patient, Burns, 40, 1587-1592, 2014	Non-randomised study, n<100 per treatment arm.
Shyu, Y. I., Liang, J., Tseng, M. Y., Li, H. J., Wu, C. C., Cheng, H. S., Chou, S. W., Chen, C. Y., Yang, C. T., Enhanced interdisciplinary care improves self-care ability and decreases emergency department visits for older Taiwanese patients over 2 years after hip-fracture surgery: a randomised controlled trial, International Journal of Nursing Studies, 56, 54-62, 2016	Intervention not in PICO - comprehensive care includes referral for depression management but not part of treatment plan.
Shyu, Yea-Ing L., Liang, Jersey, Wu, Chi-Chuan, Su, Juin-Yih, Cheng, Huey-Shinn, Chou, Shih-Wei, Chen, Min-Chi, Yang, Ching-Tzu, Adunsky, Burke Cameron Cameron Cameron Chen Chuang Crotty Hollis Kraemer Lieberman Liou Rubin Liu Randell Rubin Ryan Schafer Shyu Chen Liang Vidan Yip, Interdisciplinary intervention for hip fracture in older Taiwanese: Benefits last for 1 year, The Journals of Gerontology: Series A: Biological Sciences and Medical Sciences, 63, 92-97, 2008	Intervention not in PICO - comprehensive care includes referral for depression management but not part of treatment plan
Shyu, Yea-Ing Lotus, Liang, Jersey, Wu, Chi-Chuan, Su, Juin-Yih, Cheng, Huey-Shinn, Chou, Shih-Wei, Yang, Ching-Tzu, Adunsky, Aharonoff Ahmad Burke Chen Chen Cleeland Crotty Dai Farnworth Huusko Huusko Katz Launer Lee Lee Liu Lu Magaziner Mellinger Mossey Munin Norton O'Cathain Ostir Rubenstein Runciman Sherrington Shyu Shyu Shyu Stuck Tappen Tinetti Tsai Tseng Von Sternberg Wang Wang Yip Yip, A Pilot Investigation of the Short-Term Effects of an Interdisciplinary Intervention Program on Elderly Patients with Hip Fracture in Taiwan, Journal of the American Geriatrics Society, 53, 811-818, 2005	Intervention not in PICO - comprehensive care includes referral for depression management but not part of treatment plan

Study	Reason for Exclusion
Sibinga, E., Webb, L., Ellen, J., Mindfulness instruction improves anger regulation in US urban male youth, BMC Complementary and Alternative Medicine, 17, 2017	Conference abstract
Smith, M., Amputation: the transition from hospital to home, Nursing times, 95, 52-53, 1999	Paper unavailable.
Sorokin, Igor, De, Elise, Options for independent bladder management in patients with spinal cord injury and hand function prohibiting intermittent catheterization, Neurourology and Urodynamics, 34, 167-76, 2015	Literature review - references checked for studies. None were identified.
Spence, S. H., Cognitive-behavior therapy in the management of upper extremity cumulative trauma disorder, Journal of Occupational Rehabilitation, 8, 27-45, 1998	Narrative review
Spooner, A., A personal perspective: the psychological needs of spine-injured patients, Professional nurse (London, England), 10, 359-362, 1995	Case study
Staffel, J. Gregory, Optimizing treatment of nasal fractures, The Laryngoscope, 112, 1709-19, 2002	Non-randomised study, n<100 per treatment arm.
Stanback, R., Rebuilding lives after injury, Nursing times, 110, 27, 2014	Editorial
Stoddard, F. J., Sorrentino, E. A., Murphy, J. M., Chedekel, D. S., White, G. W., Saxe, G. N., Buterbaugh, D., Doyne, T., Zbell, T., Clark, S., Benefits of an intervention to reduce stress in 0-5 year olds with burns: Updated findings, Journal of Burn Care and Research, 32, S147, 2011	Conference abstract
Sullivan, Michael J. L., Adams, Heather, Thibault, Pascal, Corbiere, Marc, Stanish, William D., Initial depression severity and the trajectory of recovery following cognitive-behavioral intervention for work disability, Journal of Occupational Rehabilitation, 16, 63-74, 2006	Comparison not in PICO - people with differing levels of depression
Sveen, Josefin, Andersson, Gerhard, Buhrman, Bo, Sjoberg, Folke, Willebrand, Mimmie, Internet-based information and support program for parents of children with burns: A randomized controlled trial, Burns : journal of the International Society for Burn Injuries, 43, 583-591, 2017	Outcomes not in PICO - parent's PTSD, parent's health, child's health as perceived by parent and research participation
Tang, D., Li-Tsang, C. W. P., Au, R. K. C., Li, K. C., Yi, X. F., Liao, L. R., Cao, H. Y., Feng, Y. N., Liu, C. S., Functional Outcomes of Burn Patients with or Without Rehabilitation in Mainland China, Hong Kong Journal of Occupational Therapy, 26, 15-23, 2015	Non-randomised study, n<100 per treatment arm.
Task Force on Community Preventive, Services, Recommendations to reduce psychological harm from traumatic events among children and adolescents, American journal of preventive medicine, 35, 314-6, 2008	Narrative review

Study	Reason for Exclusion
Taylor, Rumina, Mellotte, Harriet, Griffiths, Maria, Compton, Agnes, Valsraj, Koravangattu, Aaltonen, Angermeyer Askey Barkham Berglund Borghetti Valer Boye Broadbent Carter Cohen Connell Crisp Falloon Falloon Fleury Garcia Glick Gracio Kuipers Mansell Norman Novak Onwumere Schweitzer Stanbridge Stanbridge Tennant Worthington, Carers matter: Promoting the inclusion of families within acute inpatient settings, Journal of Psychiatric Intensive Care, 12, 69-77, 2016	No comparative data.
Tecic, Tanja, Schneider, Alexandra, Althaus, Astrid, Schmidt, Yvette, Bierbaum, Christine, Lefering, Rolf, Mueller, Dirk, Bouillon, Bertil, Janssen, Christian, Pfaff, Holger, Erli, Hans J., Rangger, Christoph, Neugebauer, Edmund A. M., Early short-term inpatient psychotherapeutic treatment versus continued outpatient psychotherapy on psychosocial outcome: a randomized controlled trial in trauma patients, The Journal of trauma, 70, 433-41, 2011	Intervention not in PICO - psychotherapy designed to reduce PTSD
Theodorakis, Y., Beneca, A., Malliou, P., Goudas, M., Examining psychological factors during injury rehabilitation, Journal of Sport Rehabilitation, 6, 355-363, 1997	Non-randomised study, n<100 per treatment arm.
Thieme, Holm, Morkisch, Nadine, Rietz, Christian, Dohle, Christian, Borgetto, Bernhard, Acerra, Attal Bellelli Bowering Breivik Breivik Brodie Buccino Cacchio Cacchio Celnik Chan Chapman Christakou Decety Dickstein Dohle Dworkin Dworkin Ezendam Finnerup Flor Galer Gaskin Giraux Gore Gore Gustorff Holen Hoyek Jensen Kumar Lebon MacIver Maher Maihofner Manca McCabe Michenthaler Michielsen Moseley Moseley Moseley Moseley Nemeth O'Connell O'Connor Park Pelosin Perry Ramachandran Ramachandran Rothgangel Savas Seidel Stein Straube Sumitani Swart Thieme Ulger Villiger Zimmermann-Schlatter, The efficacy of movement representation techniques for treatment of limb pain-A systematic review and meta-analysis, The Journal of Pain, 17, 167-180, 2016	Systematic review - studies checked for possible inclusion. None were identified.
Tidoni, E., Tieri, G., Aglioti, S. M., Aflalo, Aglioti Aglioti Aglioti Aglioti Alimardani Alkadhi Arrighi Awad Berlucchi Bickenbach Birbaumer Birbaumer Boord Botvinick Bruehlmeier Brumberg Castro Cermik Choi Collinger Corbetta Cramer Cramer Crawley Curt Curt Curt Daly De Vignemont Decety Di Rienzo Di Rienzo Do Enzinger Finnerup Fiori Freund Freund Fuentes Gergondet Goodwin Gourab Green Green Guger Guger Gustin Gustin Gustin Henderson Herbert Hochberg Hohne Hotz-Boendermaker Hou Huggins Ikegami Jensen Jurkiewicz Jurkiewicz Kakulas Kalckert Kalckert Kambi King Kirshblum Koenraadt Kumru Lacourse Lebedev Lee Leeb Leeb Leeb	Narrative review

Study	Reason for Exclusion
Lenggenhager Lenggenhager Leonardis Leonardis Lotze Mak Manson Mattia Mikulis Millan Mole Moore Nardone Nardone Neuper Onose Ortner Pascoal-Faria Perez-Marcos Pernigo Pfurtscheller Pfurtscheller Pfurtscheller Pisotta Pons Rodrigues Roelcke Rognoni Rosso Roy Rupp Sabbah Sabre Sakurada Sanchez-Vives Scandola Scherer Scivoletto Serino Shoham Soler Tidoni Tidoni Tidoni Tidoni Tieri Tinazzi Touzalin-Chretien Tran Truccolo Tsakiris Van Gorp Villiger Vuckovic Wang Williams Wolpaw Wrigley Wydenkeller Xu Yao Yoon Zhu, Re-establishing the disrupted sensorimotor loop in deafferented and deefferented people: The case of spinal cord injuries, Neuropsychologia, 79, 301-309, 2015	
Tung, J. Y., Stead, B., Mann, W., Ba'Pham,, Popovic, M. R., Assistive technologies for self-managed pressure ulcer prevention in spinal cord injury: A scoping review, Journal of Rehabilitation Research and Development, 52, 131-146, 2015	Systematic review - studies checked for possible inclusion. None were identified.
Turpin, G., Downes, M., Mason, S., Effectiveness of giving self-help information acute traumatic injury: a randomised controlled trial, British Journal of Psychiatry, 187, 76â□□82, 2005	Duplicate paper
Turpin, G., Downs, M., Mason, S., Effectiveness of providing self-help information following acute traumatic injury: randomised controlled trial, British journal of psychiatry, 187, 76â□□82, 2005	Population not in PICO - survivors of road traffic accident, occupational injury or assault at risk of developing PTSD.
Turunen, K., Salpakoski, A., Edgren, J., Tormakangas, T., Arkela, M., Kallinen, M., Pesola, M., Hartikainen, S., Nikander, R., Sipila, S., Physical Activity After a Hip Fracture: Effect of a Multicomponent Home-Based Rehabilitation Program-A Secondary Analysis of a Randomized Controlled Trial, Archives of Physical Medicine and Rehabilitation, 98, 981-988, 2017	Outcomes not in PICO - physical activity
Van Biervliet, A., Gest, T. R., A multimedia guide to spinal cord injury: empowerment through self instruction, Medinfo. MEDINFO, 8 Pt 2, 1701, 1995	Description of intervention
van Langeveld, S. A., Post, M. W., van Asbeck, F. W., ter Horst, P., Leenders, J., Postma, K., Lindeman, E., Reliability of a New Classification System for Mobility and Self-Care in Spinal Cord Injury Rehabilitation: The Spinal Cord Injury-Interventions Classification System, Archives of Physical Medicine and Rehabilitation, 90, 1229-1236, 2009	Duplicate paper
Visser, E., Gosens, T., Den Oudsten, B. L., De Vries, J., The course, prediction, and treatment of acute and posttraumatic stress in trauma	Population not in PICO - individuals with acute stress disorder or PTSD

Study	Reason for Exclusion
patients: A systematic review, Journal of Trauma and Acute Care Surgery, 82, 1158-1183, 2017	
Vogel, L. C., Anderson, C. J., Spinal cord injuries in children and adolescents: A review, Journal of Spinal Cord Medicine, 26, 193-203, 2003	Narrative review
Vranceanu, A. M., Hageman, M., Strooker, J., ter Meulen, D., Vrahas, M., Ring, D., A preliminary RCT of a mind body skills based intervention addressing mood and coping strategies in patients with acute orthopaedic trauma, Injury, 46, 552â□□557, 2015	Intervention not in PICO - specific pain management intervention.
Wang, Zhiyun, Wang, Jianping, Maercker, Andreas, Program Use and Outcome Change in a Web-Based Trauma Intervention: Individual and Social Factors, Journal of Medical Internet Research, 18, e243, 2016	No comparative data
Watkins, P. N., Cook, E. L., May, S. R., Still, J. M., Jr., Luterman, A., Purvis, R. J., Postburn psychologic adaptation of family members of patients with burns, The Journal of burn care & rehabilitation, 17, 78-92, 1996	Case series
Wegener, Stephen T., Mackenzie, Ellen J., Ephraim, Patti, Ehde, Dawn, Williams, Rhonda, Self-management improves outcomes in persons with limb loss, Archives of Physical Medicine and Rehabilitation, 90, 373-80, 2009	Population not in PICO - support groups for amputees
Wethington, Holly R., Hahn, Robert A., Fuqua-Whitley, Dawna S., Sipe, Theresa Ann, Crosby, Alex E., Johnson, Robert L., Liberman, Akiva M., Moscicki, Eve, Price, Leshawndra N., Tuma, Farris K., Kalra, Geetika, Chattopadhyay, Sajal K., Task Force on Community Preventive, Services, The effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents: a systematic review, American journal of preventive medicine, 35, 287-313, 2008	Systematic review - studies checked for possible inclusion. None were identified.
Wheeler, Kathleen, Psychotherapeutic strategies for healing trauma, Perspectives in psychiatric care, 43, 132-41, 2007	Systematic review - studies checked for possible inclusion. None were identified.
Whitehead-Pleaux, A. M., Zebrowski, N., Baryza, M. J., Sheridan, R. L., Exploring the effects of music therapy on pediatric pain: phase 1, J Music Ther, 44, 217-41, 2007	Non-randomised study, n<100 per treatment arm.
Wiechman Askay, Shelley, Patterson, David R., Sharar, Samuel R., Mason, Shawn, Faber, Bertus, Pain management in patients with burn injuries, International review of psychiatry (Abingdon, England), 21, 522-30, 2009	Narrative review
Wiechman, S. A., Carrougher, G. J., Esselman, P. C., Angere, D., Klein, M. B., Gibran, N. S., A randomized controlled trial to test an expanded delivery model for patients with burn injuries, Journal of burn care & research, 35, S79, 2014	Conference abstract

Study	Reason for Exclusion
Wilde, Mary H., Fairbanks, Eileen, Parshall, Robert, Zhang, Feng, Miner, Sarah, Thayer, Deborah, Harrington, Brian, Brasch, Judith, McMahon, James M., Development of a Web-Based Self-management Intervention for Intermittent Urinary Catheter Users With Spinal Cord Injury, Computers, informatics, nursing : CIN, 33, 478-86, 2015	Non-randomised study, n<100 per treatment arm.
Wilde, Mary H., Fairbanks, Eileen, Parshall, Robert, Zhang, Feng, Miner, Sarah, Thayer, Deborah, Harrington, Brian, Brasch, Judith, Schneiderman, Dan, McMahon, James M., A Web-Based Self-Management Intervention for Intermittent Catheter Users, Urologic nursing, 35, 127-138, 2015	Narrative description of new intervetion
Williams, Reg Arthur, Gatien, Gary, Hagerty, Bonnie M., Kane, Michele, Otto, Laureen, Wilson, Candy, Throop, Meryia, Addressing psychosocial care using an interactive Web site for combat-wounded patients, Perspectives in psychiatric care, 49, 152-61, 2013	No comparative data
Winje, D., Ulvik, A., Confrontations with reality: crisis intervention services for traumatized families after a school bus accident in Norway, Journal of Traumatic Stress, 8, 429-44, 1995	Population not in PICO - survivors of school bus accident at risk of developing post traumatic stress disorder
Wise, James B., Ellis, Gary D., Trunnell, Eric P., Effects of a curriculum designed to generalize self-efficacy from weight-training exercises to activities of daily living among adults with spinal injuries, Journal of Applied Social Psychology, 32, 500-521, 2002	Non-randomised study, n<100 per treatment arm.
Worobey, L. A., Kirby, R. L., Heinemann, A. W., Krobot, E. A., Dyson-Hudson, T. A., Cowan, R. E., Pedersen, J. P., Shea, M., Boninger, M. L., Effectiveness of Group Wheelchair Skills Training for People With Spinal Cord Injury: A Randomized Controlled Trial, Archives of Physical Medicine and Rehabilitation, 97, 1777, 2016	Outcome not in PICO - Wheelchair Skills Test Questionnaire and Goal Attainment Scale score
Worobey, L., Boninger, M., Kirby, L., Preliminary results on effectiveness of group wheelchair skills training among individuals with spinal cord injury, Archives of Physical Medicine and Rehabilitation, 96, e25, 2015	Conference abstract
Wu, K. K. Y., A randomised controlled trial of brief cognitive-behavioural therapy and a self-help booklet as early interventions for post-traumatic stress after road trajfic accident, East Asian Archives of Psychiatry, 20, 46-47, 2010	Conference abstract
Xie, L. Q., Deng, Y. L., Zhang, J. P., Richmond, C. J., Tang, Y., Zhou, J., Effects of Progressive Muscle Relaxation Intervention in Extremity Fracture Surgery Patients, Western Journal of Nursing Research, 38, 155â□□168, 2016	Outcomes not in PICO - state anxiety and self-efficacy
Zadro, J. R., Shirley, D., Simic, M., Mousavi, S. J., Ceprnja, D., Maka, K., Sung, J., Ferreira, P.,	Intervention not in PICO - flexibility, body weight resistance, and aerobic exercises

Study	Reason for Exclusion
Video-Game-Based Exercises for Older People With Chronic Low Back Pain: A Randomized Controlledtable Trial (GAMEBACK), Physical Therapy, 99, 14-27, 2019	
Zhang, H., Huang, J., Long, C., Influence of psychological intervention before emergent ocular trauma surgery on patients' negative emotions, Eye science, 29, 74-77, 2014	Intervention not in PICO - pre-surgery psychological programme

Economic studies

All studies were excluded at the initial title and abstract screening stage. See appendix G for further information.

Excluded studies for review question: B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?

Clinical studies

Table 25: Excluded studies and reasons for their exclusion

Study	Reason for Exclusion
Abou-Setta, A. M., Beaupre, L. A., Rashiq, S., Dryden, D. M., Hamm, M. P., Sadowski, C. A., Menon, M. R. G., Majumdar, S. R., Wilson, D. M., Karkhaneh, M., Mousavi, S. S., Wong, K., Tjosvold, L., Jones, C. A., Comparative effectiveness of pain management interventions for hip fracture: A systematic review, Annals of Internal Medicine, 155, 234-245, 2011	Systematic review, included studies checked for relevance. None were found.
Allegrante, J. P., Peterson, M. G., Cornell, C. N., MacKenzie, C. R., Robbins, L., Horton, R., Ganz, S. B., Ruchlin, H. S., Russo, P. W., Paget, S. A., Charlson, M. E., Methodological challenges of multiple-component intervention: lessons learned from a randomized controlled trial of functional recovery after hip fracture, Hss j, 3, 63-70, 2007	Population not in PICO – over 18 years old
Arbour-Nicitopoulos, K. P., Ginis, K. A., Latimer, A. E., Planning, leisure-time physical activity, and coping self-efficacy in persons with spinal cord injury: a randomized controlled trial, Archives of Physical Medicine and Rehabilitation, 90, 2003-2011, 2009	Outcomes not in PICO - intentions and self-efficacy
Arefnasab, Z., Babamahmoodi, A., Babamahmoodi, F., Noorbala, A. A., Alipour, A., Panahi, Y., Shams, J., Rad, F. R., Khaze, V., Ghanei, M., Mindfulness-based Stress Reduction (MBSfR) and its effects on psychoimmunological factors of chemically pulmonary injured veterans, Iranian Journal of Allergy, Asthma and Immunology, 15, 476-486, 2016	Population not in PICO - veterans exposed to mustard gas and complications of Iran-Iraq war.
Arefnasab, Zahra, Babamahmoodi, Abdolreza, Babamahmoodi, Farhang, Noorbala, Ahmad Ali,	Population not in PICO - veterans exposed to mustard gas and complications of Iran-Iraq war.

Study	Reason for Exclusion
Alipour, Ahmad, Panahi, Yunes, Shams, Jamal, Riazi Rad, Farhad, Khaze, Vahid, Ghanei, Mostafa, Mindfulness-based Stress Reduction (MBSR) and Its Effects on Psychoimmunological Factors of Chemically Pulmonary Injured Veterans, Iranian journal of allergy, asthma, and immunology, 15, 476-486, 2016	
Arrieta, H., Rezola-Pardo, C., Gil, S. M., Virgala, J., Iturburu, M., Anton, I., Gonzalez-Templado, V., Irazusta, J., Rodriguez-Larrad, A., Effects of Multicomponent Exercise on Frailty in Long-Term Nursing Homes: A Randomized Controlled Trial, Journal of the American Geriatrics Society, 67, 1145-1151, 2019	Population not in PICO: Residents at a longterm nursing home
Baker, Virginia B., Eliasen, Kathryn M., Hack, Nawaz K., Lifestyle modifications as therapy for medication refractory post-traumatic headache (PTHA) in the military population of Okinawa, The journal of headache and pain, 19, 113, 2018	Non-comparative study
Bakker, R., Elderdesign: Home modifications for enhanced safety and self-care, Care Management Journals, 1, 47-54, 1999	Narrative review
Baron, J. S., Sullivan, K. J., Swaine, J. M., Aspinall, A., Jaglal, S., Presseau, J., White, B., Wolfe, D., Grimshaw, J. M., Self-management interventions for skin care in people with a spinal cord injury: part 1-a systematic review of intervention content and effectiveness, Spinal Cord, 56, 823-836, 2018	Systematic review - studies checked for possible inclusion. 8 were identified.
Basilici Zannetti, Emanuela, D'Agostino, Fabio, Cittadini, Noemi, Feola, Maurizio, Pennini, Annalisa, Rao, Cecilia, Vellone, Ercole, Tarantino, Umberto, Alvaro, Rosaria, Effect of tailored educational intervention to improve self-care maintenance and quality of life in postmenopausal osteoporotic women after a fragility fracture: the Guardian Angel® study, Igiene e sanita pubblica, 73, 65-76, 2017	Full text in Italian
Berube, M., Gelinas, C., Feeley, N., Martorella, G., Cote, J., Laflamme, G. Y., Rouleau, D. M., Choiniere, M., Feasibility of a Hybrid Web-Based and In-Person Self-management Intervention Aimed at Preventing Acute to Chronic Pain Transition After Major Lower Extremity Trauma (iPACT-E-Trauma): A Pilot Randomized Controlled Trial, Pain medicine (Malden, Mass.), 2019	Intervention not in PICO - specific pain management interventions
Berube, M., Gelinas, C., Martorella, G., Feeley, N., Cote, J., Laflamme, G. Y., Rouleau, D. M., Choiniere, M., Development and Acceptability Assessment of a Self-Management Intervention to Prevent Acute to Chronic Pain Transition after Major Lower Extremity Trauma, Pain management nursing : official journal of the American Society of Pain Management Nurses, 19, 671-692, 2018	Non-randomised study, n<100 per treatment arm.

Study	Reason for Exclusion
Berube, Melanie, Gelinas, Celine, Feeley, Nancy, Martorella, Geraldine, Cote, Jose, Laflamme, G. Yves, Rouleau, Dominique M., Choiniere, Manon, A Hybrid Web-Based and In-Person Self-Management Intervention Aimed at Preventing Acute to Chronic Pain Transition After Major Lower Extremity Trauma: Feasibility and Acceptability of iPACT-E-Trauma, JMIR formative research, 2, e10323, 2018	Intervention not in PICO - specific pain management interventions
Best, K. L., Miller, W. C., Huston, G., Routhier, F., Eng, J. J., Pilot Study of a Peer-Led Wheelchair Training Program to Improve Self-Efficacy Using a Manual Wheelchair: A Randomized Controlled Trial, Arch Phys Med Rehabil, 97, 37-44, 2016	Population not in PICO - wheelchair users only.
Black, O., Keegel, T., Sim, M. R., Collie, A., Smith, P., The Effect of Self-Efficacy on Return-to-Work Outcomes for Workers with Psychological or Upper-Body Musculoskeletal Injuries: A Review of the Literature, Journal of Occupational Rehabilitation, 28, 16-27, 2018	Systematic review, included studies checked for relevance
Black, O., Keegel, T., Sim, M., Collie, A., Smith, P., The effect of self-efficacy on return-to-work outcomes for workers with psychological or upper-body musculoskeletal injuries: A review of the literature, Occupational and Environmental Medicine, 73, A207, 2016	Duplicate paper
Block, P., Vanner, E. A., Keys, C. B., Rimmer, J. H., Skeels, S. E., Project Shake-It-Up: using health promotion, capacity building and a disability studies framework to increase self efficacy, Disability and Rehabilitation, 32, 741-754, 2010	Non-randomised study, n<100 per treatment arm.
Bombardier, C., Fann, J. R., Ehde, D., Reyes, M. R., Hoffman, J. M., Collaborative care for pain, depression and physical inactivity in an outpatient SCI clinic: The sci-care study, Archives of Physical Medicine and Rehabilitation, 97, e78-e79, 2016	Conference abstract
Brunelli, S., Morone, G., Iosa, M., Ciotti, C., De Giorgi, R., Foti, C., Traballesi, M., Efficacy of progressive muscle relaxation, mental imagery, and phantom exercise training on phantom limb: a randomized controlled trial, Archives of Physical Medicine and Rehabilitation, 96, 181-187, 2015	Population not in PICO - 28/40 had amputation for dysvascular causes.
Burns, A., Banerjee, S., Morris, J., Woodward, Y., Baldwin, R., Proctor, R., Tarrier, N., Pendleton, N., Sutherland, D., Andrew, G., Horan, M., Treatment and prevention of depression after surgery for hip fracture in older people: randomized, controlled trials, J Am Geriatr Soc, 55, 75-80, 2007	Intervention not in PICO - treatment and prevention of depression in hip fracture patients.
Carrougher, G. J., Brych, S. B., Pham, T. N., Mandell, S. P., Gibran, N. S., An Intervention Bundle to Facilitate Return to Work for Burn-Injured Workers: Report from a Burn Model	Intervention not in PICO: Return to work interventions (covered by NICE guideline on return to work)

Study	Reason for Exclusion
System Investigation, Journal of Burn Care and Research, 38, e70-e78, 2017	
Castillo, R. C., Wegener, S. T., Newell, M. Z., Carlini, A. R., Bradford, A. N., Heins, S. E., Wysocki, E., Pollak, A. N., Teter, H., Mackenzie, E. J., Improving outcomes at Level I trauma centers: An early evaluation of the trauma survivors network, Journal of Trauma and Acute Care Surgery, 74, 1534-1540, 2013	Population not in PICO – over 18 years old
Chertok, N. V., Dolgova, V. I., Mamylina, N. V., Bajguzhin, P. A., Kryzhanovskaya, N. V., The effect of rehabilitation technology on quality of life of middle-age women afterupper limb trauma, International Journal of Pharmacy and Technology, 8, 27186-27195, 2016	Intervention not in PICO - rehabilitation course
Chin, O. Y., Tollefson, T. T., Role of Camouflage in Management of Facial Trauma Deformities, Facial plastic surgery : FPS, 33, 643-652, 2017	Narrative review with case reports
Cogan, L., Mc Gurk, S., Cannon, J., Romero-Ortuno, R., Frawley, N., The activity and outcomes of an off-site geriatric rehabilitation unit: A 1-year study, Irish Journal of Medical Science, 182, S243, 2013	Conference abstract
Craig, A. R., Hancock, K., Dickson, H., Chang, E., Long-term psychological outcomes in spinal cord injured persons: results of a controlled trial using cognitive behavior therapy, Archives of Physical Medicine and Rehabilitation, 78, 33-8, 1997	Non-randomised study, n<100 per treatment arm.
Crotty, M., Unroe, K., Cameron, I. D., Miller, M., Ramirez, G., Couzner, L., Rehabilitation interventions for improving physical and psychosocial functioning after hip fracture in older people, Cochrane Database of Systematic Reviews, 2010	Systematic review. References checked for possible studies - 5 were identified.
Curtis, K., Hitzig, S. L., Bechsgaard, G., Stoliker, C., Alton, C., Saunders, N., Leong, N., Katz, J., Evaluation of a specialized yoga program for persons with a spinal cord injury: A pilot randomized controlled trial, Journal of Pain Research, 10, 999-1017, 2017	Intervention not in PICO - physical yoga programme
Daneshpajooh, L., Najafi Ghezeljeh, T., Haghani, H., Comparison of the effects of inhalation aromatherapy using Damask Rose aroma and the Benson relaxation technique in burn patients: A randomized clinical trial, Burns, 45, 1205-1214, 2019	Outcome not in PICO - pain anxiety
De Silva, Mary, Maclachlan, Malcolm, Devane, Declan, Desmond, Deirdre, Gallagher, Pamela, Schnyder, Ulrich, Brennan, Muireann, Patel, Vikram, Psychosocial interventions for the prevention of disability following traumatic physical injury, The Cochrane database of systematic reviews, CD006422, 2009	Systematic review, included studies checked for relevance and added to review individually when relevant
Dennis, B. M., Nolan, T. L., Brown, C. E., Vogel, R. L., Flowers, K. A., Ashley, D. W., Nakayama,	Paper unavailable.

Study	Reason for Exclusion
D. K., Using a checklist to improve family communication in trauma care, American Surgeon, 82, 59-64, 2016	
Dorsey, L., Spinal cord injury interdisciplinary education, Journal for specialists in pediatric nursing : JSPN, 10, 86-89, 2005	Narrative review
Dorstyn, D., Mathias, J., Denson, L., Efficacy of cognitive behavior therapy for the management of psychological outcomes following spinal cord injury: a meta-analysis, Journal of health psychology, 16, 374-391, 2011	Systematic review. References checked for possible studies - 1 was identified.
Dorstyn, D., Roberts, R., Murphy, G., Craig, A., Kneebone, I., Stewart, P., Chur-Hansen, A., Marshall, R., Clark, J., Migliorini, C., Work and SCI: a pilot randomized controlled study of an online resource for job-seekers with spinal cord dysfunction, Spinal Cord, 57, 221â□□228, 2019	Intervention not in PICO - online resource targeted to jobâ□□seekers with spinal cord injury or disorder
Duchnick, J. J., Letsch, E. A., Curtiss, G., Coping effectiveness training during acute rehabilitation of spinal cord injury/dysfunction: a randomized clinical trial, Rehabil Psychol, 54, 123-32, 2009	Comparison not in PICO - coping effectiveness training versus supportive group therapy. Historical non-randomised study used for secondary analysis, N >100 per arm.
Dyck, D. G., Weeks, D. L., Gross, S., Lederhos Smith, C., Lott, H. A., Wallace, A. J., Wood, S. M., Comparison of two psycho-educational family group interventions for improving psycho-social outcomes in persons with spinal cord injury and their caregivers: a randomized-controlled trial of multi-family group intervention versus an active education control condition, BMC psychology, 4, 40, 2016	Study protocol
Elbers, N. A., Akkermans, A. J., Cuijpers, P., Bruinvels, D. J., Empowerment of personal injury victims through the internet: design of a randomized controlled trial, Trials, 12, 29, 2011	Study protocol
Elbers, N. A., Akkermans, A. J., Cuijpers, P., Bruinvels, D. J., Effectiveness of a web-based intervention for injured claimants: a randomized controlled trial, Trials, 14, 227, 2013	Population not in PICO - 42% were hospitalised (after traffic accident).
Elinge, Eva, Löfgren, Britta, Gagerman, Eva, Nyberg, Lars, A Group Learning Programme for Old People with Hip Fracture: A Randomized Study, Scandinavian Journal of Occupational Therapy, 10, 27-33, 2003	Population not in PICO – over 18 years old
Ferguson, S. L., Voll, K. V., Burn Pain and Anxiety: The Use of Music Relaxation during Rehabilitation, Journal of Burn Care and Rehabilitation, 25, 8-14, 2004	Outcome not in PICO - change in pain and anxiety during relaxation intervention
Finn, Sacha B., Perry, Briana N., Clasing, Jay E., Walters, Lisa S., Jarzombek, Sandra L., Curran, Sean, Rouhanian, Minoo, Keszler, Mary S., Hussey-Andersen, Lindsay K., Weeks, Sharon R., Pasquina, Paul F., Tsao, Jack W., A Randomized, Controlled Trial of Mirror Therapy for Upper Extremity Phantom Limb Pain in Male Amputees, Frontiers in neurology, 8, 267, 2017	Intervention not in PICO – mirror therapy

Study	Reason for Exclusion
Flinn, N., Storm, K., Lower-extremity dressing for persons with quadriplegia: What are the long-term outcomes?, Archives of Physical Medicine and Rehabilitation, 91, e28, 2010	Conference abstract
Fonte, N., Urological care of the spinal cord-injured patient, Journal of wound, ostomy, and continence nursing : official publication of The Wound, Ostomy and Continence Nurses Society / WOCN, 35, 2008	Narrative review
Forchheimer, Martin, Tate, Denise G., Enhancing community re-integration following spinal cord injury, NeuroRehabilitation, 19, 103-13, 2004	Non-randomised study, n<100 per treatment arm.
Foy, T., Perritt, G., Thimmaiah, D., Heisler, L., Offutt, J. L., Cantoni, K., Hseih, C. H., Gassaway, J., Ozelie, R., Backus, D., Occupational therapy treatment time during inpatient spinal cord injury rehabilitation, Journal of Spinal Cord Medicine, 34, 162-175, 2011	Comparison not in PICO - different levels of SCI injury
Foy, Teresa, Perritt, Ginger, Thimmaiah, Deepa, Heisler, Lauren, Offutt, Jennifer Lookingbill, Cantoni, Kara, Hseih, Ching-Hui, Gassaway, Julie, Ozelie, Rebecca, Backus, Deborah, The SCIRehab project: treatment time spent in SCI rehabilitation. Occupational therapy treatment time during inpatient spinal cord injury rehabilitation, The journal of spinal cord medicine, 34, 162-75, 2011	Comparison not in PICO - different levels of SCI injury
Frenkel, L., A support group for parents of burned children: A South African Children's Hospital Burns Unit, Burns, 34, 565-569, 2008	Qualitative study
Frisbee, Kathleen L., Variations in the Use of mHealth Tools: The VA Mobile Health Study, JMIR mHealth and uHealth, 4, e89, 2016	Population not in PICO - mixture of mental and physical trauma with no way of differentiating in analysis
Frosch, E., Lewandowski, L., Psychological issues associated with acute physical injury: After the pediatric emergency department, International Review of Psychiatry, 10, 216-223, 1998	Narrative review
Galea, M. P., Levinger, P., Lythgo, N., Cimoli, C., Weller, R., Tully, E., McMeeken, J., Westh, R., A targeted home- and center-based exercise program for people after total hip replacement: a randomized clinical trial, Archives of Physical Medicine and Rehabilitation, 89, 1442â□□1447, 2008	Intervention not in PICO - physical exercise intervention
Gargaro, J., Warren, C., Boschen, K., Perceived barriers and facilitators to community reintegration after spinal cord injury: A critical review of the literature, Critical Reviews in Physical and Rehabilitation Medicine, 25, 101-141, 2013	Narrative review
Gassaway, J., Anziano, P., Peer-supported self-directed care optimizes successful community transition after catastrophic injury, Journal of Spinal Cord Medicine, 39, 562, 2016	Conference abstract

Study	Reason for Exclusion
Gassaway, J., Jones, M. L., Sweatman, W. M., Young, T., Peer-led, transformative learning approaches increase classroom engagement in care self-management classes during inpatient rehabilitation of individuals with spinal cord injury, Journal of Spinal Cord Medicine, 42, 338-346, 2019	Non-randomised study, n<100 per treatment arm.
Gassner, K., Einsiedel, T., Linke, M., Görlich, P., Mayer, J., Does mental training improve learning to walk with an above-knee prosthesis?, Der Orthopade, 36, 673â□□678, 2007	German language paper
Gernigon, C., Pereira Dias, C., Riou, F., Briki, W., Ninot, G., Reference system of competence and engagement in adapted physical activities of people with recent spinal cord injury, Disability and Rehabilitation, 37, 2192-2196, 2015	Non-randomised study, n<100 per treatment arm.
Ghazi, C., Nyland, J., Whaley, R., Rogers, T., Wera, J., Henzman, C., Social cognitive or learning theory use to improve self-efficacy in musculoskeletal rehabilitation: A systematic review and meta-analysis, Physiotherapy Theory and Practice, 34, 495-504, 2018	Systematic review - studies check for possible inclusions. None were identified.
Gill, M., Psychosocial implications of spinal cord injury, Critical care nursing quarterly, 22, 1-7, 1999	Narrative reveiw
Giummarra, M. J., Lennox, A., Dali, G., Costa, B., Gabbe, B. J., Early psychological interventions for posttraumatic stress, depression and anxiety after traumatic injury: A systematic review and meta-analysis, Clinical Psychology Review, 62, 11-36, 2018	Systematic review - studies checked for possible inclusion. None were identified.
Goodwin-Wilson, C., Watkins, M., Gardner-Elahi, C., Developing evidence-based process maps for spinal cord injury rehabilitation, Spinal Cord, 48, 122-127, 2010	No comparative data
Goudie, S., Dixon, D., McMillan, G., Ring, D., McQueen, M., Is use of a psychological workbook associated with improved disabilities of the arm, shoulder and hand scores in patients with distal radius fracture?, Clinical Orthopaedics and Related Research, 476, 832-845, 2018	Population not in PICO - isolated distal radial fracture, not complex rehabilitation needs
Griffin, Leah, Sifuentes, Mikaela M., Retrospective Payor Claims Analysis of Patients Receiving Outpatient Negative Pressure Wound Therapy With Remote Therapy Monitoring, Wounds : a compendium of clinical research and practice, 31, E9-E11, 2019	Paper unavailable.
Gual, N., Calle, A., Casino, J., Lusilla, P., Gual, A., Inzitari, M., Feasibility study of motivational interviewing to improve rehabilitation in an intermediate care hospital, European Geriatric Medicine, 6, S107, 2015	Conference abstract
Guest, R., Tran, Y., Gopinath, B., Cameron, I. D., Craig, A., Psychological distress following a motor vehicle crash: Preliminary results of a	Population not included in PICO - exclusion criteria includes presence of severe injuries

Study	Reason for Exclusion
randomised controlled trial investigating brief psychological interventions, Trials, 19, 343, 2018	
Guihan, M., Holmes, S. A., Bombardier, C. H., Ehde, D. M., Rapacki, L. M., Self-management to prevent ulcers in spinal cord injury, Journal of Spinal Cord Medicine, 36, 520, 2013	Conference abstract
Gursky, Barbara, Kestler, Lisa P., Lewis, Michael, Psychosocial intervention on procedure-related distress in children being treated for laceration repair, Journal of developmental and behavioral pediatrics : JDBP, 31, 217-22, 2010	Non-randomised study, n<100 per treatment arm.
Haik, J., Tessone, A., Nota, A., Mendes, D., Raz, L., Goldan, O., Regev, E., Winkler, E., Mor, E., Orenstein, A., Hollombe, I., The use of video capture virtual reality in burn rehabilitation: The possibilities, Journal of Burn Care and Research, 27, 195-197, 2006	Narrative description of intervention development
Hall, A. B., Englert, Z., Hanseman, D., Klein, A., Self-efficacy improvement for performance of trauma-related skills due to a military-civilian partnership, American Surgeon, 84, E505-E507, 2018	Paper unavailable.
Handoll, H. H. G., Brorson, S., Interventions for treating proximal humeral fractures in adults, Cochrane Database of Systematic Reviews, 2015	Systematic review - studies checked for possible inclusion. None were identified.
Harris, S. R., Psychogenic movement disorders in children and adolescents: an update, European Journal of Pediatrics, 178, 581-585, 2019	Narrative review
Harvey, C., Dixon, M., Padberg, N., Support group for families of trauma patients: a unique approach, Critical care nurse, 15, 59-63, 1995	Narrative review
Hashemi, Fatemeh, Rahimi Dolatabad, Fatemeh, Yektatalab, Shahrzad, Ayaz, Mehdi, Zare, Najaf, Mansouri, Parisa, Effect of Orem Self-Care Program on the Life Quality of Burn Patients Referred to Ghotb-al-Din-e-Shirazi Burn Center, Shiraz, Iran: A Randomized Controlled Trial, International journal of community based nursing and midwifery, 2, 40-50, 2014	Comparison not in PICO - no intervention rather than standard rehabilitation care.
Hearn, J. H., Finlay, K. A., Internet-delivered mindfulness for people with depression and chronic pain following spinal cord injury: a randomized, controlled feasibility trial, Spinal Cord, 56, 750-761, 2018	Population not in PICO - depression and chronic pain
Highsmith, M. Jason, Kahle, Jason T., Knight, Molly, Olk-Szost, Ayla, Boyd, Melinda, Miro, Rebecca M., Delivery of cosmetic covers to persons with transtibial and transfemoral amputations in an outpatient prosthetic practice, Prosthetics and Orthotics International, 40, 343-9, 2016	No comparative data

Study	Reason for Exclusion
Hill, Keith D., Hunter, Susan W., Batchelor, Frances A., Cavalheri, Vinicius, Burton, Elissa, Individualized home-based exercise programs for older people to reduce falls and improve physical performance: A systematic review and meta-analysis, Maturitas, 82, 72-84, 2015	Systematic review - studies checked for possible inclusion. None were identified.
Hocaloski, S., Elliott, S., Brotto, L., Breckon, E., McBride, K., A mindfulness psychoeducational group intervention targeting sexual adjustment for women with multiple sclerosis or spinal cord injury: A pilot study, Journal of Spinal Cord Medicine, 39, 583, 2016	Conference abstract
Holmes, A., Hodgins, G., Adey, S., Menzel, S., Danne, P., Kossmann, T., Judd, F., Trial of interpersonal counselling after major physical trauma, Australian and New Zealand journal of psychiatry, 41, 926-933, 2007	Population not in PICO – over 18 years old
Holstege, M. S., Caljouw, M. A. A., Van Balen, R., Gussekloo, J., Achterberg, W. P., Effectiveness of innovations in geriatric rehabilitation. The SINGER Study, European Geriatric Medicine, 4, S109-S110, 2013	Conference abstract
Hossain, M. S., Harvey, L. A., Rahman, M. A., Muldoon, S., Bowden, J. L., Islam, M. S., Jan, S., Taylor, V., Cameron, I. D., Chhabra, H. S., Lindley, R. I., Biering-Sorensen, F., Li, Q., Dhakshinamurthy, M., Herbert, R. D., Community-based InterVentions to prevent serIous Complications (CIVIC) following spinal cord injury in Bangladesh: protocol of a randomised controlled trial, BMJ Open, 6, e010350, 2016	Published protocol, recruitment still ongoing.
Houlihan, B. V., Brody, M., Everhart-Skeels, S., Pernigotti, D., Burnett, S., Zazula, J., Green, C., Hasiotis, S., Belliveau, T., Seetharama, S., Rosenblum, D., Jette, A., Randomized Trial of a Peer-Led, Telephone-Based Empowerment Intervention for Persons With Chronic Spinal Cord Injury Improves Health Self-Management, Archives of Physical Medicine and Rehabilitation, 98, 1067, 2017	Analyses and outcomes not in PICO - change in Patient Activation Measure. Quality of life and patient satisfaction reported only as difference in change scores between groups.
Houlihan, B. V., Jette, A., Friedman, R. H., Paasche-Orlow, M., Ni, P., Wierbicky, J., Williams, K., Ducharme, S., Zazula, J., Cuevas, P., et al.,, A pilot study of a telehealth intervention for persons with spinal cord dysfunction, Spinal Cord, 51, 715â□□720, 2013	Intervention not in PICO - telehealth intervention targeted towards pressure ulcers, depression and healthcare utilisation.
Houlihan, B., Brody, M., Everhart-Skeels, S., Pernigotti, D., Sam, J. Z., Hasiotis, B. S., Green, C., Seetharama, S., Belliveau, T., Rosenblum, D., Jette, A., "my care my call," a peer-led, telephone-based intervention for persons with spinal cord injury improves self-management behaviors, Archives of Physical Medicine and Rehabilitation, 97, e23, 2016	Conference abstract
Houlihan, B., Brody, M., Plant, A., Skeels, S. E., Zazula, J., Pernigotti, D., Green, C., Hasiotis, S.,	Qualitative study

Study	Reason for Exclusion
Jette, A., Health care self-advocacy strategies for negotiating health care environments: Analysis of recommendations by satisfed consumers with SCI and SCI practitioners, Topics in Spinal Cord Injury Rehabilitation, 22, 13-26, 2016	
Houlihan, B., Brody, M., Skeels, S., Pernigotti, D., Zazula, J., Burnett, S., Green, C., Seetharama, S., Hasiotis, S., Belliveau, T., Rosenblum, D., Jette, A., RCT of peer-led phone-based empowerment intervention for persons with chronic spinal cord injury improves health self-management, Archives of Physical Medicine and Rehabilitation, 98, e152, 2017	Conference abstract
Huang, T. T., Liang, S. H., A randomized clinical trial of the effectiveness of a discharge planning intervention in hospitalized elders with hip fracture due to falling, J Clin Nurs, 14, 1193-201, 2005	Intervention not in PICO - discharge planning programme.
Hughes, R. B., Robinson-Whelen, S., Taylor, H. B., Hall, J. W., Stress self-management: an intervention for women with physical disabilities, Women's health issues, 16, 389-99, 2006	Population mixed between trauma and non-trauma with no way of determining
Huston, T., Hollicky, R., Chase, T., Cuthbert, J., Charlifue, S., Enhancing self-efficacy: The re-inventing yourself after SCI project, Journal of Spinal Cord Medicine, 36, 520-521, 2013	Conference abstract
Isaacson, B. M., Weeks, S. R., Pasquina, P. F., Webster, J. B., Beck, J. P., Bloebaum, R. D., The road to recovery and rehabilitation for injured service members with limb loss: a focus on Iraq and Afghanistan, U.S. Army Medical Department journal, 31-36, 2010	Paper unavailable.
Jayasinghe, N., Moallem, I., Wyka, K., Bruce, M., Difede, J. A., Addressing anxiety with exposure-based cognitive-behavioral therapy and relaxation training in older adults after medical falls, American Journal of Geriatric Psychiatry, 23, S152, 2015	Conference abstract
Jensen, M. P., Barber, J., Romano, J. M., Hanley, M. A., Raichle, K. A., Molton, I. R., Engel, J. M., Osborne, T. L., Stoelb, B. L., Cardenas, D. D., Patterson, D. R., Effects of self-hypnosis training and EMG biofeedback relaxation training on chronic pain in persons with spinal-cord injury, International Journal of Clinical and Experimental Hypnosis, 57, 239-268, 2009	Specific pain management interventions
Johnson, K. A., Klaas, S. J., The changing nature of play: Implications for pediatric spinal cord injury, Journal of Spinal Cord Medicine, 30, S71-S75, 2007	Narrative review
Johnson, S., Increase burn patient and family satisfaction with simple diagram, Journal of Burn Care and Research, 36, S229, 2015	Conference abstract

Study	Reason for Exclusion
Jones, C., Perry, L., Bennett, B., Wickremasinghe, I. M., Addressing elevated blood pressures in spinal cord injury using mindfulness-based exercises, Journal of Spinal Cord Medicine, 37, 442-443, 2014	Conference abstract
Kamal, A. M., Fathy, H., Psychiatric assessment of disfigured burn patients following cognitive behavioral therapy program, Egyptian Journal of Neurology, Psychiatry and Neurosurgery, 50, 19-24, 2013	Paper unavailable.
Kane, F. M., Brodie, E. E., Coull, A., Coyne, L., Howd, A., Milne, A., Niven, C. C., Robbins, R., The analgesic effect of odour and music upon dressing change, British journal of nursing (Mark Allen Publishing), 13, S4â□□12, 2004	Specific pain management interventions
Kellezi, B., Beckett, K., Earthy, S., Barnes, J., Sleney, J., Clarkson, J., Regel, S., Jones, T., Kendrick, D., Understanding and meeting information needs following unintentional injury: comparing the accounts of patients, carers and service providers, Injury, 46, 564-71, 2015	Qualitative study
Khanjari, Sedigheh, Tajik, Zahra, Haghani, Hamid, The effect of family-centered education on the quality of life of adolescents with spinal cord injuries, Journal of family medicine and primary care, 8, 711-716, 2019	Non-randomised study, n<100 per treatment arm.
King, C., Kennedy, P., Coping effectiveness training for people with spinal cord injury: preliminary results of a controlled trial, The British journal of clinical psychology, 38 (Pt 1), 5-14, 1999	Non-randomised study, n<100 per treatment arm.
Kooijmans, H., Post, M. W. M., Stam, H. J., van der Woude, L. H. V., Spijkerman, D. C. M., Snoek, G. J., Bongers-Janssen, H. M. H., van Koppenhagen, C. F., Twisk, J. W., Bussmann, J. B. J., Effectiveness of a Self-Management Intervention to Promote an Active Lifestyle in Persons With Long-Term Spinal Cord Injury: The HABITS Randomized Clinical Trial, Neurorehabilitation and Neural Repair, 31, 991-1004, 2017	Population not in PICO – over 18 years old
Kono, Taro, Groff, William Frederick, Sakurai, Hiroyuki, Yamaki, Takashi, Soejima, Kazukata, Nozaki, Motohiro, Treatment of traumatic scars using plasma skin regeneration (PSR) system, Lasers in Surgery and Medicine, 41, 128-30, 2009	No comparative data
Konstantatos, A. H., Angliss, M., Costello, V., Cleland, H., Stafrace, S., Predicting the effectiveness of virtual reality relaxation on pain and anxiety when added to PCA morphine in patients having burns dressings changes, Burns, 35, 491-499, 2009	Specific pain management interventions
Kooijmans, H., Post, M. W., van der Woude, L. H., de Groot, S., Stam, H. J., Bussmann, J. B., Randomized controlled trial of a self-	Published protocol for included study (Kooijmans 2017)

Study	Reason for Exclusion
management intervention in persons with spinal cord injury: design of the HABITS (Healthy Active Behavioural Intervention in SCI) study, Disability and Rehabilitation, 35, 1111-1118, 2013	
Kramer, Didier N., Landolt, Markus A., Early psychological intervention in accidentally injured children ages 2-16: a randomized controlled trial, European Journal of Psychotraumatology, 5, 2014	Population not in PICO - individuals at risk for development of PTSD
Krichbaum, K., GAPN postacute care coordination improves hip fracture outcomes, West J Nurs Res, 29, 523-44, 2007	Population not in PICO - acute hip fracture patients without chronic rehabilitation needs.
Larroque, C. M., Abrams, A. N., Psychotherapy techniques for treating the medically ill or injured child, Journal of the American Academy of Child and Adolescent Psychiatry, 56, S117, 2017	Conference abstract
Lebon, Florent, Guillot, Aymeric, Collet, Christian, Badia, Binkley Bodian Christakou Christakou Cohen Cramer Cupal Decety Derscheid Dowling Drechsler Driediger Ekblom Evans Green Guillot Hale Heil Hermens Hoher Holmes Hortobagyi Hakkinen Ievleva Jeannerod Kaneko Kosslyn Law Liepert Lotze Louis Milne Mizner Moseley Moseley Newsom Ranganathan Ranganathan Richardson Roos Rushall Sordoni Sordoni Stinear Taylor Watson Yeung Yue Zijdewind, Increased muscle activation following motor imagery during the rehabilitation of the anterior cruciate ligament, Applied Psychophysiology and Biofeedback, 37, 45-51, 2012	Population not in PICO - do not get admitted to hospital with ligament tear.
Li, E. J. Q., Li-Tsang, C. W. P., Lam, C. S., Hui, K. Y. L., Chan, C. C. H., The effect of a "training on work readiness" program for workers with musculoskeletal injuries: A randomized control trial (RCT) study, Journal of Occupational Rehabilitation, 16, 529-541, 2006	Intervention not in PICO - 'Return to Work' intervention, crosses over with RTW NICE guideline.
Li, Yan, Bressington, Daniel, Chien, Wai Tong, Systematic Review of Psychosocial Interventions for People With Spinal Cord Injury During Inpatient Rehabilitation: Implications for Evidence-Based Practice, Worldviews on evidence-based nursing, 14, 499-506, 2017	Systematic review - studies checked for possible inclusion. One was identified.
Li, Yan, Bressington, Daniel, Chien, Wai-Tong, Pilot evaluation of a coping-oriented supportive program for people with spinal cord injury during inpatient rehabilitation, Disability and Rehabilitation, 41, 182-190, 2019	Non-randomised study, n<100 per treatment arm.
Lin, Pi-Chu, Wang, Ching-Hui, Chen, Chyang-Shiong, Liao, Li-Ping, Kao, Shu-Fen, Wu, Heng-Fei, Birmingham, Bull Chang Cooper Dai Dai Frank-Stromborg Gullberg Haddock Holbrook Houghton Liang Lin Lin Lin Magaziner Magaziner Michaels Naylor Naylor Naylor Pan Pasco Sambrook Spilker Strohmyer Theobald Wang Wang Ware Williams, To evaluate the	Intervention not in PICO - discharge-planning programme

Study	Reason for Exclusion
effectiveness of a discharge-planning programme for hip fracture patients, Journal of Clinical Nursing, 18, 1632-1639, 2009	
Littleton, S. M., Hughes, D. C., Gopinath, B., Robinson, B. J., Poustie, S. J., Smith, P. N., Cameron, I. D., The health status of people claiming compensation for musculoskeletal injuries following road traffic crashes is not altered by an early intervention programme: A comparative study, Injury, 45, 1493-1499, 2014	Non-randomised study, n<100 per treatment arm.
London, M., Motivating the back injury patient, Rehab management, 12, 46-81, 1999	Narrative review
Longabaugh, R., Woolard, R. F., Nirenberg, T. D., Minugh, A. P., Becker, B., Clifford, P. R., Carty, K., Sparadeo, F., Gogineni, A., Evaluating the effects of a brief motivational intervention for injured drinkers in the emergency department, Journal of Studies on Alcohol, 62, 806-816, 2001	Population not in PICO - hazardous or harmful drinkers
MacGillivray, M. K., Mortenson, W. B., Sadeghi, M., Mills, P. B., Adams, J., Sawatzky, B. J., Implementing a self-management mobile app for spinal cord injury during inpatient rehabilitation and following community discharge: A feasibility study, Journal of Spinal Cord Medicine, 2019	No comparative data
Mackay, J., Charles, S. T., Kemp, B., Heckhausen, J., Goal striving and maladaptive coping in adults living with spinal cord injury: associations with affective well-being, Journal of aging and health, 23, 158-176, 2011	No comparative data
Maddern, L. H., Cadogan, J. C., Emerson, M. P., 'Outlook': A psychological service for children with a different appearance, Clinical Child Psychology and Psychiatry, 11, 431-443, 2006	No comparative data
Magia, F., Bhise, A., Prabhakar, M., Shukla, Y., Effect of pranayama (yogic breathing) on lung function in traumatic thoracic spinal cord injury patients: An interventional study, Physiotherapy (United Kingdom), 101, eS927, 2015	Conference abstract
Magill, M., Apodaca, T., The route to change: Within-session predictors of Change Plan completion in a motivational interview, Alcoholism: Clinical and Experimental Research, 33, 112A, 2009	Conference abstract
Magill, M., Apodaca, T. R., An exploratory principal component analysis of the Motivational Interviewing Skill code: What do therapists and clients do in mi sessions?, Alcoholism: Clinical and Experimental Research, 34, 229A, 2010	Conference abstract
Mamashli, Leila, Mohaddes Ardebili, Fatemeh, Bozorgnejad, Mehri, Najafi Ghezeljeh, Tahereh, Manafi, Farzad, The Effect of Self-Care Compact Disk-Based Instruction Program on Physical Performance and Quality of Life of Patients with Burn At-Dismissal, World journal of plastic surgery, 8, 25-32, 2019	Comparison not in PICO - standard discharge instructions

Study	Reason for Exclusion
Manzone, M. G., Mastronardi, L., Aleotti, S., Pontini, I., Massazza, G., Integration of psychological intervention to trauma patients and their family in medical care, Early Intervention in Psychiatry, 10, 216, 2016	Conference abstract
Marsac, M. L., Kassam-Adams, N., Hildenbrand, A. K., Kohser, K. L., Winston, F. K., After the injury: initial evaluation of a web-based intervention for parents of injured children, Health Education Research, 26, 1-12, 2011	Non-randomised study, n<100 per treatment arm.
Martin, G., Swannell, S., Mill, J., Mott, J., Evans, J., Frederiksen, N., Hilder, M., Kimble, R., Spray on skin improves psychosocial functioning in pediatric burns patients: A randomized controlled trial, Burns, 34, 498-504, 2008	Analyses and outcomes not in PICO - family and behavioural functioning. Satisfaction measured but not reported by intervention/control.
Martin-Herz, S. P., Thurber, C. A., Patterson, D. R., Psychological principles of burn wound pain in children. II: Treatment applications, The Journal of burn care & rehabilitation, 21, 458-457, 2000	Narrative review
McGilton, K. S., Davis, A. M., Naglie, G., Mahomed, N., Flannery, J., Jaglal, S., Cott, C., Stewart, S., Evaluation of patient-centered rehabilitation model targeting older persons with a hip fracture, including those with cognitive impairment, BMC geriatrics, 13, 136, 2013	Non-randomised study, n<100 per treatment arm.
Meade, M. A., Trumpower, B., Forchheimer, M., Diponio, L., Development and feasibility of health mechanics: A self-management program for individuals with spinal cord injury, Topics in Spinal Cord Injury Rehabilitation, 22, 121-134, 2016	Intervention and comparison not included in PICO - not standard rehabilitation care
Meade, M. A., Wilson, C., Issues of implementation and feasibility of an in-person, individually administered self-management intervention for adults with spinal cord injury, Journal of Spinal Cord Medicine, 36, 514-515, 2013	Conference abstract
Mello, M. J., Baird, J., Lee, C., Strezsak, V., French, M. T., Longabaugh, R., A Randomized Controlled Trial of a Telephone Intervention for Alcohol Misuse with Injured Emergency Department Patients, Annals of Emergency Medicine, 67, 263-275, 2016	Outcomes not in PICO - past 30-day alcohol use at 12 months, injuries and alcohol-related injuries, alcohol-related negative consequences, and impaired driving frequency.
Mello, M. J., Baird, J., Strezsak, V., Lee, C., Longabaugh, R., A telephone intervention for risky alcohol use with injured emergency department patients, Annals of Emergency Medicine, 66, S104-S105, 2015	Conference abstract
Mercier, H. W., Ni, P., Houlihan, B. V., Jette, A. M., Differential Impact and Use of a Telehealth Intervention by Persons with MS or SCI, Am J Phys Med Rehabil, 94, 987-99, 2015	Population not in PICO – over 18 years old
Millikan, J. S., On the other side of the door, The Journal of trauma, 55, 1007-1013, 2003	Editorial

Study	Reason for Exclusion
Mohaddes Ardebili, Fatemeh, Najafi Ghezeljeh, Tahereh, Bozorgnejad, Mehri, Zarei, Mohammadreza, Ghorbani, Hooman, Manafi, Farzad, Effect of Multimedia Self-Care Education on Quality of Life in Burn Patients, World journal of plastic surgery, 6, 292-297, 2017	Population not in PICO – over 18 years old
Mohammadi Fakhar, F., Rafii, F., Jamshidi Orak, R., The effect of jaw relaxation on pain anxiety during burn dressings: Randomised clinical trial, Burns, 39, 61-67, 2013	Outcome not in PICO - pain anxiety
Morlett-Paredes, A., Perrin, P. B., Olivera, S. L., Rogers, H. L., Perdomo, J. L., Arango, J. A., Arango-Lasprilla, J. C., With a little help from my friends: social support and mental health in SCI caregivers from Neiva, Colombia, Neurorehabilitation, 35, 841-9, 2014	Non-comparative study
Moseley, G. Lorimer, Gallace, Alberto, Spence, Charles, Is mirror therapy all it is cracked up to be? Current evidence and future directions, Pain, 138, 7-10, 2008	Narrative review
Mullen, J., McKechnie, K., Niedzwecki, C., Baize, C., Gammon, S., Giovannetti, B., Lathem, P., Leger, K. L., Vakharia, M., Wirt, Z., Young, A., Stoplight mobility alert system (SMAS): Communication of mobility status for falls prevention, Archives of Physical Medicine and Rehabilitation, 96, e34, 2015	Conference abstract
Murray, K., Corney, J., Moore-Millar, K., Cairns, N., Extending the life and improving the appearance of cosmetic foam covers for people with trans-femoral amputations, Prosthetics and Orthotics International, 39, 198, 2015	Conference abstract
Naglie, G., Tansey, C., Kirkland, J. L., Ogilvie-Harris, D. J., Detsky, A. S., Etchells, E., Tomlinson, G., O'Rourke, K., Goldlist, B., Interdisciplinary inpatient care for elderly people with hip fracture: A randomized controlled trial, CMAJ, 167, 25-32, 2002	Intervention not in PICO - interdisciplinary care
Najafi Ghezeljeh, T., Mohades Ardebili, F., Rafii, F., The effects of massage and music on pain, anxiety and relaxation in burn patients: Randomized controlled clinical trial, Burns : journal of the International Society for Burn Injuries, 43, 1034-1043, 2017	Outcomes not in PICO - very short term effects (immediately after intervention)
Nanney, John T., Conrad, Erich J., Reuther, Erin T., Wamser-Nanney, Rachel A., McCloskey, Michael, Constans, Joseph I., Motivational Interviewing for Victims of Armed Community Violence: A Nonexperimental Pilot Feasibility Study, Psychology of violence, 8, 259-268, 2018	Non-randomised study, n<100 per treatment arm.
Newman, S. D., Andrews, J. O., Toatley, S. L., Rodgers, M. D., Epperly, D., Gillenwater, G., A peer navigation intervention for individuals with spinal cord injury, Journal of Spinal Cord Medicine, 37, 439-440, 2014	Conference abstract

Study	Reason for Exclusion
Nooijen, C. F., Stam, H. J., Bergen, M. P., Bongers-Janssen, H. M., Valent, L., van Langeveld, S., Twisk, J., van den Berg-Emons, R. J., A behavioural intervention increases physical activity in people with subacute spinal cord injury: a randomised trial, Journal of physiotherapy, 62, 35-41, 2016	Population not in PICO – over 18 years old
Nooijen, C. F., Stam, H. J., Schoenmakers, I., Sluis, T. A., Post, M. W., Twisk, J. W., van den Berg-Emons, R. J., Working mechanisms of a behavioural intervention promoting physical activity in persons with subacute spinal cord injury, Journal of Rehabilitation Medicine, 48, 583-588, 2016	Population not in PICO – over 18 years old
Nooijen, C. F., Stam, H. J., Sluis, T., Valent, L., Twisk, J., van den Berg-Emons, R. J., A behavioral intervention promoting physical activity in people with subacute spinal cord injury: secondary effects on health, social participation and quality of life, Clinical Rehabilitation, 31, 772-780, 2017	Population not in PICO – over 18 years old
Noroozi, S., Mokhtariaraghi, H., Barzoki, M. H., The effectiveness of trauma-focused cognitive-behavioural therapy in the treatment of depression of divorced women in Tehran, Australasian Medical Journal, 11, 245-252, 2018	Population not in PICO - divorced women
Ogawa, Tatsuya, Omon, Kyohei, Yuda, Tomohisa, Ishigaki, Tomoya, Imai, Ryota, Ohmatsu, Satoko, Morioka, Shu, Short-term effects of goal-setting focusing on the life goal concept on subjective well-being and treatment engagement in subacute inpatients: a quasi-randomized controlled trial, Clinical Rehabilitation, 30, 909-20, 2016	Non-randomised study, n<100 per treatment arm.
Ormhaug, S. M., Jensen, T. K., Wentzel-Larsen, T., Shirk, S. R., The therapeutic alliance in treatment of traumatized youths: Relation to outcome in a randomized clinical trial, Journal of Consulting and Clinical Psychology, 82, 52-64, 2014	Population not in PICO - traumatised youth
Oshvandi, K., Fallahinia, G. H., Azami, H., Tapak, L., The effect of music with relaxation on the patients' pain intensity due to burn dressing, Journal of Chemical and Pharmaceutical Sciences, 2016, 57-60, 2016	Intervention not in PICO -□“ burn care, not rehabilitation.
Oude Voshaar, Richard C., Banerjee, Sube, Horan, Mike, Baldwin, Robert, Pendleton, Neil, Proctor, Rebekah, Tarrier, Nicholas, Woodward, Yvonne, Burns, Alistair, Fear of falling more important than pain and depression for functional recovery after surgery for hip fracture in older people, Psychological Medicine, 36, 1635-45, 2006	Intervention not in PICO - cognitive behavioural therapy designed to treat depression in geriatric hip fracture patients.
Ozturk, A., Ucsular, F. D., Effectiveness of a wheelchair skills training programme for community-living users of manual wheelchairs in	Population not in PICO - manual wheelchair users, not traumatic injury.

Study	Reason for Exclusion
Turkey: a randomized controlled trial, Clin Rehabil, 25, 416-24, 2011	
Pantera, E., Fages, P., Cristina, M. C., Coudeyre, E., Therapeutic education after amputation: Literature's review, Annals of Physical and Rehabilitation Medicine, 56, e145-e146, 2013	Conference abstract
Pantera, E., Pourtier-Piotte, C., Bensoussan, L., Coudeyre, E., Patient education after amputation: Systematic review and experts' opinions, Annals of Physical and Rehabilitation Medicine, 57, 143-158, 2014	Systematic review - studies checked for possible inclusion. None were identified.
Patterson, R. W., Bushnik, T., Burdsall, D., Wright, J., Considerations of peer support for persons with high tetraplegia, Topics in Spinal Cord Injury Rehabilitation, 10, 30-37, 2005	Narrative decription of intervention
Perkes, S. J., Bowman, J., Penkala, S., Psychological therapies for the management of co-morbid depression following a spinal cord injury: a systematic review, Journal of health psychology, 19, 1597-1612, 2014	Systematic review - references checked for possible studies. None were identified.
Peterson, Margaret G. E., Ganz, Sandy B., Allegrante, John P., Cornell, Charles N., High-Intensity Exercise Training Following Hip Fracture, Topics in Geriatric Rehabilitation, 20, 273-284, 2004	Intervention not in PICO - high intensity exercise.
Pham, C. H., Fang, M., Nager, J., Matsushima, K., Inaba, K., Kuza, C. M., The Role of Psychological Support Interventions in Trauma Patients on Mental Health Outcomes: A Systematic Review and Meta-Analysis, The journal of trauma and acute care surgery, 2019	Systematic review - studies checked for possible inclusion. None were identified.
Phillips, V. L., Vesmarovich, S., Hauber, R., Wiggers, E., Egner, A., Telehealth: reaching out to newly injured spinal cord patients, Public health reports (Washington, D.C. : 1974), 116 Suppl 1, 94-102, 2001	Intervention not in PICO – Individual telephone and video rehabilitation education sessions
Pirente, N., Blum, C., Wortberg, S., Bostanci, S., Berger, E., Lefering, R., Bouillon, B., Rehm, K. E., Neugebauer, E. A., Quality of life after multiple trauma: the effect of early onset psychotherapy on quality of life in trauma patients, Langenbeck's archives of surgery / Deutsche Gesellschaft fur Chirurgie, 392, 739-745, 2007	Population not in PICO – over 18 years old
Pisconti, F., Santos, S. M. S., Lopes, J., Cardoso, J. R., Lavado, E. L., Cross-cultural and psychometric properties assessment of the exercise self-efficacy scale in individuals with spinal cord injury, Acta Medica Portuguesa, 30, 783-789, 2017	No comparative data
Pjanic, I., Messerli-Burgy, N., Bachmann, M. S., Siegenthaler, F., Hoffmann-Richter, U., Znoj, H., Predictors of depressed mood 12 months after injury. Contribution of self-efficacy and social	No comparative data

Study	Reason for Exclusion
support, Disability and Rehabilitation, 36, 1258-1263, 2014	
Plaza, A., Paratz, J., Stockton, K., Muller, M., Hoskin, B., Exercise programmes are effective and safe in a burns population: A controlled trial, Journal of Burn Care and Research, 32, S117, 2011	Conference abstract
Pol, M. C., Ter Riet, G., van Hartingsveldt, M., Krose, B., Buurman, B. M., Effectiveness of sensor monitoring in a rehabilitation programme for older patients after hip fracture: a three-arm stepped wedge randomised trial, Age and Ageing, 2019	Analyses and outcomes not in PICO
Postma, K., Haisma, J. A., Hopman, M. T., Bergen, M. P., Stam, H. J., Bussmann, J. B., Resistive inspiratory muscle training in people with spinal cord injury during inpatient rehabilitation: a randomized controlled trial, Physical Therapy, 94, 1709-1719, 2014	Intervention not in PICO - resistive inspiratory muscle training
Pourmand, Ali, Davis, Steven, Lee, Danny, Barber, Scott, Sikka, Neal, Emerging Utility of Virtual Reality as a Multidisciplinary Tool in Clinical Medicine, Games for health journal, 6, 263-270, 2017	Systematic review - included studies searched for possible inclusions. None were identified.
Prang, K. H., Berecki-Gisolf, J., Newnam, S., The influence of social support on healthcare service use following transport-related musculoskeletal injury, BMC health services research, 16, 310, 2016	No comparative data
Prang, K. H., Berecki-Gisolf, J., Newnam, S., Recovery from musculoskeletal injury: The role of social support following a transport accident, Health and Quality of Life Outcomes, 13, 97, 2015	No comparative data
Prensner, J. D., Yowler, C. J., Smith, L. F., Steele, A. L., Fratianne, R. B., Music therapy for assistance with pain and anxiety management in burn treatment, Journal of Burn Care and Rehabilitation, 22, 83-88, 2001	Case series
Purdue, G. F., Hunt, J. L., Burns and trauma, Problems in General Surgery, 20, 106-111, 2003	Narrative review
Quan, Judy, Managing the occupational injury case: do you manage or monitor?, Professional case management, 13, 116-7, 2008	Editorial
Rajanna, V., Vo, P., Barth, J., Mjelde, M., Grey, T., Oduola, C., Hammond, T., KinoHaptics: An Automated, Wearable, Haptic Assisted, Physio-therapeutic System for Post-surgery Rehabilitation and Self-care, Journal of Medical Systems, 40, 1-12, 2016	Non-randomised study, n<100 per treatment arm.
Ramirez, M., Toussaint, M., Woods-Jaeger, B., Harland, K., Wetjen, K., Wilgenbusch, T., Pitcher, G., Jennissen, C., Link for Injured Kids: A Patient-Centered Program of Psychological First Aid after Trauma, Pediatric Emergency Care, 33, 532-537, 2017	Qualitative study

Study	Reason for Exclusion
Rintala, D. H., Garber, S. L., Friedman, J. D., Holmes, S. A., Preventing recurrent pressure ulcers in veterans with spinal cord injury: impact of a structured education and follow-up intervention, Arch Phys Med Rehabil, 89, 1429-41, 2008	Outcomes not in PICO - pressure ulcer recurrence.
Robb, Sheri L., Nichols, Ray J., Rutan, Randi L., Bishop, Bonnie L., Parker, Jayne C., The effects of music assisted relaxation on preoperative anxiety, Journal of Music Therapy, 32, 2-21, 1995	Outcome not in PICO - operative anxiety
Roberts, J. L., Pritchard, A. W., Williams, M., Totton, N., Morrison, V., D. In N.U, Williams, N. H., Mixed methods process evaluation of an enhanced community-based rehabilitation intervention for elderly patients with hip fracture, BMJ Open, 8 (8) (no pagination), 2018	No quantitative data presented
Roosink, Meyke, Robitaille, Nicolas, Jackson, Philip L., Bouyer, Laurent J., Mercier, Catherine, Baumbauer, Beaumont Betker Boudreau Bouffard Bowering Decety Di Rienzo Donnelly Gustin Jackson Jeannerod Kizony Kumru Lamothe Longo Malouin Malouin Malouin Mercier Mercier Moseley Moseley Moseley Moseley Mulder Raffin Roosink Sayenko Sharp Siddall Soler Sumitani Tawashy Turner Villiger Villiger Widerstrom-Noga Witmer Zigmond Zimmerli, Interactive virtual feedback improves gait motor imagery after spinal cord injury: An exploratory study, Restorative Neurology and Neuroscience, 34, 227-235, 2016	Non-randomised study, n<100 per treatment arm.
Rottkamp, B. C., An experimental nursing study: a behavior modification approach to nursing therapeutics in body positioning of spinal cord-injured patients, Nurs Res, 25, 181-6, 1976	Date restriction, pre-1995.
Rowland, Jennifer L., White, Glen W., Wyatt, David A., Analysis of An Intervention to Reduce or Prevent Secondary Conditions for People with Spinal Cord Injuries, Journal of Clinical Psychology in Medical Settings, 13, 263-271, 2006	Outcomes not in PICO - development of secondary conditions.
Rubin, E., Ostrowsky, L., Janopaul-Naylor, E., Sehgal, P., Cama, S., Tanski, E., Curtin, C., The sibling support demonstration project: A pilot study assessing feasibility, preliminary effectiveness, and participant satisfaction, Adolescent Psychiatry, 8, 48-60, 2018	Population not in PICO - psychiatric inpatients.
Ruchlin, H. S., Elkin, E. B., Allegrante, J. P., The economic impact of a multifactorial intervention to improve postoperative rehabilitation of hip fracture patients, 45, 446-52, 2001	Outcomes not in PICO - health economic outcomes only.
Rutherford, L. G., von Wenckstern, T., Trauma Information Group: A Level I Trauma Center's Integrated Approach to Family Support, Journal of trauma nursing : the official journal of the Society of Trauma Nurses, 23, 357-360, 2016	No comparative data

Study	Reason for Exclusion
Ryan, C. M., Lee, A. F., Kazis, L. E., Schneider, J. C., Palmieri, T. L., Pidcock, F., Reilly, D. A., Meyer, Iii W. J., Sheridan, R. L., Tompkins, R. G., The impact of facial burns on patient reported health outcomes following burn injuries in young adults: A five year study, Journal of Burn Care and Research, 36, S94, 2015	Conference abstract
Sabino, J., Polfer, E., Tintle, S., Jessie, E., Fleming, M., Martin, B., Shashikant, M., Valerio, I. L., A decade of conflict: flap coverage options and outcomes in traumatic war-related extremity reconstruction, Plastic and Reconstructive Surgery, 135, 895-902, 2015	Intervention not in PICO - surgical reconstruction
Sathiya, K., Effect of Progressive Relaxation Therapy among Orthopaedic Trauma Patients, The Nursing journal of India, 106, 186-189, 2015	Outcome not in PICO - post traumatic stress disorder
Saw, A., Chan, C. K., Penafort, R., Sengupta, S., A simple practical protocol for care of metal-skin interface of external fixation, Medical Journal of Malaysia, 61, 2006	Paper unavailable.
Schulz, Richard, Czaja, Sara J., Lustig, Amy, Zdaniuk, Bozena, Martire, Lynn M., Perdomo, Dolores, Improving the quality of life of caregivers of persons with spinal cord injury: a randomized controlled trial, Rehabilitation Psychology, 54, 1-15, 2009	Population not in PICO – over 18 years old
Seehausen, A., Ripper, S., Germann, G., Hartmann, B., Wind, G., Renneberg, B., Efficacy of a burn-specific cognitive-behavioral group training, Burns, 41, 308-316, 2015	Non-randomised study, n<100 per treatment arm.
Seel, R. T., Douglas, J., Dennison, A. C., Heaner, S., Farris, K., Rogers, C., Specialized early treatment for persons with disorders of consciousness: program components and outcomes, Archives of Physical Medicine & RehabilitationArch Phys Med Rehabil, 94, 1908-23, 2013	No comparative data
Shamout, S., Biardeau, X., Corcos, J., Campeau, L., Outcome comparison of different approaches to self-intermittent catheterization in neurogenic patients: a systematic review, Spinal Cord, 55, 629-643, 2017	Systematic review - studies checked for possible inclusion. None were identified.
Shepherd-Banigan, Megan E., Shapiro, Abigail, McDuffie, Jennifer R., Brancu, Mira, Sperber, Nina R., Van Houtven, Courtney H., Kosinski, Andrzej S., Mehta, Neha N., Nagi, Avishek, Williams, John W., Jr., Interventions That Support or Involve Caregivers or Families of Patients with Traumatic Injury: a Systematic Review, Journal of General Internal Medicine, 33, 1177-1186, 2018	Systematic review - studies checked for possible inclusion. None were identified.
Shields, B. A., Brown, J. N., Aden, J. K., Salgueiro, M., Mann-Salinas, E. A., Chung, K. K., A pilot review of gradual versus goal re-initiation of enteral nutrition after burn surgery in	Non-randomised study, n<100 per treatment arm.

Study	Reason for Exclusion
the hemodynamically stable patient, Burns, 40, 1587-1592, 2014	
Shyu, Y. I., Liang, J., Tseng, M. Y., Li, H. J., Wu, C. C., Cheng, H. S., Chou, S. W., Chen, C. Y., Yang, C. T., Enhanced interdisciplinary care improves self-care ability and decreases emergency department visits for older Taiwanese patients over 2 years after hip-fracture surgery: a randomised controlled trial, International Journal of Nursing Studies, 56, 54-62, 2016	Intervention not in PICO - comprehensive care includes referral for depression management but not part of treatment plan.
Shyu, Yea-Ing L., Liang, Jersey, Wu, Chi-Chuan, Su, Juin-Yih, Cheng, Huey-Shinn, Chou, Shih-Wei, Chen, Min-Chi, Yang, Ching-Tzu, Adunsky, Burke Cameron Cameron Cameron Chen Chuang Crotty Hollis Kraemer Lieberman Liou Rubin Liu Randell Rubin Ryan Schafer Shyu Chen Liang Vidan Yip, Interdisciplinary intervention for hip fracture in older Taiwanese: Benefits last for 1 year, The Journals of Gerontology: Series A: Biological Sciences and Medical Sciences, 63, 92-97, 2008	Intervention not in PICO - comprehensive care includes referral for depression management but not part of treatment plan
Shyu, Yea-Ing Lotus, Liang, Jersey, Wu, Chi-Chuan, Su, Juin-Yih, Cheng, Huey-Shinn, Chou, Shih-Wei, Yang, Ching-Tzu, Adunsky, Aharonoff Ahmad Burke Chen Chen Cleeland Crotty Dai Farnworth Huusko Huusko Katz Launer Lee Lee Liu Lu Magaziner Mellinger Mossey Munin Norton O'Cathain Ostir Rubenstein Runciman Sherrington Shyu Shyu Shyu Stuck Tappen Tinetti Tsai Tseng Von Sternberg Wang Wang Yip Yip, A Pilot Investigation of the Short-Term Effects of an Interdisciplinary Intervention Program on Elderly Patients with Hip Fracture in Taiwan, Journal of the American Geriatrics Society, 53, 811-818, 2005	Intervention not in PICO - comprehensive care includes referral for depression management but not part of treatment plan
Sibinga, E., Webb, L., Ellen, J., Mindfulness instruction improves anger regulation in US urban male youth, BMC Complementary and Alternative Medicine, 17, 2017	Conference abstract
Smith, M., Amputation: the transition from hospital to home, Nursing times, 95, 52-53, 1999	Paper unavailable.
Sorokin, Igor, De, Elise, Options for independent bladder management in patients with spinal cord injury and hand function prohibiting intermittent catheterization, Neurourology and Urodynamics, 34, 167-76, 2015	Literature review - references checked for studies, none were identified.
Spence, S. H., Cognitive-behavior therapy in the management of upper extremity cumulative trauma disorder, Journal of Occupational Rehabilitation, 8, 27-45, 1998	Narrative review
Spooner, A., A personal perspective: the psychological needs of spine-injured patients, Professional nurse (London, England), 10, 359-362, 1995	Case study

Study	Reason for Exclusion
Staffel, J. Gregory, Optimizing treatment of nasal fractures, The Laryngoscope, 112, 1709-19, 2002	Non-randomised study, n<100 per treatment arm.
Stanback, R., Rebuilding lives after injury, Nursing times, 110, 27, 2014	Editorial
Stoddard, F. J., Sorrentino, E. A., Murphy, J. M., Chedekel, D. S., White, G. W., Saxe, G. N., Buterbaugh, D., Doyne, T., Zbell, T., Clark, S., Benefits of an intervention to reduce stress in 0-5 year olds with burns: Updated findings, Journal of Burn Care and Research, 32, S147, 2011	Conference abstract
Sullivan, Michael J. L., Adams, Heather, Thibault, Pascal, Corbiere, Marc, Stanish, William D., Initial depression severity and the trajectory of recovery following cognitive-behavioral intervention for work disability, Journal of Occupational Rehabilitation, 16, 63-74, 2006	Comparison not in PICO - people with differing levels of depression
Sveen, Josefin, Andersson, Gerhard, Buhrman, Bo, Sjoberg, Folke, Willebrand, Mimmie, Internet-based information and support program for parents of children with burns: A randomized controlled trial, Burns : journal of the International Society for Burn Injuries, 43, 583-591, 2017	Outcomes not in PICO - parent's PTSD, parent's health, child's health as perceived by parent and research participation
Tang, D., Li-Tsang, C. W. P., Au, R. K. C., Li, K. C., Yi, X. F., Liao, L. R., Cao, H. Y., Feng, Y. N., Liu, C. S., Functional Outcomes of Burn Patients with or Without Rehabilitation in Mainland China, Hong Kong Journal of Occupational Therapy, 26, 15-23, 2015	Non-randomised study, n<100 per treatment arm.
Task Force on Community Preventive, Services, Recommendations to reduce psychological harm from traumatic events among children and adolescents, American journal of preventive medicine, 35, 314-6, 2008	Narrative review
Taylor, Rumina, Mellotte, Harriet, Griffiths, Maria, Compton, Agnes, Valsraj, Koravangattu, Aaltonen, Angermeyer Askey Barkham Berglund Borghetti Valer Boye Broadbent Carter Cohen Connell Crisp Falloon Falloon Fleury Garcia Glick Gracio Kuipers Mansell Norman Novak Onwumere Schweitzer Stanbridge Stanbridge Tennant Worthington, Carers matter: Promoting the inclusion of families within acute inpatient settings, Journal of Psychiatric Intensive Care, 12, 69-77, 2016	No comparative data.
Tecic, Tanja, Schneider, Alexandra, Althaus, Astrid, Schmidt, Yvette, Bierbaum, Christine, Lefering, Rolf, Mueller, Dirk, Bouillon, Bertil, Janssen, Christian, Pfaff, Holger, Erli, Hans J., Rangger, Christoph, Neugebauer, Edmund A. M., Early short-term inpatient psychotherapeutic treatment versus continued outpatient psychotherapy on psychosocial outcome: a	Intervention not in PICO - psychotherapy designed to reduce PTSD

Study	Reason for Exclusion
randomized controlled trial in trauma patients, The Journal of trauma, 70, 433-41, 2011	
Theodorakis, Y., Beneca, A., Malliou, P., Goudas, M., Examining psychological factors during injury rehabilitation, Journal of Sport Rehabilitation, 6, 355-363, 1997	Non-randomised study, n<100 per treatment arm.
Thieme, Holm, Morkisch, Nadine, Rietz, Christian, Dohle, Christian, Borgetto, Bernhard, Acerra, Attal Bellelli Bowering Breivik Breivik Brodie Buccino Cacchio Cacchio Celnik Chan Chapman Christakou Decety Dickstein Dohle Dworkin Dworkin Ezendam Finnerup Flor Galer Gaskin Giraux Gore Gore Gustorff Holen Hoyek Jensen Kumar Lebon MacIver Maher Maihofner Manca McCabe Michenthaler Michielsen Moseley Moseley Moseley Moseley Nemeth O'Connell O'Connor Park Pelosin Perry Ramachandran Ramachandran Rothgangel Savas Seidel Stein Straube Sumitani Swart Thieme Ulger Villiger Zimmermann-Schlatter, The efficacy of movement representation techniques for treatment of limb pain-A systematic review and meta-analysis, The Journal of Pain, 17, 167-180, 2016	Systematic review - studies checked for possible inclusion. None were identified.
Tidoni, E., Tieri, G., Aglioti, S. M., Aflalo, Aglioti Aglioti Aglioti Aglioti Alimardani Alkadhi Arrighi Awad Berlucchi Bickenbach Birbaumer Birbaumer Boord Botvinick Bruehlmeier Brumberg Castro Cermik Choi Collinger Corbetta Cramer Cramer Crawley Curt Curt Curt Daly De Vignemont Decety Di Rienzo Di Rienzo Do Enzinger Finnerup Fiori Freund Freund Fuentes Gergondet Goodwin Gourab Green Green Guger Guger Gustin Gustin Gustin Henderson Herbert Hochberg Hohne Hotz-Boendermaker Hou Huggins Ikegami Jensen Jurkiewicz Jurkiewicz Kakulas Kalckert Kalckert Kambi King Kirshblum Koenraadt Kumru Lacourse Lebedev Lee Leeb Leeb Leeb Lenggenhager Lenggenhager Leonardis Leonardis Lotze Mak Manson Mattia Mikulis Millan Mole Moore Nardone Nardone Neuper Onose Ortner Pascoal-Faria Perez-Marcos Pernigo Pfurtscheller Pfurtscheller Pfurtscheller Pisotta Pons Rodrigues Roelcke Rognoni Rosso Roy Rupp Sabbah Sabre Sakurada Sanchez-Vives Scandola Scherer Scivoletto Serino Shoham Soler Tidoni Tidoni Tidoni Tidoni Tieri Tinazzi Touzalin-Chretien Tran Truccolo Tsakiris Van Gorp Villiger Vuckovic Wang Williams Wolpaw Wrigley Wydenkeller Xu Yao Yoon Zhu, Re-establishing the disrupted sensorimotor loop in deafferented and deefferented people: The case of spinal cord injuries, Neuropsychologia, 79, 301-309, 2015	Narrative review
Tung, J. Y., Stead, B., Mann, W., Ba'Pham,, Popovic, M. R., Assistive technologies for self-managed pressure ulcer prevention in spinal	Systematic review - studies checked for possible inclusion. None were identified.

Study	Reason for Exclusion
cord injury: A scoping review, Journal of Rehabilitation Research and Development, 52, 131-146, 2015	
Turpin, G., Downes, M., Mason, S., Effectiveness of giving self-help information acute traumatic injury: a randomised controlled trial, British Journal of Psychiatry, 187, 76â□□82, 2005	Duplicate paper
Turpin, G., Downs, M., Mason, S., Effectiveness of providing self-help information following acute traumatic injury: randomised controlled trial, British journal of psychiatry, 187, 76â□□82, 2005	Population not in PICO -□“ survivors of road traffic accident, occupational injury or assault at risk of developing PTSD.
Turunen, K., Salpakoski, A., Edgren, J., Tormakangas, T., Arkela, M., Kallinen, M., Pesola, M., Hartikainen, S., Nikander, R., Sipila, S., Physical Activity After a Hip Fracture: Effect of a Multicomponent Home-Based Rehabilitation Program-A Secondary Analysis of a Randomized Controlled Trial, Archives of Physical Medicine and Rehabilitation, 98, 981-988, 2017	Outcomes not in PICO - physical activity
Van Biervliet, A., Gest, T. R., A multimedia guide to spinal cord injury: empowerment through self instruction, Medinfo. MEDINFO, 8 Pt 2, 1701, 1995	Description of intervention
van Langeveld, S. A., Post, M. W., van Asbeck, F. W., ter Horst, P., Leenders, J., Postma, K., Lindeman, E., Reliability of a New Classification System for Mobility and Self-Care in Spinal Cord Injury Rehabilitation: The Spinal Cord Injury-Interventions Classification System, Archives of Physical Medicine and Rehabilitation, 90, 1229-1236, 2009	Duplicate paper
Visser, E., Gosens, T., Den Oudsten, B. L., De Vries, J., The course, prediction, and treatment of acute and posttraumatic stress in trauma patients: A systematic review, Journal of Trauma and Acute Care Surgery, 82, 1158-1183, 2017	Population not in PICO - individuals with acute stress disorder or PTSD
Vogel, L. C., Anderson, C. J., Spinal cord injuries in children and adolescents: A review, Journal of Spinal Cord Medicine, 26, 193-203, 2003	Narrative review
Vranceanu, A. M., Hageman, M., Strooker, J., ter Meulen, D., Vrahas, M., Ring, D., A preliminary RCT of a mind body skills based intervention addressing mood and coping strategies in patients with acute orthopaedic trauma, Injury, 46, 552â□□557, 2015	Intervention not in PICO - specific pain management intervention.
Wang, Zhiyun, Wang, Jianping, Maercker, Andreas, Program Use and Outcome Change in a Web-Based Trauma Intervention: Individual and Social Factors, Journal of Medical Internet Research, 18, e243, 2016	No comparative data
Watkins, P. N., Cook, E. L., May, S. R., Still, J. M., Jr., Luterman, A., Purvis, R. J., Postburn	Case series

Study	Reason for Exclusion
psychologic adaptation of family members of patients with burns, The Journal of burn care & rehabilitation, 17, 78-92, 1996	
Wegener, Stephen T., Mackenzie, Ellen J., Ephraim, Patti, Ehde, Dawn, Williams, Rhonda, Self-management improves outcomes in persons with limb loss, Archives of Physical Medicine and Rehabilitation, 90, 373-80, 2009	Population not in PICO - support groups for amputees
Wethington, Holly R., Hahn, Robert A., Fuqua-Whitley, Dawna S., Sipe, Theresa Ann, Crosby, Alex E., Johnson, Robert L., Liberman, Akiva M., Moscicki, Eve, Price, Leshawndra N., Tuma, Farris K., Kalra, Geetika, Chattopadhyay, Sajal K., Task Force on Community Preventive, Services, The effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents: a systematic review, American journal of preventive medicine, 35, 287-313, 2008	Systematic review - studies checked for possible inclusion. None were identified.
Wheeler, Kathleen, Psychotherapeutic strategies for healing trauma, Perspectives in psychiatric care, 43, 132-41, 2007	Systematic review - studies checked for possible inclusion. None were identified.
Whitehead-Pleaux, A. M., Zebrowski, N., Baryza, M. J., Sheridan, R. L., Exploring the effects of music therapy on pediatric pain: phase 1, J Music Ther, 44, 217-41, 2007	Non-randomised study, n<100 per treatment arm.
Wiechman Askay, Shelley, Patterson, David R., Sharar, Samuel R., Mason, Shawn, Faber, Bertus, Pain management in patients with burn injuries, International review of psychiatry (Abingdon, England), 21, 522-30, 2009	Narrative review
Wiechman, S. A., Carrougher, G. J., Esselman, P. C., Angere, D., Klein, M. B., Gibran, N. S., A randomized controlled trial to test an expanded delivery model for patients with burn injuries, Journal of burn care & research, 35, S79, 2014	Conference abstract
Wiechman, S. A., Carrougher, G. J., Esselman, P. C., Klein, M. B., Martinez, E. M., Engrav, L. H., Gibran, N. S., An expanded delivery model for outpatient burn rehabilitation, Journal of burn care & research, 36, 14-22, 2015	Population not in PICO – over 18 years old
Wilde, Mary H., Fairbanks, Eileen, Parshall, Robert, Zhang, Feng, Miner, Sarah, Thayer, Deborah, Harrington, Brian, Brasch, Judith, McMahon, James M., Development of a Web-Based Self-management Intervention for Intermittent Urinary Catheter Users With Spinal Cord Injury, Computers, informatics, nursing : CIN, 33, 478-86, 2015	Non-randomised study, n<100 per treatment arm.
Wilde, Mary H., Fairbanks, Eileen, Parshall, Robert, Zhang, Feng, Miner, Sarah, Thayer, Deborah, Harrington, Brian, Brasch, Judith, Schneiderman, Dan, McMahon, James M., A Web-Based Self-Management Intervention for Intermittent Catheter Users, Urologic nursing, 35, 127-138, 2015	Narrative description of new intervetion

Study	Reason for Exclusion
Williams, Reg Arthur, Gatien, Gary, Hagerty, Bonnie M., Kane, Michele, Otto, Laureen, Wilson, Candy, Throop, Meryia, Addressing psychosocial care using an interactive Web site for combat-wounded patients, Perspectives in psychiatric care, 49, 152-61, 2013	No comparative data
Winje, D., Ulvik, A., Confrontations with reality: crisis intervention services for traumatized families after a school bus accident in Norway, Journal of Traumatic Stress, 8, 429-44, 1995	Population not in PICO - survivors of school bus accident at risk of developing post traumatic stress disorder
Wise, James B., Ellis, Gary D., Trunnell, Eric P., Altmaier, Baechle Bandura Bandura Bandura Bandura Bandura Brill Brody Caruso Cohen Ewart Ewart Holloway Horn Janssen Janssen Janssen Kelley Lou Lox McAuley Mihalko Noreau Rejeski Semenick Smith Stevens Stone Stumbo Taylor Wise, Effects of a curriculum designed to generalize self-efficacy from weight-training exercises to activities of daily living among adults with spinal injuries, Journal of Applied Social Psychology, 32, 500-521, 2002	Non-randomised study, n<100 per treatment arm.
Worobey, L. A., Kirby, R. L., Heinemann, A. W., Krobot, E. A., Dyson-Hudson, T. A., Cowan, R. E., Pedersen, J. P., Shea, M., Boninger, M. L., Effectiveness of Group Wheelchair Skills Training for People With Spinal Cord Injury: A Randomized Controlled Trial, Archives of Physical Medicine and Rehabilitation, 97, 1777, 2016	Outcome not in PICO - Wheelchair Skills Test Questionnaire and Goal Attainment Scale score
Worobey, L., Boninger, M., Kirby, L., Preliminary results on effectiveness of group wheelchair skills training among individuals with spinal cord injury, Archives of Physical Medicine and Rehabilitation, 96, e25, 2015	Conference abstract
Wu, K. K. Y., A randomised controlled trial of brief cognitive-behavioural therapy and a self-help booklet as early interventions for post-traumatic stress after road trajfic accident, East Asian Archives of Psychiatry, 20, 46-47, 2010	Conference abstract
Xie, L. Q., Deng, Y. L., Zhang, J. P., Richmond, C. J., Tang, Y., Zhou, J., Effects of Progressive Muscle Relaxation Intervention in Extremity Fracture Surgery Patients, Western Journal of Nursing Research, 38, 155â□□168, 2016	Outcomes not in PICO - state anxiety and self-efficacy
Zadro, J. R., Shirley, D., Simic, M., Mousavi, S. J., Ceprnja, D., Maka, K., Sung, J., Ferreira, P., Video-Game-Based Exercises for Older People With Chronic Low Back Pain: A Randomized Controlledtable Trial (GAMEBACK), Physical Therapy, 99, 14-27, 2019	Intervention not in PICO - flexibility, body weight resistance, and aerobic exercises
Zhang, H., Huang, J., Long, C., Influence of psychological intervention before emergent ocular trauma surgery on patients' negative emotions, Eye science, 29, 74-77, 2014	Intervention not in PICO - pre-surgery psychological programme
Zidén, L., Frändin, K., Kreuter, M., Home rehabilitation after hip fracture. A randomized	Population not in PICO – over 18 years old

Study	Reason for Exclusion
controlled study on balance confidence, physical function and everyday activities, Clinical Rehabilitation, 22, 1019-1033, 2008	

Economic studies

All studies were excluded at the initial title and abstract screening stage. See appendix G for further information.

Appendix L – Research recommendations

Research recommendations for review questions:

B.3a What psychological and psychosocial rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

B.3b What psychological and psychosocial rehabilitation interventions are effective and acceptable for children and young people with complex rehabilitation needs after traumatic injury?

Research question

What is the effectiveness of rehabilitation programmes combined with self-management materials compared with rehabilitation programmes alone in people with complex rehabilitation needs after a traumatic injury?

Why this is important?

Currently, standard rehabilitation for individuals with traumatic injuries lack self-management material to complement currently utilised rehabilitation methods such as therapist-led individual or groups sessions. There are many areas of rehabilitation that could be supported with good quality material.

The evidence is unclear whether providing self-management material would be effective in helping the people rehabilitate following traumatic injuries. However, it has been utilised effectively with other patient groups (for example, people suffering with arthritic pain and type 2 diabetes. There would be an initial cost to produce the material, however high volume of patients and their carers and family could benefit from this material. It may also reduce the need for people to utilise certain resources (for example, GP consultations).

Table 26: Research recommendation rationale

Research question	
Why is this needed	
Importance to 'patients' or the population	Rehabilitation for patients can be complex and multifaceted. No single professional will be an 'expert' in all the areas that the patient may require help for example from pain management to sleep issues to dietary advice. Furthermore, there may be questions that patients feel uneasy asking their medical team or therapists. Rehabilitation aims to maximise people's independence, and the ability to self-manage aspects of their rehabilitation is important in progress towards their own individual goals. Self-management materials may be helpful for patients and their carers to take ownership of aspects of their rehabilitation and thus lead to improvements in their health-related quality of life and general well-being. It may also reduce the resource impact on other services e.g. G.P. appointments.

Research question	
Relevance to NICE guidance	High - The committee were unable to issue strong recommendations on the use of self-management material alongside rehabilitation interventions due to a lack good quality evidence. The committee used their experience and expertise and evidence of low certainty to make weak recommendations instead. By conducting research in this area, it is hoped that more definitive NICE guidance on the use of self-management materials in rehabilitation can be issued in future iterations of this guideline.
Relevance to the NHS	High – it already exists in some NHS patient groups e.g. Escape-pain programme for those with arthritic pain and HeLP Diabetes an online tool for those with type 2 diabetes. With a moderate initial outlay, the materials could be provided to a high volume of patients and family/carers. Whilst improving the patient's quality of life it may also have positive resource implications throughout the patient's rehabilitation journey such as reduction in GP appointments.
National priorities	• The NHS long term plan (2019) supports self-management programmes in a number of clinical areas e.g. diabetes. The long term plan also wants digital technology to be driving the way for patient's to access advice and care.
Current evidence base	Four studies (3 randomised controlled trials and 1 non-randomised comparative study) conducted in diverse adult populations with complex rehabilitation needs (adults with ≥ 1 extremity injury; older adults with hip or vertebral fracture; adults with chronic spinal cord injury; and adults with burns, respectively) investigating the use of wide-varying self-management interventions (standard care plus access to a trauma support network versus standard care alone; small-group learning programme plus home-training schedule versus standard care and rehabilitation; active behaviour intervention programme plus information booklet versus single information meeting and information booklet; and motivational self-care CD plus routine self-care information versus routine self-care information alone, respectively). The evidence provided by these 4 studies were of low or very low certainty for all reported outcomes.
Equality	Self-management materials already exist for certain NHS patient groups e.g. chronic pain patients. All people with complex trauma deserve to receive optimal care and materials, just like other patient groups, to achieve the best possible outcomes.
Feasibility	A prospective multi-centre randomised controlled trial would allow trauma units to continue their

Research question	
	current rehabilitation ('standard care') and should have little impact on their practice.
Other comments	• None.

NHS: National Health Service; NICE: National Institute for Health and Care Excellence; RCT: randomised controlled trial

Table 27: Research recommendation modified PICO table

Criterion	Explanation
Population	• People with complex rehabilitation needs resulting from traumatic injury that requires admission to hospital
Intervention	• Rehabilitation programme combined with self-help materials, e.g., booklets, video, apps.
Comparator	• Same rehabilitation programme as the intervention group, but without self-help materials
Outcomes	• Overall quality of life (validated scales) • Patient acceptability (any direct measure) • Changes in activity of daily living (validated scales) • Changes in mood (validated scales) • Return to nursery, education or work • Resource use i.e., hospital re-admissions, outpatient visits, primary and community care visits
Study design	Randomised controlled trial
Timeframe	12-24 months
Additional information	None.