National Institute for Health and Care Excellence

Draft for consultation

Rehabilitation in adults with complex psychosis and related severe mental health conditions

[G] Integrated rehabilitation care pathways involving multiple providers

NICE guideline TBC

Evidence review

January 2020

Draft for Consultation

This evidence review was developed by the National Guideline Alliance which is part of the Royal College of Obstetricians and Gynaecologists

Disclaimer

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive. All NICE guidance is subject to regular review and may be updated or withdrawn.

ISBN:

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Integrated rehabilitation care pathways involving multiple providers

Review question 2.4 What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

Introduction

For the full range of rehabilitative support it is likely that services users will need to be seen by multiple providers. This review sought to determine the factors that facilitate successful cooperation amongst multiple providers to produce an effective care pathway, as well as the factors that can hinder this collaboration.

Summary of the protocol

Please see Table 1 for a summary of the Population, Interest and Context (PICo) characteristics of this review.

Table 1: Summary of the protocol (PICo table)

Population	Staff/Services who work with adults with complex psychosis and related severe mental health conditions in or alongside providing rehabilitation services. Also users of these services themselves and their families and carers.
Phenomena of interest	Facilitators: • Named lead-coordinator for each individual who understands and carries out their responsibilities who has appropriate skills for placement review (CPA care management processes). • Defining who's responsible for each component. • Explicit shared goals, visions and outcomes • Inclusive of preferences of service users, staff and family/carers • Focus on person rather than service. • Good communication between services • Clear strategy for rehabilitation and supported accommodation. • Shared budget • Integrated treatment plan • System of regular inspection, review + monitor by commissioning provider • Each locality has complex care team/community rehab team and/or panel • Inclusion of experts by experience Barriers: • Distance • Urban versus rural location • Social healthcare system versus Private healthcare system • Different professions and specialisations (e.g. mental health versus addiction)

	• Financial factors, including repeated reinvention and retendering • High staff turnover (failure of long-term contracting). • Skillset to fill out funding applications for funding panel. • Management of housing – not understanding or cooperative • Use of Mental Capacity Act 2005 in timely manner. • Comorbidities within individual
Context	Countries: UK, Australasia, Europe, USA, Canada. Date: Studies conducted post 1990

CPA = Care Program Approach

For further details see the review protocol in appendix A

Clinical evidence

Included studies

A total of 13 qualitative studies were identified investigating the factors that facilitate successful cooperation amongst multiple providers to produce an effective care pathway, and the factors that hinder this collaboration.

One of the studies identified was from the UK, 1 was from the Australia, 3 were from Sweden and 5 were from the USA. There was also 1 study from the Netherlands and 2 from Canada.

The included studies were published between 2003 and 2018. Five of the studies utilised semi-structured interviews, one used structured interviews, one used open interviews, and one used focus groups only. The remaining five used a mix of qualitative methods.

The included studies are summarised in Table 2. See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review with reasons for their exclusions are provided in appendix K.

Summary of clinical studies included in the evidence review

A summary of the studies that were included in this review are presented in Table 2. See the full evidence tables in appendix D and map of the themes in Appendix E.

Table 2: Summary of included studies

Study, country and aim	Participants	Methods	Themes
Bejerholm 2011 **Country** Sweden **Aim of the study** To illustrate the IPS approach in the Swedish welfare system and thus the welfare	**Sample size** Unclear number of staff, directors and participants of an RCT **Diagnoses** People with severe mental illness **Characteristics** Demographic details not reported. Participants were involved in the IPS intervention arm of an RCT as staff, directors and participants.	**Recruitment details** Unclear **Data collection details** Mixed qualitative methods **Analysis details** Content analysis	• A shared vision • Practicalities of integrating • Service landscape

Study, country and aim	Participants	Methods	Themes
Bengtsson-Tops 2014 **Country** Sweden **Aim of the study** To describe user experiences of living in supportive housing for people with SMI	**Sample size** 16 landlords (mixed private and publicly owned) **Diagnoses** Severe mental illness - defined as psychiatric symptoms such as hallucinations, delusions or paranoia **Characteristics** Sex (M/F) = 9/7; Mean age (Range) = 45.5 (25-62)	**Recruitment details** Purposefully sampled to cover both rural and urban communities as well as big and small companies **Data collection details** Open interviews **Analysis details** Thematic latent content analysis	• Practicalities of integrating • Service landscape
Berry 2017 **Country** UK **Aim of the study** To identify the effects of formulation on practice from the perspectives of staff and patient participating in the trial, including barriers and enhancers to implementing the intervention.	**Sample size** 57 staff and 20 inpatients of psychiatric rehabilitation wards **Diagnoses** Schizophrenia = 80%, schizoaffective disorder (10%), bipolar disorder (10%) **Characteristics** Staff: Mean age (range) = 41.67 (11.22); Gender (M/F) = 33.3%, 66.7%; White = 86%, Black = 14% Patients: Mean age (range) = 36.2 (11.93); Gender (M/F) = 65%/35%; White = 85%, Black = 10%, Mixed = 5%	**Recruitment details** Purposive sampling of all staff and patients still present on the wards at the 6-month follow-up of an RCT intervention testing 'team formulation' **Data collection details** Semi-structured interviews **Analysis details** Thematic analysis	• A shared vision • Staff animosities
Chen 2014 **Country** USA **Aim of the study** To add depth and details to the CTI model description and to support broad implementation of critical time interventions	**Sample size** 12 CTI (critical time intervention) workers **Diagnoses** Severe mental illness **Characteristics** Mean age (SD) = 37.5 (8.5); Gender: Male/Female = 8/4; Race: Asian = 1, Black = 5, Hispanic = 5, White = 1	**Recruitment details** Approached practitioners from four community agencies providing CTI services **Data collection details** Semi-structured interviews **Analysis details** Thematic analysis.	• Practicalities of integrating • Staff animosities
Dadich 2013 **Country** Australia **Aim of the study** To understand how non-clinical case managers can work effectively with clinical services	**Sample size** 20 service users 22 family members and mental health **Diagnoses** Chronic mental illness - most had a primary diagnosis of schizophrenia **Characteristics** Consumers' mean age was 37 years	**Recruitment details** Twenty services users were randomly approached, with equal representation from the three NGOs involved **Data collection details** Semi-structured interviews **Analysis details** Constant comparison analysis followed by member checking	• A shared vision • Practicalities of integrating

Study, country and aim	Participants	Methods	Themes
Drake 2003 **Country** USA **Aim of the study** To understand how non-clinical case managers can work effectively with clinical services	**Sample size** Not stated **Diagnoses** Severe mental illness **Characteristics** Not reported - found in three constituent study reports	**Recruitment details** Data taken from unpublished qualitative data from three other studies, each with their own recruitment procedures. **Data collection details** Mixed qualitative methods **Analysis details** Themes consistent across the three studies were reported	• Practicalities of integrating • Staff animosities
Hansson 2010 **Country** Sweden **Aim of the study** To describe the development and nature of coordination within a mental health and social care consortium and to assess the impact on care processes and client outcomes	**Sample size** 6 joint-coordinators **Diagnoses** Mental health clients in rehabilitation - the majority of whom are diagnosed with schizophrenia **Characteristics** Not reported. Authors deliberately omitted this information.	**Recruitment details** Those most available, recruited from three rehabilitation units. **Data collection details** Structured interviews **Analysis details** Basic content analysis	• A shared vision • Practicalities of integrating • Staff animosities
Kumar 2017 **Country** Canada **Aim of the study** To identify challenges and facilitators of sustaining a Housing First intervention at the conclusion of a research demonstration project in Toronto.	**Sample size** 13 organizational leaders, 14 service team members and 9 program participants **Diagnoses** Serious mental illness **Characteristics** Not reported.	**Recruitment details** Not reported. **Data collection details** Mixed qualitative methods. **Analysis details** Thematic analysis.	• A shared vision • Funding
McGinty 2018 **Country** USA **Aim of the study** To examine the implementation of a unique model for integrating behavioural, somatic, and social services for people with serious mental illness.	**Sample size** 41 nurse care managers, 31 psychiatric rehabilitation program directors **Diagnoses** Serious mental illness **Characteristics** Sex % (M/F) = 15/85, White/Not white % = 78/22	**Recruitment details** Leaders at all active Maryland sites were asked to participate. **Data collection details** Semi-structured interviews **Analysis details** Thematic analysis.	• A shared vision • Practicalities of integrating • Service landscape
Oulvey 2013 **Country** USA **Aim of the study** Examine strategies for Vocational Rehabilitation to enhance employment outcomes through better collaboration with IPS programs.	**Sample size** 21 groups of between 4 and 13 staff, professionals or consumers. **Diagnoses** Severe mental illness **Characteristics** Not reported.	**Recruitment details** Not reported. **Data collection details** Focus groups. **Analysis details** Thematic analysis.	• A shared vision • Funding

Study, country and aim	Participants	Methods	Themes
Pogoda 2011 **Country** USA **Aim of the study** To document perceived barriers to supported employment implementation as described by Department of Veterans Affairs employees.	**Sample size** 84 staff **Diagnoses** Serious mental illness **Characteristics** Not reported.	**Recruitment details** Unclear. **Data collection details** Semi-structured interviews **Analysis details** Inductive and a deductive thematic analysis	• A shared vision • Staff animosities
Rebeiro Gruhl 2012 **Country** Canada **Aim of the study** To examine the influence of place on access to employment for persons with serious mental illness	**Sample size** 46 staff and service users **Diagnoses** Serious mental illness **Characteristics** Not reported.	**Recruitment details** Purposive sampling. **Data collection details** Mixed qualitative methods. **Analysis details** Thematic analysis.	• A shared vision • Staff animosities • Service landscape • Funding
Vukadin 2018 **Country** The Netherlands **Aim of the study** To improve IPS implementation by improving the collaboration between all organizations involved, and realising secured IPS funding with a 'pay for performance' element.	**Sample size** 8 practitioners and 7 decision makers **Diagnoses** Severe mental illness **Characteristics** Not reported.	**Recruitment details** All stakeholders in the region asked to join. **Data collection details** Semi-structured interviews. **Analysis details** Thematic content approach.	• A shared vision • Practicalities of integrating • Staff animosities • Funding

CTI: critical time intervention; IPS: individual placement and support; M/F: male/female; NGO: non-government organisation; RCT: randomised controlled trial; SD: standard deviation; SMI: serious mental illness

See the full evidence tables in appendix D and the theme map in Appendix E.

Quality assessment of clinical outcomes included in the evidence review

See the clinical evidence profiles in appendix F and quotes extracted from the qualitative studies in appendix M.

Economic evidence

Included studies

A systematic review of the economic literature was conducted but no economic studies were identified which were applicable to this review question.

Excluded studies

Studies not included in this review with reasons for their exclusions are provided in appendix K.

Summary of studies included in the economic evidence review

No economic evidence was identified for this review (and so there are no economic evidence tables).

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation. Furthermore, only a qualitative review was being undertaken for this question and therefore there was no effectiveness evidence available to inform economic modelling.

Qualitative evidence statements

Theme 1) A shared vision

1.1) Services work better together when they have shared ethos and end goals. Integration is less successful when services approach rehabilitation from different theoretical positions. This was based on moderate quality evidence from 5 studies from Sweden, UK, USA and Canada.

1.2) Collaborations work better when services accommodate each other and present a united front to the service user. This may require some changes to staff roles, systems and ways of working. This was based on moderate quality evidence from 4 studies from Australia, Sweden and USA.

1.3) Services integrate more successfully when they make the client the centre of the service and collaborate around them. They must be prepared to tailor their services to the individual needs of service users, while taking care not to make the service user feel 'ganged up' on. This was based on low quality evidence from 4 studies from Sweden, UK and Australia.

1.4) Collaborations of services benefit from leadership champions that are enthusiastic about the vision of the integration. Services integrate less successfully when they don't have strong, clear support and inspiration from management driving it. This was based on moderate quality evidence from 3 studies from Canada, USA and the Netherlands.

Theme 2) Practicalities of integrating

2.1) Collaborations benefit from access to the same record systems, version of client goals etc. Services who use separate or incompatible systems find it harder to share information, and it is often duplicated and may be inconsistent. This was based on moderate quality evidence from 3 studies from Australia, Sweden and USA.

2.2) Integrations are more successful when each service and worker has clearly defined roles and responsibilities. These should be documented and available to refer to. This helps for reference and to resolve difficulties that arise. This was based on moderate quality evidence from 3 studies from Sweden, USA and the Netherlands.

2.3) Integrations are more successful when the staff involved are familiar with each other. Regular contact, updates and meetings allow the workers to build more functional and personal relationships. This was based on moderate quality evidence from 6 studies from Sweden, USA, Australia and the Netherlands.

Theme 3) Staff animosities

3.1) Integrations are more difficult when staff and services feel competitive with each other. Staff may mistrust outsiders or be wary of being judged by them. This was based on low quality evidence from 3 studies from UK, USA and Canada.

3.2) Integrations are less successful when team members don't understand the function of the other professionals, or appreciate the contributions of their role. Collaborations allow for new perspectives and a more holistic insight on service users. Integrations

are stronger when the members have experienced the effectiveness of other roles firsthand, or have been presented an explanation and evidence of the benefits. This was based on moderate quality evidence from 4 studies from UK, USA and Canada.

3.3) Integrations are more successfully when team members know they can rely on each other. Tension may arise when staff members must wait for another to complete their job before being able to continue theirs. This was based on very low quality evidence from 3 studies from USA and Sweden.

Theme 4) Service landscape

4.1) Welfare systems and housing services may take away someone's benefits or housing if they work more than a certain number of hours, causing a clash with employment services. This was based on very low quality evidence from 2 studies from Sweden and Canada.

4.2) Landlords are relied on for providing accommodation, but may not have any authority to instigate mental health support at times of crisis. This was based on low quality evidence from 1 study from Sweden.

4.3) Being geographically remote or collaborating across large rural areas could be a barrier to collaboration. Co-location of services facilitates integration. This was based on low quality evidence from 2 studies from USA and Canada.

Theme 5) Funding

5.1) Integrations are more successful when the collaboration project has its own funding. When funding for a collaboration ceases the individual services struggle to bridge the financial gap. Individual services may struggle to apply for funding using an evidence base taken from a collaborative project. This was based on low quality evidence from 3 studies from Canada and the Netherlands.

5.2) Climates of competitive funding or 'payment by results' diminish collaboration. Services that are competing for funding, or who don't stand to be paid unless they produce the result, do not want to risk losing payment for their work to competitors. This was based on very low quality evidence from 1 study from Canada.

5.3) Collaborations take time to foster, and short-term or temporary contracts make collaborations seem less worth the effort to services and staff. This was based on low quality evidence from 2 studies from USA and the Netherlands.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

This was a qualitative review and so the most important outcomes emerged from the themes rather than being predefined in the protocol. The committee felt the most important facilitator for the integration of services was a clear shared ethos amongst all levels of staff and services that the service-user's individual needs should be at the centre of all actions and decisions. The other important factors were strong leadership and direction, sufficient funding, a communicative and collaborative relationship between staff, and compatible systems for recording and sharing data and information.

The thematic map (see appendix E) was presented to the committee summarising the themes and also any interactions between them, although there were no interactions in this case.

The quality of the evidence

The evidence statements were assessed using GRADE CERQual methodology, and ranged in quality from very-low to moderate. Where the ratings were downgraded this was most often due to methodological limitations in the studies (individually assessed using the CASP quality ratings) limiting how much confidence could be had in their findings. For a couple of the evidence statements there was some downgrading due to adequacy of the data, as a few of the evidence statements had only had one or two studies supporting them. Only one of the studies identified was from a UK context, and so themes were also downgraded if they did not include UK insight or had been found in the context of at least three countries.

Benefits and harms

The committee felt that local and regional commissioners were the best placed to lead with making these changes happen. They began with a discussion about harmful funding models and the evidence that short sighted or siloed funding for multiple services is detrimental to rehabilitation. They agreed that competitive funding amongst services, or payment according to how many service users they had, could lead to a perverse incentive that discourages services from collaborating with each other and discourages them from supporting service users to move on to treatment avenues outside of their own. A more open pathway would allow other providers from across health and social care provision an option to develop services for individuals. They agreed that collaborative services needed a budget that is sufficient to facilitate stability and cooperation. Funding for collaboration amongst services would need to be 'front-loaded' to allow collaborations to start positively, build professional relationships and a service framework together, and then be sufficiently funded to maintain a service that follows the individuals through the pathway.

The evidence indicated that service integration is more successful when there is strong, clear support and inspiration from management driving it. For this reason, the committee recommended that health and social care commissioners should jointly designate a lead commissioner to oversee the commissioning of rehabilitation services. They considered this person would need to have in-depth knowledge and experience of commissioning effective rehabilitation services and the local rehabilitation services and partnerships which would help them to ensure that regular communication, shared budgets and collaborative funding mechanisms are in place.

The committee agreed that clearly defined roles were a good idea to ensure collaborating services understand who is responsible for what. However the committee were wary that this might also lead staff or organisations to neglect certain tasks that they perceived to be 'not their responsibility'. The committee agreed this would be reduced if there was an underlying agreement between services that they all shared a primary aim and responsibility to care for the person's overall wellbeing. They recommended that the integrated rehabilitation pathway is staffed by appropriately skilled staff with defined roles and responsibilities.

Evidence about the importance of compatible clinical record sharing was discussed by the committee – for example between the NHS and the independent sector at the point of a referral. They noted that systems for sharing records are slowly improving as technology is developed and implemented, but the risks around data security and privacy make it difficult. Duplication is wasteful and risks inconsistencies. They agreed that for any collaboration it is essential that there is some kind of system for sharing critical information about individuals for whom they share care.

The committee concurred with evidence that regular meetings (e.g. gatekeeping meetings) between collaborating services is an important aspect of collaboration to discuss progress and care plans of their service users, and to develop functional and personal relationships. Another benefit of regular meetings is to help different specialists gain a better understanding and increased respect for each other's role – a barrier identified in the evidence and recognised by the committee. Evidence suggested that having a shared location or at least

being geographically close makes this easier, however the committee did not want to make a recommendation suggesting that services should seek to collocate based on low quality evidence, as this seemed unrealistic with potentially significant cost implications. They agreed with evidence that distance or rurality of services might make successful collaboration harder, and so technological services (e.g. skype) should be utilised.

Evidence suggested that the service/funding landscape may leave gaps or cause the goals of different services to clash, and again the committee concluded that it was the responsibility for different staff and care-coordinators to collaborate via the shared primary aim of helping the service user move forward with their recovery. It was suggested that all services should remain involved in the multidisciplinary team and in gatekeeping meetings and discharge planning. To help ensure collaborative working in a timely and flexible way between relevant services and agencies the committee recommended service level agreements are developed.

The committee agreed that a shared, holistic vision to 'help the service user move forward with their recovery' was perhaps the most important factor in successful collaborations for rehabilitation. Staff and coordinators at all levels have a role in this – including gatekeepers of beds, plan discharges, and monitor ongoing needs. However the committee concluded that commissioners are ultimately the best placed people to lead on establishing a pathway and ensuring progress through services is possible to avoid prolonged inappropriate stays and delayed discharges. Commissioners have the power to create a system and outline the process, including arranging how services should integrate to make this happen, and so it was agreed that the vision needs to start with them.

Cost effectiveness and resource use

A systematic review of the economic literature was conducted but no relevant studies were identified which were applicable to this review question.

The committee believed that changes in attitude and practice amongst staff and services is already part of their role and so would not require additional cost. The recommendations that commissioners ensure collaborations are funded properly, could require more resources, however the committee believed more effective and collaborative service pathways will lead to a reduction in inpatient beds and crisis services used downstream.

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Appendices

Appendix A – Review protocols

Review protocol for review question 2.4 What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

Table 3: Review protocol for barriers and facilitators to integrated rehabilitation care pathways involving multiple providers

Field (based on PRISMA-P	Content
Review question	2.4 What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?
Type of review question	Qualitative systematic review
Objective of the review	To determine the factors that facilitate successful cooperation amongst multiple providers to produce an effective care pathway, as well as the factors that hinder this collaboration.
Eligibility criteria – population & disease	Staff/Services who work with adults with complex psychosis and related severe mental health conditions in or alongside providing rehabilitation services. Also users of these services themselves and their families and carers.
Eligibility criteria – intervention	N/A
Eligibility criteria – comparator	N/A
Outcomes and prioritisation	Themes and specific outcomes will be identified from the literature, but expected themes are: Facilitators • Named lead-coordinator for each individual who understands and carries out their responsibilities who has appropriate skills for placement review (CPA care management processes). • Defining who's responsible for each component. • Explicit shared goals, visions and outcomes

Field (based on PRISMA-P	Content
	• Inclusive of preferences of service users, staff and family/carers • Focus on person rather than service. • Good communication between services • Clear strategy for rehabilitation and supported accommodation. • Shared budget. • Integrated treatment plan. • System of regular inspection, review + monitor by commissioning provider. • Each locality has complex care team/community rehab team and/or panel. • Inclusion of experts by experience Barriers • Distance • Urban vs rural location • Social healthcare system vs Private healthcare system • Different professions and specialisations (e.g. mental health vs addiction) • Financial factors, including repeated reinvention and retendering • High staff turnover (failure of long-term contracting). • Skillset to fill out funding applications for funding panel. • Management of housing – not understanding or cooperative • Use of Mental Capacity Act 2005 in timely manner. • Comorbidities within individual
Eligibility criteria – study design	Qualitative studies: semi-structured and structured interviews, focus groups investigating experiences, needs, opinions and preferences on the provision of rehabilitation services. Qualitative components of effectiveness and mixed methods studies will be included. Systematic review findings will be extracted from directly if the quality and detail of their synthesis is high – in the case of low quality syntheses (where important details are lost) the component studies will be extracted from individually.

Field (based on PRISMA-P	Content
	Opinion pieces by authors will not be included. Policy papers will not be included, however any that are prominent/commonly mentioned and relevant to the current time and UK context will be highlighted in the discussion for context.
Other inclusion exclusion criteria	Other inclusion criteria: • Studies conducted post 1990 only. Studies before 1990 were included in the electronic search but then excluded during the manual sifting phase. The date limit for studies after 1990 was suggested by the committee considering the change in provision of mental health services from institutionalized care in the 1970s to deinstitutionalise and community based care from 1990s onwards. • Country limit: UK, USA, Australasia, Europe, Canada. The committee limited to these countries because they have similar cultures to the UK, given the importance of the cultural setting in which mental health rehabilitation takes place. Note for GRADE CERQual scoring: Findings that have only been observed in one or two non-UK countries may be culturally specific to that context and so will be downgraded. If a finding is replicated in 3 or more non-UK countries, it will be considered that there is a reasonable chance it's applicable in the UK context also and so will not be downgraded. • English language papers only • Complete peer reviewed papers only – abstracts, conferences papers and dissertations excluded.
Proposed sensitivity/sub-group analysis, or meta-regression	No subgroup analysis proposed
Selection process – duplicate screening/selection/analysis	Sifting, data extraction, appraisal of methodological quality and GRADE-CERQual assessment will be performed by the systematic reviewer. A random sample of the references identified in the search will be sifted by a second reviewer. This sample size of this pilot round will be 10% of the total, (with a minimum of 100 studies). Resolution of any disputes will be with the senior systematic reviewer and the Topic Advisor. Quality control will be performed by the senior systematic reviewer.
Data management (software)	NGA STAR software will be used for generating bibliographies and citations, study sifting, data extraction and recording quality assessment of studies. A GRADE-CERQual Microsoft Excel template will be used to record the overall quality of findings from the qualitative evidence; a Microsoft Excel template will also be used to organise data into themes

Field (based on PRISMA-P	Content
Information sources – databases and dates	Sources to be searched: Embase, Medline, PsycINFO, Cochrane library (CDSR and CENTRAL), DARE and HTA (via CRD) Limits (e.g. date, study design): Human studies/English language
Identify if an update	This review question is not an update
Author contacts	Developer: The National Guideline Alliance
Highlight if amendment to previous protocol	For details please see section 4.5 of Developing NICE guidelines: the manual 2014
Search strategy – for one database	For details please see appendix B
Data collection process – forms/duplicate	A standardised evidence table format will be used, and published as appendix D (clinical evidence tables) or H (economic evidence tables)
Data items – define all variables to be collected	A standardised evidence table format will be used, and published as appendix G (evidence tables) or H (economic evidence tables) of the guideline.
Methods for assessing bias at outcome/study level	For details please see evidence tables in appendix G (evidence tables) or H (economic evidence tables) of the guideline.
Criteria for quantitative synthesis (where suitable)	Standard study checklists were used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual 2014 Surveys would be assessed using the quality checklist for questionnaire surveys (CEBM checklist) listed as the preferred checklist in appendix H of the NICE guideline Manual (2018). The confidence in the evidence extracted from the included studies will be evaluated for each theme using GRADE CERQual approach: https://www.cerqual.org/
Methods for analysis – combining studies and exploring (in)consistency	For details please see section 6.4 of Developing NICE guidelines: the manual 2014
Meta-bias assessment – publication bias, selective reporting bias	For details please see the methods chapter of the guideline
Assessment of confidence in cumulative evidence	For details please see section 6.2 of Developing NICE guidelines: the manual 2014

Field (based on PRISMA-P	Content
Rationale/context – Current management	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual 2014
Describe contributions of authors and guarantor	For details please see the introduction to the evidence review in the guideline.
Sources of funding/support	A multidisciplinary committee [add link to history page of the guideline] developed the evidence review. The committee was convened by the NGA and chaired by Gillian Baird in line with section 3 of Developing NICE guidelines: the manual. Staff from the NGA undertook systematic literature searches, appraised the evidence, conducted meta-analysis and cost-effectiveness analysis where appropriate, and drafted the evidence review in collaboration with the committee. For details please see Developing NICE guidelines: the manual.
Name of sponsor	The National Guideline Alliance is funded by NICE and hosted by The Royal College of Obstetricians and Gynaecologists
Roles of sponsor	The National Guideline Alliance is funded by NICE and hosted by The Royal College of Obstetricians and Gynaecologists
PROSPERO registration number	NICE funds The National Guideline Alliance to develop guidelines for those working in the NHS, public health, and social care in England

CERQual: Confidence in the Evidence from Reviews of Qualitative Research; CPA = Care Program Approach; GRADE: Grading of Recommendations Assessment, Development and Evaluation; MCA: Mental Capacity Act; N/A: not applicable; NGA: National Guideline Alliance; NICE: National Institute for Health and Care Excellence; NHS: National Health Service; RCOG: Royal College of Obstetricians and Gynaecologist

Appendix B – Literature search strategies

Literature search strategies for review question 2.4: What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

Databases: Embase/Medline/PsycInfo

Date searched: 02/10/2018

#	Searches
1	exp psychosis/ use emczd
2	Psychotic disorders/ use ppez
3	exp psychosis/ use psyh
4	(psychos?s or psychotic).tw.
5	exp schizophrenia/ use emczd
6	exp schizophrenia/ or exp "schizophrenia spectrum and other psychotic disorders"/ use ppez
7	(exp schizophrenia/ or "fragmentation (schizophrenia)"/) use psyh
8	schizoaffective psychosis/ use emczd
9	schizoaffective disorder/ use psyh
10	(schizophren* or schizoaffective*).tw.
11	exp bipolar disorder/ use emczd
12	exp "Bipolar and Related Disorders"/ use ppez
13	exp bipolar disorder/ use psyh
14	((bipolar or bipolar type) adj2 (disorder* or disease or spectrum)).tw.
15	Depressive psychosis/ use emczd
16	Delusional disorder/ use emczd
17	delusions/ use psyh
18	(delusion* adj3 (disorder* or disease)).tw.
19	mental disease/ use emczd
20	mental disorders/ use ppez
21	mental disorders/ use psyh
22	(psychiatric adj2 (illness* or disease* or disorder* or disabilit* or problem*)).tw.
23	((severe or serious) adj3 (mental adj2 (illness* or disease* or disorder* or disabilit* or problem*))).tw.
24	(complex adj2 (mental adj2 (illness* or disease* or disorder* or disabilit* or problem*))).tw.
25	or/1-24
26	(Rehabilitation/ or cognitive rehabilitation/ or community based rehabilitation/ or psychosocial rehabilitation/ or rehabilitation care/ or rehabilitation center/) use emczd
27	(exp rehabilitation/ or exp rehabilitation centers/) use ppez
28	(Rehabilitation/ or cognitive rehabilitation/ or neuropsychological rehabilitation/ or psychosocial rehabilitation/ or independent living programs/ or rehabilitation centers/ or rehabilitation counselling/) use psyh
29	residential care/ use emczd
30	(residential facilities/ or assisted living facilities/ or halfway houses/) use ppez
31	(residential care institutions/ or halfway houses/ or assisted living/) use psyh
32	(resident* adj (care or centre or center)).tw.
33	(halfway house* or assist* living).tw.
34	((inpatient or in-patient or long-stay) adj3 (psychiatric or mental health)).tw.
35	(Support* adj (hous* or accommodat* or living)).tw.
36	(rehabilitation or rehabilitative or rehabilitate).tw.
37	rehabilitation.fs.
38	or/26-37
39	exp Interview/ use emczd

#	Searches
40	interview/ use ppez
41	interviews/ use psyh
42	(interview* adj3 (in-depth or indepth or semistructured or semi structured or unstructured or un structured)).tw.
43	(interview* and (attitude* or choice* or dissatisf* or expectation* or experienc* or inform* or opinion* or perceive* or perception* or perspective* or preferen* or priorit* or satisf* or view*)).tw.
44	open ended questionnaire/ use emczd
45	((open end* or openend*) adj3 questionnaire*).tw.
46	qualitative research/
47	qualitative*.tw.
48	(ethno* or fieldwork or field work or focus group* or grounded theory or key informant or theoretical sampl*).tw.
49	thematic analysis/ use emczd
50	(thematic* adj3 analys*).tw.
51	(parental attitude/ or patient satisfaction/ or patient preference/ or personal experience/) use emczd
52	(exp parental attitudes/ or exp client attitudes/) use psyh
53	exp patient satisfaction/ use ppez
54	((carer* or caregiver* or care giver* or famil* or father* or mother* or brother or sister or parent* or patient* or participant* or service user) adj2 (dissatisf* or experienc* or opinion* or perceive* or perspective* or preferenc* or satisf* or views)).tw.
55	shared decision making/ use emczd
56	((share* or collaborat*) adj3 decision).tw.
57	((access* or aversion or barrier* or facilitat* or hinder* or obstacle* or obstruct*) adj2 (intervention* or pathway* or program* or rehab* or service* or therap* or treat*)).ti,ab.
58	or/39-57
59	25 and 38 and 58
60	limit 59 to (yr="1970 - current" and english language)
61	animals/ not humans/ use ppez
62	animal/ not human/ use emczd
63	nonhuman/ use emczd
64	"primates (nonhuman)"/
65	exp Animals, Laboratory/ use ppez
66	exp Animal Experimentation/ use ppez
67	exp Animal Experiment/ use emczd
68	exp Experimental Animal/ use emczd
69	animal research/ use psyh
70	exp Models, Animal/ use ppez
71	animal model/ use emczd
72	animal models/ use psyh
73	exp Rodentia/ use ppez
74	exp Rodent/ use emczd
75	rodents/ use psyh
76	(rat or rats or mouse or mice).ti.
77	or/61-76
78	60 not 77
79	limit 78 to yr=1970-2005
80	limit 78 to yr=2006-2015
81	limit 78 to yr=2016 - current
82	remove duplicates from 79
83	remove duplicates from 80
84	remove duplicates from 81
85	82 or 83 or 84

1

1 **Database: Cochrane Library**

2 Date searched: 02/10/2018

#	Searches
1	MeSH descriptor: [Psychotic Disorders] explode all trees
2	(psychos?s or psychotic):ti,ab,kw
3	MeSH descriptor: [Schizophrenia] explode all trees
4	(schizophren* or schizoaffective*):ti,ab,kw
5	MeSH descriptor: [Bipolar Disorder] explode all trees
6	(((bipolar or bipolar type) near/2 (disorder* or disease or spectrum))):ti,ab,kw
7	MeSH descriptor: [Delusions] this term only
8	((delusion* near/3 (disorder* or disease))):ti,ab,kw
9	MeSH descriptor: [Mental Disorders] this term only
10	((psychiatric near/2 (illness* or disease* or disorder* or disabilit* or problem*))):ti,ab,kw
11	(((severe or serious) near/3 (mental adj2 (illness* or disease* or disorder* or disabilit* or problem*)))):ti,ab,kw
12	((complex near/2 (mental adj2 (illness* or disease* or disorder* or disabilit* or problem*)))):ti,ab,kw
13	(#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12)
14	MeSH descriptor: [Rehabilitation] this term only
15	MeSH descriptor: [Rehabilitation, Vocational] this term only
16	MeSH descriptor: [Residential Facilities] this term only
17	MeSH descriptor: [Assisted Living Facilities] this term only
18	MeSH descriptor: [Halfway Houses] this term only
19	((resident* near (care or centre or center))):ti,ab,kw
20	(((inpatient or in-patient or long-stay) near/3 (psychiatric or mental health))):ti,ab,kw
21	(((Support*) near (hous* or accommodat* or living))):ti,ab,kw
22	((halfway house* or assist* living)):ti,ab,kw
23	(rehabilitation or rehabilitative or rehabilitate):ti,ab,kw
24	(#14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21 OR #22 OR #23)
25	MeSH descriptor: [Interviews as Topic] explode all trees
26	(interview* near/3 (in-depth or indepth or semistructured or semi structured or unstructured or un structured)):ti,ab,kw
27	(interview* and (attitude* or choice* or dissatisf* or expectation* or experienc* or inform* or opinion* or perceive* or perception* or perspective* or preferen* or priorit* or satisf* or view*)):ti,ab,kw
28	((open end* or openend*) near/3 questionnaire*):ti,ab,kw
29	MeSH descriptor: [Qualitative Research] explode all trees
30	qualitative*:ti,ab,kw
31	(ethno* or fieldwork or field work or focus group* or grounded theory or key informant or theoretical sampl*):ti,ab,kw
32	(thematic* near/3 analys*):ti,ab,kw
33	MeSH descriptor: [Patient Satisfaction] explode all trees
34	((carer* or caregiver* or care giver* or famil* or father* or mother* or brother or sister or parent* or patient* or participant* or service user) near/2 (dissatisf* or experienc* or opinion* or perceive* or perspective* or preferenc* or satisf* or views)):ti,ab,kw
35	((share* or collaborat*) near/3 decision):ti,ab,kw
36	((access* or aversion or barrier* or facilitat* or hinder* or obstacle* or obstruct*) near/2 (intervention* or pathway* or program* or rehab* or service* or therap* or treat*)):ti,ab,kw
37	(#25 OR #26 OR #27 OR #28 OR #29 OR #30 OR #31 OR #32 OR #33 OR #34 OR #35 OR #36)
38	(#13 AND #24 AND #37) with Cochrane Library publication date between Jan 1970 and Nov 2018

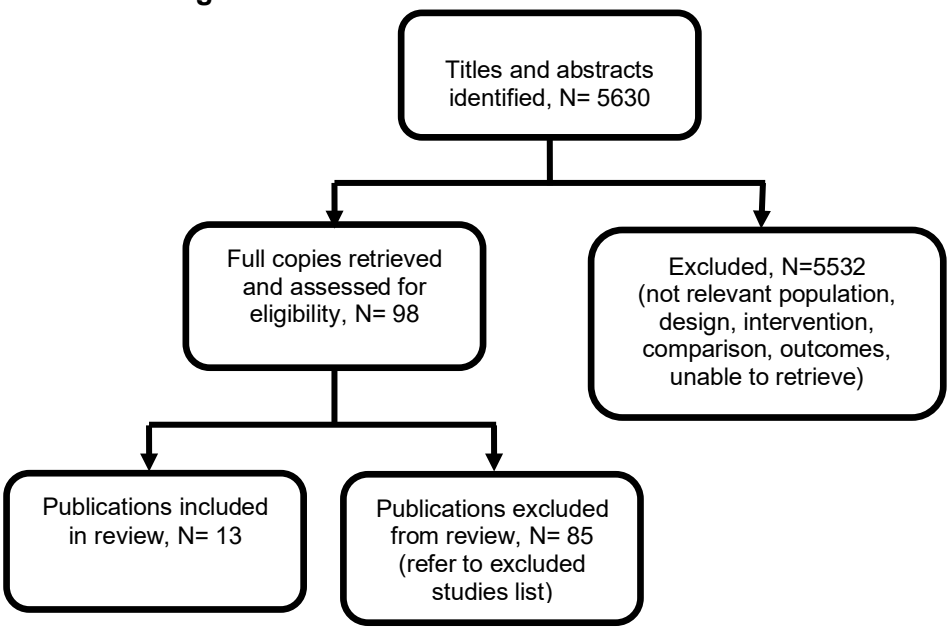
3

4

Appendix C – Clinical evidence study selection

Clinical study selection for review question 2.4: What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

Figure 1: Flow diagram of clinical article selection



Appendix D – Clinical evidence tables

Clinical evidence tables for review question 2.4 What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

Table 4: Clinical evidence tables

Study details	Participants	Methods	Themes and findings	Comments
Full citation Bejerholm, U., Larsson, L., Hofgren, C., Individual placement and support illustrated in the Swedish welfare system: A case study, Journal of Vocational Rehabilitation, 35, 59-72, 2011 **Ref Id** 905985 **Country where the study was carried out** Sweden **Study type** Mixed qualitative methods **Aim of the study** To illustrate the IPS approach in the Swedish welfare system and thus the welfare **Date of data collection** N/S **Source of funding**	**Sample size** Unclear number of staff, directors and participants of an RCT **Diagnosis** People with severe mental illness **Characteristics** Unclear **Inclusion criteria** Those involved in the IPS intervention arm of an RCT as staff, directors and participants. **Exclusion criteria** N/S	**Phenomenon of interest** The experiences of those involved in the implementation of an IPS intervention in Sweden **Recruitment Details** Unclear **Collection Details** Interview data was derived from fidelity assessments - interviews using the Supported Employment Fidelity Scale (SEFS). Findings were either digitally recorded or written down, and transcribed. **Analysis Details** Content analysis was conducted on the data, analysed between two of the authors. Data came from the interviews to construct categories, and these were reinforced by data from	**Findings:** IPS and welfare regulations Interpreting and communicating rules and regulations Time added to IPS **Findings are summarised under the following themes:** A shared vision Practicalities of integrating Service landscape	**Limitations (CASP: checklist for qualitative studies)** **Q1: Was there a clear statement of the aims of the research?** Unclear - there was an aim, but it was quite passive. **Q2: Was a qualitative methodology appropriate?** Yes **Q3 Was the research design appropriate to address the aims of the research?** Unclear - the data used was a by-product of the intervention and its planned analysis. This qualitative analysis seems to have been an afterthought eith available data rather than a deliberate piece of research. **Q4: Was the recruitment strategy appropriate to the aims of the research?** Unclear - an opportunity sample was taken from staff and participants involved in the trial, although it is unclear exactly who was chosen, who was not included and why. **Q5: Were the data collected in a way that addressed the research issue?** Unclear - The data was a byproduct of the intervention, and this was described - they were not seeking answers to a clear issue.

Study details	Participants	Methods	Themes and findings	Comments
Swedish Council for Social Research and Working Life, Finsam in Malmo, and the Vardal Institute for financial support.		some of the other written and qualitative sources.		**Q6: Has the relationship between researcher and participants been adequately considered?** Unclear - they discuss that a bias may be present, but it was not clearly addressed or accounted for. **Q7: Have ethical issues been taken into consideration?** Unclear - The larger study has approval from an ethics board, but there is not a detailed discussion of the ethics of this qualitative analysis. **Q8: Was the data analysis sufficiently rigorous?** Yes - described well **Q9: Is there a clear statement of findings?** Unclear - there are broad titles, and the findings are discussed quite generally without much supporting quotations. **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - it is not certain how well it will apply to a UK context **Overall methodological limitations** Serious
Full citation Bengtsson-Tops, A., Hansson, L., Landlords' experiences of housing tenants suffering from severe mental illness: a Swedish empirical study, Community Mental Health Journal, 50, 111-119, 2014 **Ref Id** 906003 **Country where the study was carried out**	**Sample size** 16 landlords (mixed private and publicly owned) **Diagnosis** Severe mental illness - defined as psychiatric symptoms such as hallucinations, delusions or paranoia and having difficulties in social	**Phenomenon of interest** Landlords' experiences of having tenants suffering from SMI. **Recruitment Details** Purposefully sampled to cover both rural and urban communities as well as big and small companies. **Collection Details**	**Findings:** Neglected When Needing Help: seeking collaboration **Findings are summarised under the following themes:** Practicalities of integrating	**Limitations (CASP: checklist for qualitative studies)** **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?** Yes **Q3 Was the research design appropriate to address the aims of the research?** Yes, sought experiences

Study details	Participants	Methods	Themes and findings	Comments
Sweden **Study type** Open interviews **Aim of the study** To describe landlords' experiences of having tenants suffering from severe mental illness **Date of data collection** Winter 2010 **Source of funding** N/S	interaction and managing everyday life. **Characteristics** Sex (M/F) = 9/7 Mean age (Range) = 45.5 (25-62) **Inclusion criteria** Consented to participate **Exclusion criteria** N/S	Open, face-to-face, in-depth interviews. These took place at the participants' workplaces, lasted 30-60mins and were subsequently transcribed by the author. Interviewers asked two main questions - (1) What are your experiences of housing tenants suffering from SMI? (2) How do you go about working with these tenants? **Analysis Details** Thematic latent content analysis.	Service landscape	**Q4: Was the recruitment strategy appropriate to the aims of the research?** Yes, sought a range of experiences **Q5: Were the data collected in a way that addressed the research issue?** Yes **Q6: Has the relationship between researcher and participants been adequately considered?** No **Q7: Have ethical issues been taken into consideration?** Yes **Q8: Was the data analysis sufficiently rigorous?** Yes - clearly described **Q9: Is there a clear statement of findings?** Yes **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - it is not clear how well the findings relate to a UK context **Overall methodological limitations** Minor
Full citation Berry, K., Haddock, G., Kellett, S., Awenat, Y., Szpak, K., Barrowclough, C., Understanding Outcomes in a Randomized Controlled Trial of a Ward-based	**Sample size** 57 staff and 20 inpatients of psychiatric rehabilitation wards **Diagnosis**	**Phenomenon of interest** Views of cross-professional 'team formulation' sessions **Recruitment Details** Purposive sampling of all staff and patients still	**Findings:** Improved staff team working Overcoming initial anxiety	**Limitations (CASP: checklist for qualitative studies)** **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?**

Study details	Participants	Methods	Themes and findings	Comments
Intervention on Psychiatric Inpatient Wards: A Qualitative Analysis of Staff and Patient Experiences, Journal of clinical psychology, 73, 1211-1225, 2017 **Ref Id** 906026 **Country where the study was carried out** UK **Study type** Semi-structured interviews **Aim of the study** To identify the effects of formulation on practice from the perspectives of staff and patient participating in the trial, including barriers and enhancers to implementing the intervention. **Date of data collection** 2011 - 2013 **Source of funding** Funded by a National Institute of Health Research Postdoctoral Fellowship	Schizophrenia = 80%, schizoaffective disorder (10%), bipolar disorder (10%) **Characteristics** Staff: Mean age (range) = 41.67 (11.22) Gender (M/F) = 33.3%, 66.7% White = 86%, Black = 14% Patients: Mean age (range) = 36.2 (11.93) Gender (M/F) = 65%/35% White = 85%, Black = 10%, Mixed = 5% **Inclusion criteria** Criteria for staff and patients: (a) at least 3 months experience of working or residing on the ward, (b) no plans to leave within the next 6 months, and (c) informed consent as assessed by trained researchers. **Exclusion criteria** Staff were excluded if they worked only nights as collaborative	present on the wards at the 6-month follow-up of an RCT intervention testing 'team formulation' **Collection Details** Employed a flexible topic guide comprised of semistructured questions. The guide evolved overtime as a result of both new themes emerging. Interviews were audio-recorded and transcribed verbatim. **Analysis Details** Interviews were transcribed and thematic analysis was conducted. Each transcript was coded by the first author and at least one of the student researchers.	**Findings are summarised under the following themes:** A shared vision Staff animosities	Yes **Q3 Was the research design appropriate to address the aims of the research?** Yes, sought experiences and perspectives **Q4: Was the recruitment strategy appropriate to the aims of the research?** No - this was a rehabilitation ward yet only the experiences of those present 6 months after implementation were sought. Many of the most relevant participants may have left the ward by then. **Q5: Were the data collected in a way that addressed the research issue?** Yes **Q6: Has the relationship between researcher and participants been adequately considered?** Yes - although an external researcher the acknowledges the author had an investment in the study and so may have unintentionally biased the interviewees. **Q7: Have ethical issues been taken into consideration?** Yes - informed consent sought, and ethics board approved. **Q8: Was the data analysis sufficiently rigorous?** Yes **Q9: Is there a clear statement of findings?** Yes - and clearly backed up with quotes and explanation **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Yes - UK context

Study details	Participants	Methods	Themes and findings	Comments
	sessions took place in the day only.			**Overall methodological limitations** Moderate
Full citation Chen, F., Developing community support for homeless people with mental illness in transition, Community Mental Health Journal, 50, 520-530, 2014 **Ref Id** 906347 **Country where the study was carried out** USA **Study type** Semi-structured interviews **Aim of the study** To add depth and details to the CTI model description and to support broad implementation of critical time interventions **Date of data collection** June - November 2008 **Source of funding** Funding was provided by the Columbia Center for Homelessness Prevention Studies	**Sample size** 12 CTI workers (critical time intervention) **Diagnosis** Severe mental illness **Characteristics** Mean age (SD) = 37.5 (8.5) Gender: Male/Female = 8/4 Race: Asian = 1, Black = 5, Hispanic = 5, White = 1 **Inclusion criteria** Opportunity sample of all 13 CTI workers trained and practising in New York City. **Exclusion criteria** N/S	**Phenomenon of interest** Experiences that were significant from the professionals' own perspectives. **Recruitment Details** All four community agencies providing CTI services were approached for the details of practitioners, who were contacted directly and asked to consent. **Collection Details** Semi-structured, audio-taped interviews lasted from 40 to 90 min. Questions were generic and open-ended. Questions in later interviews evolved on the basis of ongoing analysis to facilitate theoretical sampling. **Analysis Details** Thematic analysis. Transcribed interviews were coded first line-by-line, and then connections across these concepts were formulated.	**Findings:** Developing a Worker–Primary Support Relationship **Findings are summarised under the following themes:** Practicalities of integrating Staff animosities	**Limitations (CASP: checklist for qualitative studies)** **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?** Yes **Q3 Was the research design appropriate to address the aims of the research?** Yes, sought experiences of practitioners **Q4: Was the recruitment strategy appropriate to the aims of the research?** Yes - sought the experiences of every practitioner in their region. Currently only a small population. **Q5: Were the data collected in a way that addressed the research issue?** Yes **Q6: Has the relationship between researcher and participants been adequately considered?** Unclear - not discussed, however there was no obvious power relationship between the author and the interviewees. **Q7: Have ethical issues been taken into consideration?** **Q8: Was the data analysis sufficiently rigorous?** Unclear who did it, any verification

Study details	Participants	Methods	Themes and findings	Comments
				Q9: Is there a clear statement of findings? Yes - ethics board approved, and informed consent sought **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - not certain how this applies to a UK context **Overall methodological limitations** Minor
Full citation Dadich, A., Fisher, K. R., Muir, K., How can non-clinical case management complement clinical support for people with chronic mental illness residing in the community?, Psychology, health & medicine, 18, 482-489, 2013 **Ref Id** 906568 **Country where the study was carried out** Australia **Study type** Semi-structured interviews **Aim of the study** To understand how non-clinical case managers can work effectively with clinical services **Date of data collection** N/S	**Sample size** 20 service users 22 family members and mental health workers **Diagnosis** Chronic mental illness - most had a primary diagnosis of schizophrenia **Characteristics** Demographic information was provided for 14 of the 20 consumers. Consumers' mean age was 37 years. **Inclusion criteria** Service users and stakeholders involved in the mental health Housing and Accommodation Support Initiative	**Phenomenon of interest** Practices that facilitate (a) psychosocial rehabilitation, (b) consumer involvement and (c) service integration. **Recruitment Details** Twenty services users were randomly approached, with equal representation from the three NGOs involved. All consented to participate. **Collection Details** Semi-structured, open-ended interview schedules were used to guide the interviews. **Analysis Details** Analysis involved two interrelated processes – constant comparison analysis and member checking. After coding themes were identified relating to the study aims,	**Findings:** Consumer needs, preferences and clinical considerations Inclusive, active partner participation **Findings are summarised under the following themes:** A shared vision Practicalities of integrating	**Limitations (CASP: checklist for qualitative studies)** **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?** Yes **Q3 Was the research design appropriate to address the aims of the research?** Yes, sought barriers and facilitators **Q4: Was the recruitment strategy appropriate to the aims of the research?** Unclear - no clear inclusion or exclusion criteria were given, or an explanation of why not. **Q5: Were the data collected in a way that addressed the research issue?** Unclear - it is not clear who conducted the interviews, if the interviews were taped, or whether they were transcribed for coding. **Q6: Has the relationship between researcher and participants been adequately considered?** Unclear - not discussed.

Study details	Participants	Methods	Themes and findings	Comments
Source of funding Based on research commissioned by NSW Health	(HASI) were approached. **Exclusion criteria** N/S	compared between sites, and then discussed with the stakeholders.		**Q7: Have ethical issues been taken into consideration?** Yes - approval from an ethics board and consent sort. Most of the ethical considerations are discussed in a separate report on the intervention. **Q8: Was the data analysis sufficiently rigorous?** Yes **Q9: Is there a clear statement of findings?** Yes - sufficient with discussion and quotes. **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - not clear how applicable the findings are to a UK context **Overall methodological limitations** Moderate
Full citation Drake, R. E., Becker, D. R., Bond, G. R., Mueser, K. T., A process analysis of integrated and non-integrated approaches to supported employment, Journal of Vocational Rehabilitation, 18, 51-58, 2003 **Ref Id** 906752 **Country where the study was carried out**	**Sample size** N/S **Diagnosis** Severe mental illness **Characteristics** N/S (found in three constiuent study reports)	**Phenomenon of interest** Why integrated services appear to yield better employment outcomes than non integrated services **Recruitment Details** Data taken from unpublished qualitative data from three other studies, each with their own recruitment procedures. **Collection Details**	**Findings:** Communication The philosophy of mental health treatment **Findings are summarised under the following themes:** Practicalities of integrating Staff animosities	**Limitations (CASP: checklist for qualitative studies)** **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?** Yes **Q3 Was the research design appropriate to address the aims of the research?** Yes - experiences of service integration. **Q4: Was the recruitment strategy appropriate to the aims of the research?** Unclear - the recruitment strategies of the three included studies was not reported here.

Study details	Participants	Methods	Themes and findings	Comments
USA **Study type** Mixed qualitative methods **Aim of the study** To understand how non-clinical case managers can work effectively with clinical services **Date of data collection** N/S **Source of funding** Supported by U.S. Public Health Service grants from the National Institute of Mental Health and the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration	**Inclusion criteria** Data taken from unpublished qualitative data from three other studies, each with their own inclusion criteria. **Exclusion criteria** N/S	Interviews with supervisors and practitioners were reviewed to identify themes. **Analysis Details** Findings that were consistent across the three studies were presented.		**Q5: Were the data collected in a way that addressed the research issue?** Unclear - the data collection methods of the three included studies was not reported here. **Q6: Has the relationship between researcher and participants been adequately considered?** Unclear - the considerations of the three included studies was not reported here. **Q7: Have ethical issues been taken into consideration?** Unclear - the ethical considerations of the three included studies were not reported here. **Q8: Was the data analysis sufficiently rigorous?** No - the considerations of the three included studies was not reported here. The method for synthesis in this report was seemingly very crude. **Q9: Is there a clear statement of findings?** Yes **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - the applicability of the findings to a UK context is not clear. **Overall methodological limitations** Moderate
Full citation Hansson, J., Ovretveit, J., Askerstam, M., Gustafsson, C., Brommels, M., Coordination in networks for improved mental health service, International Journal	**Sample size** 6 joint-coordinators **Diagnosis** Mental health clients in rehabilitation - the majority of whom	**Phenomenon of interest** To explore the joint coordinators view on coordination activities aimed at supporting the clients' needs. To investigate how the joint coordinators act according to	**Findings:** Theme B: Psychotic symptoms. Theme C: Authorities and financial issues.	**Limitations (CASP: checklist for qualitative studies)** **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?**

Study details	Participants	Methods	Themes and findings	Comments
of Integrated Care [Electronic Resource], 10, 25, 2010 **Ref Id** 907322 **Country where the study was carried out** Sweden **Study type** Structured interviews **Aim of the study** To describe the development and nature of coordination within a mental health and social care consortium and to assess the impact on care processes and client outcomes **Date of data collection** 2009 **Source of funding** Funded by a joint research foundation set up by The Vårdal Foundation, VINNOVA (Swedish Governmental Agency for Innovation Systems), The Swedish Association of Local Authorities and Regions and The Swedish Ministry of Health and Social Affairs.	are diagnosed with schizophrenia **Characteristics** N/S. The authors 'deliberately omitted' this information. **Inclusion criteria** Joint coordinators who gave informed consent to participate. **Exclusion criteria** N/S	the consortium's holistic approach. **Recruitment Details** Those most available, recruited from three rehabilitation units. **Collection Details** Participants were informed about the study aims and then interviewed in pairs. Interviews lasted 60-90mins and were audio recorded. The interview schedule was concerned with network interaction in five domains - daytime activities, psychotic symptoms, contact with authorities and financial issues, interaction with family and relatives, drug and alcohol. **Analysis Details** Interviews were transcribed and analysed following basic content analysis, using the five categories from the interview structure.	**Findings are summarised under the following themes:** A shared vision Practicalities of integrating Staff animosities	Yes **Q3 Was the research design appropriate to address the aims of the research?** No - the study sought views and experiences but used a strict pre-formed structure, which would have limited the participants' flexibility to express their answers. **Q4: Was the recruitment strategy appropriate to the aims of the research?** Unclear -the participants were chosen for their 'practical ability to participate' but it is not clear what this means. **Q5: Were the data collected in a way that addressed the research issue?** No - setting and other information are not clear. It is explained where the restrictive 'structured' nature of the interview was developed from, but it is not justified in comparison to a semi-structured approach. **Q6: Has the relationship between researcher and participants been adequately considered?** Unclear - the relationship between the participants and the researchers is not discussed. **Q7: Have ethical issues been taken into consideration?** Unclear - consent was sought and an ethics board approved the study, but no other considerations are discussed. **Q8: Was the data analysis sufficiently rigorous?** Unclear - little information was reported, it is unclear if more than one researcher was involved or any other verifications were conducted. **Q9: Is there a clear statement of findings?**

Study details	Participants	Methods	Themes and findings	Comments
				Yes - under the structured format of the study the evidence is clearly explained and backed up with quotes. **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - It is not certain how applicable this research may be to a UK context **Overall methodological limitations** Serious
Full citation Kumar, N., Plenert, E., Hwang, S. W., O'Campo, P., Stergiopoulos, V., Sustaining Housing First After a Successful Research Demonstration Trial: Lessons Learned in a Large Urban Center, Psychiatric Services, 68, 739-742, 2017 **Ref Id** 907948 **Country where the study was carried out** Canada **Study type** Mixed qualitative methods **Aim of the study** To identify challenges and facilitators of sustaining a Housing First intervention at the conclusion of a research demonstration project in Toronto.	**Sample size** 13 organizational leaders 14 service team members 9 program participants **Diagnosis** Serious mental illness **Characteristics** N/S **Inclusion criteria** Stakeholders in a Toronto housing project **Exclusion criteria** N/S	**Phenomenon of interest** Managers were asked about strategies for securing sustainability in the collaborative program and other contextual influences in the program's transition to a funded program. Staff and clients were asked about their experiences on the ground. **Recruitment Details** The authors do not explain how the sample was selected. Client participants received $25 and transport fares for participating. **Collection Details** 13 key informants were interviewed. The remaining staff were interviewed in three focus groups, and the clients in a single focus group.	**Findings:** Results **Findings are summarised under the following themes:** A shared vision Funding	**Limitations (CASP: checklist for qualitative studies)** **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?** Yes **Q3 Was the research design appropriate to address the aims of the research?** Yes - sought experiences, barriers and facilitators **Q4: Was the recruitment strategy appropriate to the aims of the research?** Unclear - it was not made clear why the participants were selected over others **Q5: Were the data collected in a way that addressed the research issue?** Yes - format explained and justified **Q6: Has the relationship between researcher and participants been adequately considered?** Unclear - did not discuss the relationship between researcher and participants

Study details	Participants	Methods	Themes and findings	Comments
Date of data collection September 2014 - January 2015 **Source of funding** Funding from Health Canada		**Analysis Details** Interviews were transcribed and subject to a thematic analysis. Investigator triangulation during data analysis and member check-in with interviewees were used to establish trustworthiness of the data.		**Q7: Have ethical issues been taken into consideration?** Unclear - study approved by an ethics board and sought consent, but no discussion about ethics issues raised **Q8: Was the data analysis sufficiently rigorous?** Yes **Q9: Is there a clear statement of findings?** Yes - quotes and findings presented, although not organised into clear themes and titles **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - applicability to a UK context is uncertain **Overall methodological limitations** Moderate
Full citation McGinty, E. E., Kennedy-Hendricks, A., Linden, S., Choksy, S., Stone, E., Daumit, G. L., An innovative model to coordinate healthcare and social services for people with serious mental illness: A mixed-methods case study of Maryland's Medicaid health home program, General Hospital Psychiatry, 51, 54-62, 2018 **Ref Id** 908431 **Country where the study was carried out**	**Sample size** 41 nurse care managers 31 psychiatric rehabilitation program directors **Diagnosis** Serious mental illness **Characteristics** Male/female = 15%/85% White/Not white = 78%/22% **Inclusion criteria**	**Phenomenon of interest** Leaders' perceptions of health home implementation strategies, barriers, and facilitators **Recruitment Details** Leaders at all 48 active Maryland sites were contacted and ask to participate. **Collection Details** Participants were interviewed individually. Semi-structured interviews of around 30-45mins were	**Findings:** Organizational fit Geographic proximity Health IT Shifting staff roles to support implementation **Findings are summarised under the following themes:** A shared vision Practicalities of integrating	**Limitations (CASP: checklist for qualitative studies)** **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?** Yes **Q3 Was the research design appropriate to address the aims of the research?** Yes - sought barriers and facilitators **Q4: Was the recruitment strategy appropriate to the aims of the research?** Yes - sought representatives from all sites in their area, although it is not clear who declined to participate

Study details	Participants	Methods	Themes and findings	Comments
USA **Study type** Mixed qualitative methods **Aim of the study** To examine the implementation of Maryland's Medicaid health home program, a unique model for integration of behavioral, somatic, and social services for people with serious mental illness (SMI) in the psychiatric rehabilitation program setting. **Date of data collection** November 2015 - December 2016 **Source of funding** Funded by the National Institute of Mental Health	Program directors and nurse care managers leading health home implementation in Maryland Medicaid health home sites. **Exclusion criteria** N/S	conducted by two researchers. **Analysis Details** Interviews were recorded, transcribed, and coded using a hybrid inductive/deductive coding approach. Two researchers coded independently and then compared their transcripts to produce the initial codebook, which was iteratively updated until data saturation was reached. The participants subsequently reviewed the key themes to confirmed if they perceived them to be accurate based on their experiences.	Service landscape	**Q5: Were the data collected in a way that addressed the research issue?** Yes **Q6: Has the relationship between researcher and participants been adequately considered?** Yes - the limitations section discusses and addresses these biases **Q7: Have ethical issues been taken into consideration?** Yes - consent sought and the study was approved by a board, some discussion on ethical considerations. **Q8: Was the data analysis sufficiently rigorous?** Yes **Q9: Is there a clear statement of findings?** Yes **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - may not be applicable to a UK context **Overall methodological limitations** Minor
Full citation Oulvey, E., Carpenter-Song, E. A., Swanson, S. J., Principles for enhancing the role of state vocational rehabilitation in IPS-supported employment, Psychiatric rehabilitation journal, 36, 4-6, 2013	**Sample size** 21 groups of 4 to 13 members. Consumers of IPS services = 5 groups, staff serving on IPS teams = 5 groups, mental health practitioners working	**Phenomenon of interest** Experience, expertise, and insight regarding vocational rehabilitation for people with psychiatric impairments **Recruitment Details** Unclear	**Findings:** Consistency Integration	**Limitations (CASP: checklist for qualitative studies)** 1 **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?** Yes

Study details	Participants	Methods	Themes and findings	Comments
Ref Id 908952 **Country where the study was carried out** USA **Study type** Focus groups **Aim of the study** To examine strategies for Vocational Rehabilitation (VR) to enhance employment outcomes through better collaboration with IPS programs **Date of data collection** 2008 - 2009 **Source of funding** N/S	with IPS teams = 5 groups, state VR counselors and VR office = 6 groups **Diagnosis** Severe mental illnesses **Characteristics** N/S **Inclusion criteria** Consumers of IPS services, staff serving on IPS teams, mental health practitioners working with IPS teams, and state VR counselors in Illinois. **Exclusion criteria** N/S	**Collection Details** Moderators trained in standard focus group techniques ran and audio-recorded the groups according to focus group topic guides, each lasting 60-90mins. **Analysis Details** Transcripts were thematically analysed by a multi-disciplinary team, separately for each stakeholder group. Comparisons were made within the themes between sites that seemed to show strong versus weak collaboration.	**Findings are summarised under the following themes:** A shared vision Funding	**Q3 Was the research design appropriate to address the aims of the research?** Yes - sought experiences **Q4: Was the recruitment strategy appropriate to the aims of the research?** Unclear - not clear how the participants were recruited **Q5: Were the data collected in a way that addressed the research issue?** No - it is not clear that focus groups were the best way to extract peoples experiences, as they likely led to several biases in the experiences that participants shared **Q6: Has the relationship between researcher and participants been adequately considered?** No - relationship was not discussed **Q7: Have ethical issues been taken into consideration?** Unclear - study approved by an ethics board and sought consent, but no discussion about ethical issues the study raised **Q8: Was the data analysis sufficiently rigorous?** Unclear - several experts were involved, but the process was quite large and involved lots of people and lots of data. It is not clear how final decisions were made. **Q9: Is there a clear statement of findings?** Yes - although highly reduced **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - the findings may not be relevant to a UK context

Study details	Participants	Methods	Themes and findings	Comments
				Overall methodological limitations Serious
Full citation Pogoda, T. K., Cramer, I. E., Rosenheck, R. A., Resnick, S. G., Qualitative analysis of barriers to implementation of supported employment in the Department of Veterans Affairs, Psychiatric Services, 62, 1289-95, 2011 **Ref Id** 909115 **Country where the study was carried out** USA **Study type** Semi-structured interviews **Aim of the study** To document perceived barriers to supported employment implementation as described by Department of Veterans Affairs (VA) employees **Date of data collection** July 2006 for approximately two years **Source of funding** Supported by the Department of Veterans Affairs	**Sample size** 84 senior and middle leadership members, mental health leaders and clinicians, and supported employment program staff **Diagnosis** Serious mental illness **Characteristics** N/S **Inclusion criteria** VAMC senior and middle leadership, mental health leaders and clinicians, and supported employment program staff at 21 sites across the USA. **Exclusion criteria** N/S	**Phenomenon of interest** Perceived barriers to supported employment implementation **Recruitment Details** Potential interviewees were emailed an invitation - although it is not clear if they worked off a list off all potential candidates. **Collection Details** Semistructured interviews conducted and audio recorded **Analysis Details** Transcripts of interviews were subjected to both an inductive and a deductive thematic analysis by the two authors separately, with discrepancies resolved by consensus.	**Findings:** Paternalistic-uninformed Organizational barriers: Lack of education about the model Organizational barriers: Inadequate involvement of leadership **Findings are summarised under the following themes:** A shared vision Staff animosities	**Limitations (CASP: checklist for qualitative studies)** **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?** Yes **Q3 Was the research design appropriate to address the aims of the research?** Yes - sought barriers and facilitators **Q4: Was the recruitment strategy appropriate to the aims of the research?** Unclear - not clearly specified who was or wasn't approached, and who declined to participate **Q5: Were the data collected in a way that addressed the research issue?** Yes **Q6: Has the relationship between researcher and participants been adequately considered?** Unclear - not discussed, although no clear power dynamic was present **Q7: Have ethical issues been taken into consideration?** Yes - study approved by an ethics board and sought consent **Q8: Was the data analysis sufficiently rigorous?** Yes

Study details	Participants	Methods	Themes and findings	Comments
				Q9: Is there a clear statement of findings? Yes **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - US veteran context may not be especially applicable to a UK context **Overall methodological limitations** Minor
Full citation Rebeiro Gruhl, K. L., Kauppi, C., Montgomery, P., James, S., Employment services for persons with serious mental illness in northeastern Ontario: the case for partnerships, Work, 43, 77-89, 2012 **Ref Id** 909246 **Country where the study was carried out** Canada **Study type** Mixed qualitative methods **Aim of the study** To better understand why employment success is low, a case study was conducted to examine the influence of place on access to employment for persons with serious mental illness	**Sample size** 46 individuals or groups of decision-makers, providers and people with SMI **Diagnosis** Serious mental illness **Characteristics** N/S **Inclusion criteria** Decision-makers, providers and people with SMI **Exclusion criteria** Individuals were not included in the study if they had been at any time a client of the researcher	**Phenomenon of interest** To understand access to competitive employment for persons with SMI **Recruitment Details** Community partners were approached. Sampling was purposive to provide different instances of different people across different places by case community and by rural or urban residency. **Collection Details** Qualitative data collection techniques included (a) individual interviews, (b) group interviews, (c) field notes, and (d) theoretical memos. **Analysis Details**	**Findings:** Rural and northern tensions Jurisdictional tensions Funding tensions **Findings are summarised under the following themes:** A shared vision Staff animosities Service landscape Funding	**Limitations (CASP: checklist for qualitative studies)** **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?** Yes **Q3 Was the research design appropriate to address the aims of the research?** Yes - sought personal experiences and personal meaning **Q4: Was the recruitment strategy appropriate to the aims of the research?** Unclear - recruitment strategy was not well described **Q5: Were the data collected in a way that addressed the research issue?** Unclear - data was collected in several ways but the details of the processes are not well described. **Q6: Has the relationship between researcher and participants been adequately considered?** Yes

Study details	Participants	Methods	Themes and findings	Comments
Date of data collection N/S **Source of funding** Funding from the Canadian Institutes of Health Research		Primarily inductive analysis of the qualitative data was supplemented by an analysis based upon the empirical literature and the conceptual framework of the study. Themes were developed iteratively, and interviews were continued until data saturation was reached. Emergent themes were verified by the participants.		**Q7: Have ethical issues been taken into consideration?** No - not discussed, including consent **Q8: Was the data analysis sufficiently rigorous?** Yes - described in detail **Q9: Is there a clear statement of findings?** Unclear - lots of description, but not consistently reinforced with quotes **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - it is not certain how applicable the findings are to a UK context **Overall methodological limitations** Serious
Full citation Vukadin, M., Schaafsma, F. G., Westerman, M. J., Michon, H. W. C., Anema, J. R., Experiences with the implementation of Individual Placement and Support for people with severe mental illness: A qualitative study among stakeholders, BMC Psychiatry, 18 (1) (no pagination), 2018 **Ref Id** 910235 **Country where the study was carried out** The Netherlands **Study type** Semi-structured interviews	**Sample size** 8 practitioners and 7 decision makers **Diagnosis** Severe mental illness **Characteristics** N/S **Inclusion criteria** Individual Placement and Support (IPS) stakeholders in the municipality of Amsterdam **Exclusion criteria**	**Phenomenon of interest** Facilitators and barriers to the organizational and a financial implementation of IPS **Recruitment Details** All stakeholders in the municipality of Amsterdam involved in the first year of this collaboration were asked to participate in this qualitative study. Unclear how many declined. **Collection Details** Semi-structured interviews were conducted by a trained researcher. Interviews lasted	**Findings:** Collaboration IPS funding **Findings are summarised under the following themes:** A shared vision Practicalities of integrating Staff animosities Funding	**Limitations (CASP: checklist for qualitative studies** **Q1: Was there a clear statement of the aims of the research?** Yes **Q2: Was a qualitative methodology appropriate?** Yes **Q3 Was the research design appropriate to address the aims of the research?** Yes, sought experiences of barriers and facilitators **Q4: Was the recruitment strategy appropriate to the aims of the research?** Unclear - approached all stakeholders on the area but it was unclear how many declined to participate or why.

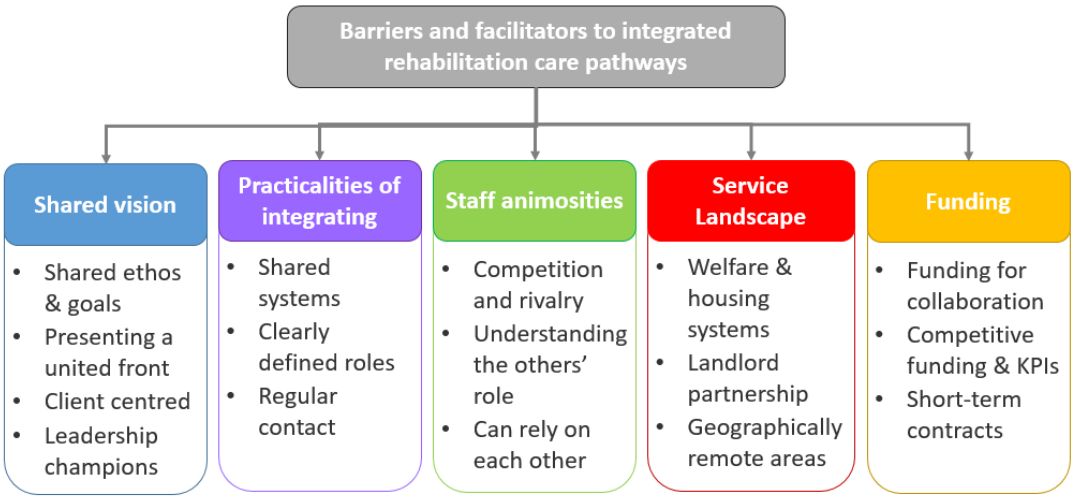
Study details	Participants	Methods	Themes and findings	Comments
Aim of the study To improve IPS implementation by improving the collaboration between all organizations involved, and realising secured IPS funding with a 'pay for performance' element **Date of data collection** October 2015 - June 2016 **Source of funding** Funded by the Dutch Social Security Institute: the Institute for Employee Benefits Schemes (UWV) (funding number 2001170)	N/S	30-95mins, usually about an hour, and were voice recorded. They were conducted in person, usually at the person's place of work - except one which was conducted by phone. **Analysis Details** Interviews were transcribed and analysed iteratively with a thematic content approach. Transcripts were coded initially by one researcher, and the five richest interviews were also coded by a second researcher. Themes were refined, sorted and collated according to overarching themes.		**Q5: Were the data collected in a way that addressed the research issue?** Yes **Q6: Has the relationship between researcher and participants been adequately considered?** Unclear - not discussed, although there is no obvious power dynamic between the researcher and the participants. **Q7: Have ethical issues been taken into consideration?** Unclear - indicated that a board gave approval, but no other considerations were discussed **Q8: Was the data analysis sufficiently rigorous?** Yes - explained in detail **Q9: Is there a clear statement of findings?** Yes - with quotes and discussions **Q10: Is the research valuable for the UK? (1. Contribution to literature and 2. Transferability)** Unclear - how well it can be applied to a UK context **Overall methodological limitations** Moderate

1 *CTI: critical time intervention; IT: Information Technology; IPS: individual placement and support; M/F: male/female; N/S: not stated; NGO: non-government organisation; RCT:*
2 *randomised controlled trial; SD: standard deviation; SMI: serious mental illness*

Appendix E – Thematic map

Thematic map for review question 2.4 What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

Figure 2: Theme map



1 Appendix F – GRADE CERQual tables

2 GRADE CERQual tables for review question 2.4 What are the barriers and facilitators to integrated rehabilitation care 3 pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

4 **Table 5: Summary of evidence (GRADE-CERQual), Topic I. Barriers and facilitators**

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
Theme 1) A shared vision							
5 studies (Bejerholm 2011, Berry 2017, McGinty 2018, Pogoda 2011, Rebeiro Gruhl 2012)	3 mixed qualitative methods, 2 semi-structured interviews	Services work better together when they have shared ethos and end goals. Integration is less successful when services approach rehabilitation from different theoretical positions.	Moderate concerns[1]	Minor concerns	Very minor concerns	Very minor concerns	MODERATE
4 studies (Dadich 2013, Hansson 2010, McGinty 2018, Oulvey 2013)	1 mixed qualitative methods, 1 semi-structured interviews, 1 structured interviews, 1 focus groups	Collaborations work better when services accommodate each other and present a united front to the service user. This may require some changes to staff roles, systems and ways of working.	Moderate concerns[1]	Minor concerns	Minor concerns	Minor concerns	MODERATE
4 studies (Bejerholm 2011, Berry 2017, Dadich 2013, Hansson 2010)	1 mixed qualitative methods, 2 semi-structured interviews, 1 structured interviews	Services integrate more successfully when they make the client the centre of the service and collaborate around them. They must be prepared to tailor their services to the individual needs of service users, while taking care not to make the service user feel 'ganged up' on.	Serious concerns[2]	Moderate concerns[3]	Minor concerns	Very minor concerns	LOW
3 studies (Kumar 2017, Pogoda	1 mixed qualitative methods, 2	Collaborations of services benefit from leadership champions that are enthusiastic about the vision	Moderate concerns[1]	Minor concerns	Minor concerns	Minor concerns	MODERATE

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
2011, Vukadin 2018)	semi-structured interviews	of the integration. Services integrate less successfully when they don't have strong, clear support and inspiration from management driving it.					
Theme 2) Practicalities of integrating							
3 studies (Dadich 2013, Hansson 2010, McGinty 2018)	1 mixed qualitative methods, 1 semi-structured interviews, 1 structured interviews	Collaborations benefit from access to the same record systems, version of client goals etc. Services who use separate or incompatible systems find it harder to share information, and it is often duplicated and may be inconsistent.	Moderate concerns[1]	Minor concerns	Minor concerns	Minor concerns	MODERATE
3 studies (Chen 2014, Hansson 2010, Vukadin 2018)	2 semi-structured interviews, 1 structured interviews	Integrations are more successful when each service and worker has clearly defined roles and responsibilities. These should be documented and available to refer to. This helps for reference and to resolve difficulties that arise.	Moderate concerns[1]	Minor concerns	Minor concerns	Minor concerns	MODERATE
6 studies (Bejerholm 2011, Bengtsson-Tops 2014, Chen 2014, Dadich 2013, Drake 2003, Vukadin 2018)	2 mixed qualitative methods, 1 open interviews, 3 semi-structured interviews,	Integrations are more successful when the staff involved are familiar with each other. Regular contact, updates and meetings allow the workers to build more functional and personal relationships.	Moderate concerns[1]	Minor concerns	Minor concerns	Very minor concerns	MODERATE
Theme 3) Staff animosities							
3 studies (Berry 2017, Chen 2014, Rebeiro Gruhl 2012)	1 mixed qualitative methods, 2 semi-structured interviews	Integrations are more difficult when staff and services feel competitive with each other. Staff may mistrust outsiders or be wary of being judged by them.	Moderate concerns[1]	Moderate concerns[3]	Minor concerns	Minor concerns	LOW
4 studies (Berry 2017, Drake	1 mixed qualitative	Integrations are less successful when team members don't	Moderate concerns[1]	Minor concerns	Minor concerns	Minor concerns	MODERATE

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
2003, Pogoda 2011, Vukadin 2018)	methods, 3 semi-structured interviews	understand the function of the other professionals, or appreciate the contributions of their role. Collaborations allow for new perspectives and a more holistic insight on service users. Integrations are stronger when the members have experienced the effectiveness of other roles firsthand, or have been presented an explanation and evidence of the benefits.					
3 studies (Chen 2014, Drake 2003, Hansson 2010)	1 mixed qualitative methods, 1 semi-structured interviews, 1 structured interviews	Integrations are more successfully when team members know they can rely on each other. Tension may arise when staff members must wait for another to complete their job before being able to continue theirs.	Moderate concerns[1]	Moderate concerns[3]	Moderate concerns[4]	Minor concerns	VERY LOW
Theme 4) Service landscape							
2 studies (Bejerholm 2011, Rebeiro Gruhl 2012)	2 mixed qualitative methods	Welfare systems and housing services may take away someone's benefits or housing if they work more than a certain number of hours, causing a clash with employment services.	Serious concerns[2]	Minor concerns	Moderate concerns[4]	Moderate concerns[5]	VERY LOW
1 study (Bengtsson-Tops 2014)	1 open interviews	Landlords are relied on for providing accommodation, but may not have any authority to instigate mental health support at times of crisis.	Minor concerns	Minor concerns	Moderate concerns[4]	Serious concerns[6]	LOW
2 studies (McGinty 2018, Rebeiro Gruhl 2012)	2 mixed qualitative methods	Being geographically remote or collaborating across large rural areas could be a barrier to collaboration. Co-location of services facilitates integration.	Minor concerns	Minor concerns	Moderate concerns[4]	Moderate concerns[5]	LOW
Theme 5) Funding							

Study information		Description of Theme or Finding	CERQUAL Quality Assessment				
Number of studies	Design		Methodological Limitations	Coherence of findings	Applicability of evidence	Adequacy of Data	Overall Confidence
3 studies (Kumar 2017, Rebeiro Gruhl 2012, Vukadin 2018)	2 mixed qualitative methods, 1 semi-structured interviews	Integrations are more successful when the collaboration project has its own funding. When funding for a collaboration ceases the individual services struggle to bridge the financial gap. Individual services may struggle to apply for funding using an evidence base taken from a collaborative project.	Serious concerns[2]	Minor concerns	Moderate concerns[4]	Minor concerns	LOW
1 study (Rebeiro Gruhl 2012)	1 mixed qualitative methods	Climates of competitive funding or 'payment by results' diminish collaboration. Services that are competing for funding, or who don't stand to be paid unless they produce the result, do not want to risk losing payment for their work to competitors	Serious concerns[2]	Minor concerns	Moderate concerns[4]	Serious concerns[6]	VERY LOW
2 studies (Oulvey 2013, Vukadin 2018)	1 semi-structured interviews, 1 focus groups	Collaborations take time to foster, and short-term or temporary contracts make collaborations seem less worth the effort to services and staff.	Serious concerns[2]	Minor concerns	Moderate concerns[4]	Moderate concerns[5]	LOW

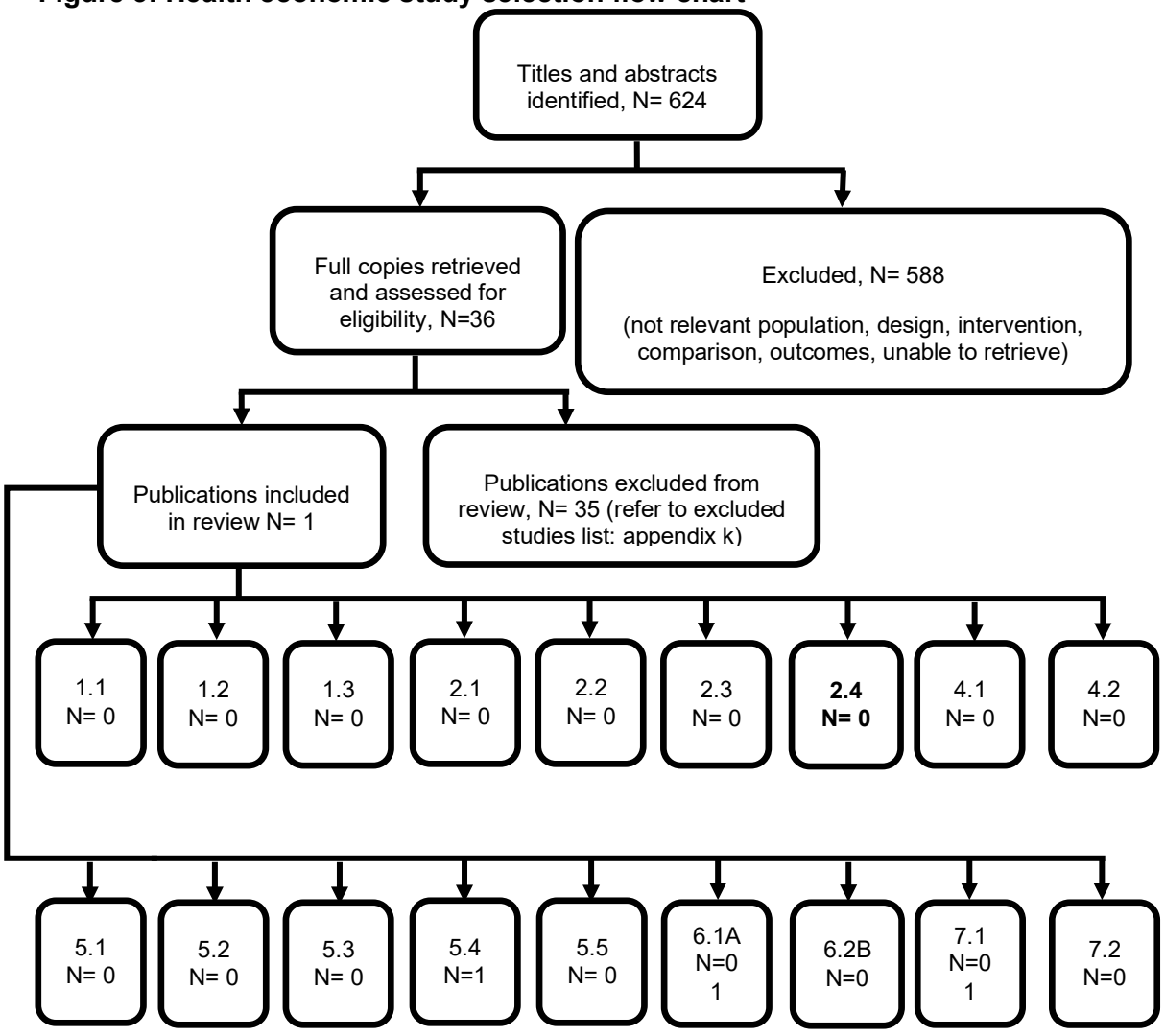
1 Downgraded by 1 following CASP assessment as at least half of the studies used had moderate or serious limitations
2 Downgraded by 2 following CASP assessment as all of the studies used had moderate limitations and at least one had serious limitations
3 Evidence was downgraded 1 due to incoherence of findings, as the construct contained contradiction and divergence of experiences, without enough detail to explain why.
4 Evidence downgraded by 1 due to applicability of evidence, as there were no UK studies included, and not 3 or more different countries studied
5 Evidence was downgraded by 1 due to adequacy of data, as only two studies supported the review's findings (offering thin data)
6 Evidence was downgraded by 2 due to adequacy of data, as only one study supported the review's findings (offering poor data)

Appendix G – Economic evidence study selection

Economic evidence study selection for review question 2.4: What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

A global health economic literature search was undertaken, covering all review questions in this guideline. However, as shown in Figure 3, no evidence was identified which was applicable to this review question.

Figure 3: Health economic study selection flow chart



Appendix H – Economic evidence tables

Economic evidence tables for review question 2.4: What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

No evidence was identified which was applicable to this review question.

Appendix I – Health economic evidence profiles

Economic evidence profiles for review question 2.4: What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

No evidence was identified which was applicable to this review question.

Appendix J – Health economic analysis

Health economic analysis for review question 2.4: What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

No evidence was identified which was applicable to this review question.

Appendix K – Excluded studies

Excluded clinical and economic studies for review question 2.4: What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

Table 6: Excluded clinical studies

Study	Reason for Exclusion
Ahrens, M. P., A model for dual disorder treatment in acute psychiatry in a VA population, Journal of Substance Abuse Treatment, 15, 107-12, 1998	Study was not in a rehabilitation setting
Allen, R. E., Read, J., Integrated mental health care: practitioners' perspectives, The Australian and New Zealand journal of psychiatry, 31, 496-503, 1997	Study was not in a rehabilitation setting Study was not specific to our population or a rehabilitation setting
Ammeraal, M. A., Coppers, J., Understanding living skills: first steps to evidence-based practice. Lessons learned from a practice-based journey in the Netherlands, Occupational therapy international, 19, 45-53, 2012	Topic was not on integrating multiple providers
Andresen, R., Oades, L., Caputi, P., The experience of recovery from schizophrenia: Towards an empirically validated stage model, Australian and New Zealand Journal of Psychiatry, 37, 586-594, 2003	Topic was not on integrating multiple providers
Andrews, S. B., Drake, T., Haslett, W., Munusamy, R., Developing web-based online support tools: the Dartmouth decision support software, Psychiatric rehabilitation journal, 34, 37-41, 2010	Topic was not on integrating multiple providers
Ash, D., Suetani, S., Halpin, M., Burton, C., The role of consumer feedback in shaping recovery services for agitated psychotic people, Schizophrenia Research, 1), S285-S286, 2014	Conference abstract
Ashby, S. E., Ryan, S., Gray, M., James, C., Factors that influence the professional resilience of occupational therapists in mental health practice, Australian Occupational Therapy Journal, 60, 110-119, 2013	Topic was not on integrating multiple providers
Baigent, M., Holme, G., Hafner, R. J., Self reports of the interaction between substance abuse and schizophrenia, Australian & New Zealand Journal of PsychiatryAust N Z J Psychiatry, 29, 69-74, 1995	Study did not use qualitative methods specified in the scope
Barnes, L., Rudge, T., Co-operation and co-morbidity: managing dual diagnosis in rural South Australia, Collegian (Royal College of Nursing, Australia), 10, 25-28, 2003	Study was not specific to the psychosis population or a rehabilitation setting
Battams, S., Baum, F., What policies and policy processes are needed to ensure that people with psychiatric disabilities have access to appropriate housing?, Social Science and Medicine, 70, 1026-1034, 2010	Participants' diagnoses not specified, unclear if they match target population specification
Beasley, Joan Birnberg, Coordinated community mental health care for individuals with mental illness and mental retardation: Four years of service outcomes and retrospective family caregiver service experiences, Dissertation Abstracts International: Section B: The Sciences and Engineering, 61, 1863, 2000	Dissertation
Bell, M. D., Weinstein, A., Simulated job interview skill training for people with psychiatric disability: Feasibility and	Topic was not on integrating multiple service providers

Study	Reason for Exclusion
tolerability of virtual reality training, Schizophrenia Bulletin, 37, S91-S97, 2011	
Bowles, N., Jones, A., Whole systems working and acute inpatient psychiatry: an exploratory study, Journal of Psychiatric & Mental Health Nursing, 12, 283-9, 2005	Study was not in a rehabilitation setting
Brady, C., Moss, H., Kelly, B. D., A fuller picture: evaluating an art therapy programme in a multidisciplinary mental health service, Medical Humanities, 43, 30-34, 2017	Topic was not on integrating multiple service providers
Brinchmann, B., Lorentsen, O., Early intervention: Integrating vocational and medical rehabilitation during admittance in a mental health institution. A study in a rural part of North-Norway, Early Intervention in Psychiatry, 6 (SUPPL.1), 111, 2012	Conference abstract
Brousselle, A., Lamothe, L., Sylvain, C., Foro, A., Perreault, M., Integrating services for patients with mental and substance use disorders: What matters?, Health care management review, 35, 212-223, 2010	Study was not in a rehabilitation setting and broad about the mental health population it was focused on
Brousselle, A., Lamothe, L., Sylvain, C., Foro, A., Perreault, M., Key enhancing factors for integrating services for patients with mental and substance use disorders, Mental Health and Substance Use: Dual Diagnosis, 3, 203-218, 2010	Study was not specifically in a rehabilitation setting and very broad about the mental health population it was focused on.
Cabassa, L. J., Stefancic, A., Context before implementation: a qualitative study of decision makers' views of a peer-led healthy lifestyle intervention for people with serious mental illness in supportive housing, Translational Behavioral Medicine, 04, 04, 2018	Integrating a peer-led intervention into a service, rather than multiple services
Cameron, J., Walker, C., Hart, A., Sadlo, G., Haslam, I., Retain Support, Group, Supporting workers with mental health problems to retain employment: users' experiences of a UK job retention project, Work (Reading, Mass.), 42, 461-471, 2012	Topic was not on integrating multiple service providers
Celona, D., Garino, D., Bertossi, F., Impagnatiello, M., Botter, V., Sandri, F., Pascolo-Fabrici, E., Multidimensional approach in persons with schizophrenia spectrum disorders, European Psychiatry, 1), 868, 2015	Conference abstract
Chen, Fang-pei, Building a working community: Staff practices in a clubhouse for people with severe mental illness, Administration and Policy in Mental Health and Mental Health Services Research, 44, 651-663, 2017	Topic was not on integrating multiple service providers
Citron, T., Brooks-Lane, N., Crandell, D., Brady, K., Cooper, M., Revell, G., A revolution in the employment process of individuals with disabilities: Customized employment as the catalyst for system change, Journal of Vocational Rehabilitation, 28, 169-179, 2008	Study was very broad about the disabled population it was focused on
Cleary, M., Horsfall, J., O'Hara-Aarons, M., Hunt, G. E., Mental health nurses' views of recovery within an acute setting, International Journal of Mental Health Nursing, 22, 205-212, 2013	Study was not in a rehabilitation setting
Comtois, G., Morin, C., Lesage, A., Lalonde, P., Likavcanova, E., L'Ecuyer, G., Patients versus rehabilitation practitioners: A comparison of assessments of needs for care, Canadian Journal of Psychiatry, 43, 159-165, 1998	Topic was not on integrating multiple service providers

Study	Reason for Exclusion
Cook, J. A., Morrow, M., Battersby, L., Intersectional policy analysis of self-directed mental health care in Canada, Psychiatric rehabilitation journal, 40, 244-251, 2017	Topic was not on integrating multiple service providers
Cook, J. A., Shore, S. E., Burke-Miller, J. K., Jonikas, J. A., Ferrara, M., Colegrove, S., Norris, W. T., Ruckdeschel, B., Batteiger, A. P., Ohrtman, M., Grey, D. D., Hicks, M. E., Participatory action research to establish self-directed care for mental health recovery in Texas, Psychiatric rehabilitation journal, 34, 137-144, 2010	Study did not use qualitative methods as specified in the scope
Cook, Sarah, Chambers, Eleni, What helps and hinders people with psychotic conditions doing what they want in their daily lives, The British Journal of Occupational Therapy, 72, 238-248, 2009	Topic was not on integrating multiple service providers
Crain, M., Penhale, C., Newstead, C., Heah, T., Barclay, K., The contribution of IPS to recovery from serious mental illness: A case study, Work, 33, 459-464, 2009	Case study
Cuddeback, G. S., Pettus-Davis, C., Scheyett, A., Consumers' perceptions of forensic assertive community treatment, Psychiatric rehabilitation journal, 35, 101-109, 2011	Less than two thirds of the service users had a diagnosis of psychosis or related disorder
DiFranco, E., Bressi, S. K., Salzer, M. S., Understanding consumer preferences for communication channels to create consumer-directed health promotion efforts in psychiatric rehabilitation settings, Psychiatric rehabilitation journal, 29, 251-257, 2006	Study did not use qualitative methods as specified in the scope
Every-Palmer, S., Huthwaite, M. A., Elmslie, J. L., Grant, E., Romans, S. E., Long-term psychiatric inpatients' perspectives on weight gain, body satisfaction, diet and physical activity: A mixed methods study 11 Medical and Health Sciences 1117 Public Health and Health Services, BMC Psychiatry, 18 (1) (no pagination), 2018	Topic was not on integrating multiple service providers
Fanner, D., Urqhuart, C., Bibliotherapy for mental health service users Part 2: a survey of psychiatric libraries in the UK, Health Information & Libraries Journal, 26, 109-17, 2009	Study was very broad about the mental health population it was focused upon
Faulkner, G. E. J., Gorczynski, P. F., Cohn, T. A., Psychiatric illness and obesity: Recognizing the "Obesogenic" nature of an inpatient psychiatric setting, Psychiatric Services, 60, 538-541, 2009	Topic was not on integrating multiple service providers
Fegan, C., Cook, S., Experiences of volunteering: a partnership between service users and a mental health service in the UK, Work, 43, 13-21, 2012	Integrating service users into a service, rather than multiple services
Fortune, T., Fitzgerald, M. H., The challenge of interdisciplinary collaboration in acute psychiatry: Impacts on the occupational milieu, Australian Occupational Therapy Journal, 56, 81-88, 2009	Study was not in a rehabilitation setting and very broad about the mental health population it was focused on
Gahnstrom-Standqvist, K., Josephsson, S., Tham, K., Stories of clients with mental illness: The structure of occupational therapists' interactions, OTJR Occupation, Participation and Health, 24, 134-143, 2004	Topic was not on integrating multiple service providers
Gates, L. B., Klein, S. W., Akabas, S. H., Myers, R., Schawager, M., Kaelin-Kee, J., Outcomes-based funding for vocational services and employment of people with mental health conditions, Psychiatric Services, 56, 1429-1435, 2005	Topic was not on integrating multiple service providers

Study	Reason for Exclusion
Gilburt, H., Slade, M., Bird, V., Oduola, S., Craig, T. K. J., Promoting recovery-oriented practice in mental health services: A quasi-experimental mixed-methods study, BMC Psychiatry, 13 (no pagination), 2013	Study was not specifically in a rehabilitation setting and very broad about the mental health population it was focused on
Glover, C. M., Frounfelker, R. L., Competencies of more and less successful employment specialists, Community Mental Health Journal, 49, 311-6, 2013	Did not use qualitative interview methods as specified in the scope
Hautala-Jylha, P. L., Nikkonen, M., Jylha, J., Continuity of care in psychiatric post-ward outpatient services--conceptions of patients and personnel concerning factors contributing to the continuity of care, Journal of Psychiatric & Mental Health Nursing, 12, 38-50, 2005	Not clearly in a rehabilitation setting
Howard, V., Holmshaw, J., Inpatient staff perceptions in providing care to individuals with co-occurring mental health problems and illicit substance use, Journal of Psychiatric and Mental Health Nursing, 17, 862-872, 2010	Qualitative component did not focus on a rehabilitation setting and was very broad about the mental health population it was focused on
Isaacs, Anton N., Sutton, Keith, Dalziel, Kim, Maybery, Darryl, Outcomes of a care coordinated service model for persons with severe and persistent mental illness: A qualitative study, International Journal of Social Psychiatry, 63, 40-47, 2017	Study enquired about outcomes, not barriers and facilitators
Jormfeldt, H., Brunt, D. A., Rask, M., Bengtsson, A., Svedberg, P., Staff's experiences of a person-centered health education group intervention for people with a persistent mental illness, Issues in Mental Health Nursing, 34, 488-96, 2013	Exclude did not investigate integration of services.
Jormfeldt, H., Svensson, B., Hansson, L., Svedberg, P., Relatives' experiences of the Boston Psychiatric Rehabilitation approach: a qualitative study, International journal of qualitative studies on health and well-being, 9, 22918, 2014	Topic was not on integrating multiple service providers
Kilpatrick, E., Keeney, S., McCauley, C. O., Tokenistic or genuinely effective? Exploring the views of voluntary sector staff regarding the emerging peer support worker role in mental health, Journal of Psychiatric and Mental Health Nursing, 24, 503-512, 2017	Integrating a peer-led intervention into a service, rather than multiple services
King, J., Cleary, C., Harris, M. G., Lloyd, C., Waghorn, G., Employment-related information for clients receiving mental health services and clinicians, Work (Reading, Mass.), 39, 291-303, 2011	Topic was not on integrating multiple service providers
Kleinman, R., Kehn, M., Wishon Siegwarth, A., Brown, J., State strategies for coordinating Medicaid and housing services, Psychiatric Rehabilitation Journal, 40, 225-232, 2017	Study was very broad about the mental health population it was focused upon
Knaeps, J., Desmet, A., Van Audenhove, C., The IPS fidelity scale as a guideline to implement Supported Employment, Journal of Vocational Rehabilitation, 37, 13-23, 2012	Topic was not on integrating multiple service providers
Knaeps, J., DeSmet, A., Van Audenhove, C., Supported employment fidelity in Flemish vocational programs, Psychiatrische Praxis. Conference: 9th International Conference of the European Network for Mental Health Service Evaluation, ENMESH, 38, 2011	Conference abstract

Study	Reason for Exclusion
Kostick, K. M., Whitley, R., Bush, P. W., Client-centeredness in supported employment: specialist and supervisor perspectives, Journal of Mental Health, 19, 523-31, 2010	Very broad about the diagnoses referred to, and not specific to a rehabilitation setting
Kriegel, L. S., Henwood, B. F., Gilmer, T. P., Implementation and Outcomes of Forensic Housing First Programs, Community Mental Health Journal, 52, 46-55, 2016	Topic was not on integrating multiple service providers
Krupa, T., Eastabrook, S., Beattie, P., Carriere, R., McIntyre, D., Woodman, R., Challenges faced by service providers in the delivery of Assertive Community Treatment, Canadian Journal of Community Mental Health, 23, 115-27, 2004	Topic was not on ways to integrate multiple service providers
Lal, S., Mercier, C., Thinking out of the box: An intersectoral model for vocational rehabilitation, Psychiatric rehabilitation journal, 26, 145-153, 2002	Study was not specifically in a rehabilitation setting and very broad about the mental health population it was focused on
Lexen, A., Emmelin, M., Bejerholm, U., Individual Placement and Support is the keyhole: Employer experiences of supporting persons with mental illness, Journal of Vocational Rehabilitation, 44, 135-147, 2016	Collaboration between a service and employers, rather than between multiple services
Lobban, F., Glentworth, D., Haddock, G., Wainwright, L., Clancy, A., Bentley, R., React, Team, The views of relatives of young people with psychosis on how to design a Relatives Education And Coping Toolkit (REACT), Journal of Mental Health, 20, 567-79, 2011	Topic was not on integrating multiple service providers
Lysaker, P. H., France, C. M., Psychotherapy as an element in supported employment for persons with severe and persistent mental illness, Psychiatry, 62, 209-221, 1999	Study enquired about outcomes, not barriers and facilitators
MacDonald, E. M., Luxmoore, M., Pica, S., Tanti, C., Blackman, J. M., Catford, N., Stockton, P., Social networks of people with dual diagnosis: the quantity and quality of relationships at different stages of substance use treatment, Community Mental Health Journal, 40, 451-64, 2004	Study enquired about outcomes, not barriers and facilitators
Macnaughton, E., Stefancic, A., Nelson, G., Caplan, R., Townley, G., Aubry, T., McCullough, S., Patterson, M., Stergiopoulos, V., Vallee, C., Tsemberis, S., Fleury, M. J., Piat, M., Goering, P., Implementing Housing First Across Sites and Over Time: Later Fidelity and Implementation Evaluation of a Pan-Canadian Multi-site Housing First Program for Homeless People with Mental Illness, American Journal of Community Psychology, 55, 279-91, 2015	Partnerships were a suggested outcome, but did not give barriers and facilitators
Maisto, S. A., Carey, K. B., Carey, M. P., Purnine, D. M., Barnes, K. L., Methods of changing patterns of substance use among individuals with co-occurring schizophrenia and substance use disorder, Journal of Substance Abuse Treatment, 17, 221-7, 1999	Study enquired about outcomes, not barriers and facilitators
McKibbin, C. L., Kitchen, K. A., Wykes, T. L., Lee, A. A., Barriers and facilitators of a healthy lifestyle among persons with serious and persistent mental illness: perspectives of community mental health providers, Community Mental Health Journal, 50, 566-576, 2014	Topic was not on ways to integrate multiple service providers

Study	Reason for Exclusion
McQueen, J. M., Turner, J., Exploring forensic mental health service users' views on work: An interpretative phenomenological analysis, British Journal of Forensic Practice, 14, 168-179, 2012	Study recommended collaboration, but did not look at not barriers and facilitators
Mellifont, D., DESperately Seeking Service: A narrative review informing a disability employment services reform framework for Australians with mental illness, Work (Reading, Mass.), 58, 463-472, 2017	Study did not use qualitative methods as specified in the scope
Mesidor, M., Gidugu, V., Rogers, E. S., Kash-Macdonald, V. M., Boardman, J. B., A qualitative study: barriers and facilitators to health care access for individuals with psychiatric disabilities, Psychiatric rehabilitation journal, 34, 285-294, 2011	Not specific to a rehabilitation setting
Meyer-Kalos, P. S., Lee, M. G., Studer, L. M., Line, T. A., Fisher, C. M., Opportunities for Integrating Physical Health Within Assertive Community Treatment Teams: Results from Practitioner Focus Groups, Community Mental Health Journal, 53, 306-315, 2017	Integrating a new topic with a single service, not integrating multiple services
Mize, Timothy I., Paolo-Calabrese, Michelle A., Williams, Thelma J., Margolin, Helen K., Managing the landlord role: How can one agency provide both rehabilitation services and housing with collaboration?, Psychiatric rehabilitation journal, 22, 117-122, 1998	This review paper did not present any qualitative data
Mohan, R., Slade, M., Fahy, T. A., Clinical characteristics of community forensic mental health services, Psychiatric Services, 55, 1294-8, 2004	Study was not specifically in a rehabilitation setting and very broad about the mental health population it was focused on
Moll, S., Holmes, J., Geronimo, J., Sherman, D., Work transitions for peer support providers in traditional mental health programs: Unique challenges and opportunities, Work, 33, 449-458, 2009	Integrating a peer-led intervention into a service, rather than multiple services
Morant, N., Lloyd-Evans, B., Gilburt, H., Slade, M., Osborn, D., Johnson, S., Implementing successful residential alternatives to acute in-patient psychiatric services: Lessons from a multi-centre study of alternatives in England, Epidemiology and Psychiatric Sciences, 21, 175-185, 2012	Study was not in a rehabilitation setting
Moxham, L., Patterson, C., Taylor, E., Perlman, D., Sumskis, S., Brighton, R., A multidisciplinary learning experience contributing to mental health rehabilitation, Disability and rehabilitation, 39, 98-103, 2017	Topic was not on ways to integrate multiple service providers
Panayiotopoulos, Christos, Kerfoot, Michael, Evaluative Survey of Service Users and Professional Experiences of a Vocational Rehabilitation Unit for the Mentally Ill in Cyprus, International Journal of Mental Health, 42, 3-16, 2013	Study recommended collaboration, but did not look at not barriers and facilitators
Piat, M., Sabetti, J., Bloom, D., The transformation of mental health services to a recovery-orientated system of care: Canadian decision maker perspectives, The International journal of social psychiatry, 56, 168-177, 2010	The focus is on recovery ethos across services, not on integrating services
Pringle, J., Grasso, K., Lederer, L., Integrating the Integrated: Merging Integrated Dual Diagnosis Treatment (IDDT) with Housing First, Community Mental Health Journal, 53, 672-678, 2017	Topic evaluated one service, not integrating multiple service providers
Randolph, F., Blasinsky, M., Leginski, W., Parker, L. B., Goldman, H. H., Creating integrated service systems for	Study did not use qualitative methods as specified in the scope

Study	Reason for Exclusion
homeless persons with mental illness: The ACCESS program, Psychiatric Services, 48, 369-373, 1997	
Rapp, C. A., Etzel-Wise, D., Marty, D., Coffman, M., Carlson, L., Asher, D., Callaghan, J., Whitley, R., Evidence-based practice implementation strategies: results of a qualitative study, Community Mental Health Journal, 44, 213-24; discussion 225-6, 2008	Study did not use qualitative methods as specified in the scope
Rasch, R. F. R., Davidson, D., Seiters, J., MacMaster, S. A., Adams, S., Darby, K., Cooper, R. L., Integrated recovery management model for ex-offenders with co-occurring mental health and substance use disorders and high rates of hiv risk behaviors, Journal of the Association of Nurses in AIDS Care, 24, 438-448, 2013	Study enquired about outcomes, not barriers and facilitators
Roberts, D. L., Penn, D. L., Labate, D., Margolis, S. A., Sterne, A., Transportability and feasibility of Social Cognition And Interaction Training (SCIT) in community settings, Behavioural & Cognitive Psychotherapy, 38, 35-47, 2010	Study did not use qualitative methods as specified in the scope
Rohde, D., Nehls, N., Caring for individuals with severe and persistent mental illness: the contributions and challenges of residential case aides, Issues in Mental Health Nursing, 17, 325-336, 1996	Topic was not on integrating multiple service providers
Ryan, T., Pearsall, A., Hatfield, B., Poole, R., Long term care for serious mental illness outside the NHS: A study of out of area placements, Journal of Mental Health, 13, 425-429, 2004	Study did not enquired about barriers and facilitators to service integration
Schindler, V. P., Sauerwald, C., Outcomes of a 4-year program with higher education and employment goals for individuals diagnosed with mental illness, Work, 46, 325-36, 2013	Topic was not on ways to integrate multiple service providers
Schmidt, Laura, Specialization in alcoholism and mental health residential treatment: The "dual diagnosis" problem, Journal of Drug Issues, 21, 859-874, 1991	Study was not specifically in a rehabilitation setting and very broad about the mental health population it was focused on
Seebohm, P., Secker, J., Increasing the vocational focus of the community mental health team, Journal of interprofessional care, 17, 281-291, 2003	Study was not specifically in a rehabilitation setting and very broad about the mental health population it was focused on
Smith, E., Mackenzie, L., How occupational therapists are perceived within inpatient mental health settings: The perceptions of seven Australian nurses, Australian Occupational Therapy Journal, 58, 251-260, 2011	Study was not specifically in a rehabilitation setting and very broad about the mental health population it was focused on
Sumsion, T., Lencucha, R., Balancing challenges and facilitating factors when implementing client-centred collaboration in a mental health setting, British Journal of Occupational Therapy, 70, 513-520, 2007	Topic was not on ways to integrate multiple service providers
Young, N. K., Grella, C. E., Mental health and substance abuse treatment services for dually diagnosed clients: results of a statewide survey of county administrators, Journal of Behavioral Health Services & Research, 25, 83-92, 1998	Study did not use qualitative methods as specified in the scope
Zarate, R., Glynn, S., Turner, L., Mitchell, S., Smith, K., Green, M. F., Kopelowicz, A., Liberman, R., Kern, R. S., Peer advocates as implementers of evidence-based supported employment/education services: Preliminary	Conference abstract

Study	Reason for Exclusion
findings on feasibility and efficacy, Schizophrenia Bulletin, 1), 285, 2011	

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2 **Economic studies**

3 A global economic literature search was undertaken for this guideline, covering all 18 review
4 questions. The table below is a list of excluded studies across the entire guideline and
5 studies listed were not necessarily identified for this review question.

6 **Table 7: Excluded studies from the economic component of the review**

Study	Reason for Exclusion
Aitchison, K J, Kerwin, R W, Cost-effectiveness of clozapine: a UK clinic-based study (Structured abstract), British Journal of PsychiatryBr J Psychiatry, 171, 125-130, 1997	Available as abstract only.
Barnes, T. R., Leeson, V. C., Paton, C., Costelloe, C., Simon, J., Kiss, N., Osborn, D., Killaspy, H., Craig, T. K., Lewis, S., Keown, P., Ismail, S., Crawford, M., Baldwin, D., Lewis, G., Geddes, J., Kumar, M., Pathak, R., Taylor, S., Antidepressant Controlled Trial For Negative Symptoms In Schizophrenia (ACTIONS): a double-blind, placebo-controlled, randomised clinical trial, Health Technology Assessment (Winchester, England)Health Technol Assess, 20, 1-46, 2016	Does not match any review questions considered in the guideline.
Barton, Gr, Hodgekins, J, Mugford, M, Jones, Pb, Croudace, T, Fowler, D, Cognitive behaviour therapy for improving social recovery in psychosis: cost-effectiveness analysis (Structured abstract), Schizophrenia ResearchSchizophr Res, 112, 158-163, 2009	Available as abstract only.
Becker, T., Kilian, R., Psychiatric services for people with severe mental illness across western Europe: what can be generalized from current knowledge about differences in provision, costs and outcomes of mental health care?, Acta Psychiatrica Scandinavica, SupplementumActa Psychiatr Scand Suppl, 9-16, 2006	Not an economic evaluation.
Beecham, J, Knapp, M, McGilloway, S, Kavanagh, S, Fenyo, A, Donnelly, M, Mays, N, Leaving hospital II: the cost-effectiveness of community care for former long-stay psychiatric hospital patients (Structured abstract), Journal of Mental HealthJ Ment Health, 5, 379-94, 1996	Available as abstract only.
Beecham, J., Knapp, M., Fenyo, A., Costs, needs, and outcomes, Schizophrenia BulletinSchizophr Bull, 17, 427-39, 1991	Costing analysis prior to year 2000
Burns, T., Raftery, J., Cost of schizophrenia in a randomized trial of home-based treatment, Schizophrenia BulletinSchizophr Bull, 17, 407-10, 1991	Not an economic evaluation. Date is prior to 2000

Study	Reason for Exclusion
Bush, P. W., Drake, R. E., Xie, H., McHugo, G. J., Haslett, W. R., The long-term impact of employment on mental health service use and costs for persons with severe mental illness, Psychiatric ServicesPsychiatr Serv, 60, 1024-31, 2009	A United States costing analysis. Outcomes which relate to the Welfare system differs in substantial ways to a UK context.
Chalamat, M., Mihalopoulos, C., Carter, R., Vos, T., Assessing cost-effectiveness in mental health: vocational rehabilitation for schizophrenia and related conditions, Australian & New Zealand Journal of PsychiatryAust N Z J Psychiatry, 39, 693-700, 2005	Australian cost-benefit analysis - welfare system differs from UK context.
Chan, S., Mackenzie, A., Jacobs, P., Cost-effectiveness analysis of case management versus a routine community care organization for patients with chronic schizophrenia, Archives of Psychiatric NursingArch Psychiatr Nurs, 14, 98-104, 2000	Study conducted in Hong Kong. A costing analysis.
Clark, R. E., Teague, G. B., Ricketts, S. K., Bush, P. W., Xie, H., McGuire, T. G., Drake, R. E., McHugo, G. J., Keller, A. M., Zubkoff, M., Cost-effectiveness of assertive community treatment versus standard case management for persons with co-occurring severe mental illness and substance use disorders, Health Services ResearchHealth Serv Res, 33, 1285-308, 1998	Not cost-utility analysis. Cost-effectiveness analysis but does not consider UK setting. Date of study is prior to year 2000.
Crawford, M. J., Killaspy, H., Barnes, T. R., Barrett, B., Byford, S., Clayton, K., Dinsmore, J., Floyd, S., Hoadley, A., Johnson, T., Kalaitzaki, E., King, M., Leurent, B., Maratos, A., O'Neill, F. A., Osborn, D., Patterson, S., Soteriou, T., Tyrer, P., Waller, D., Matisse project team, Group art therapy as an adjunctive treatment for people with schizophrenia: a randomised controlled trial (MATISSE), Health Technology Assessment (Winchester, England)Health Technol Assess, 16, iii-iv, 1-76, 2012	Study not an economic evaluation.
Dauwalder, J. P., Ciompi, L., Cost-effectiveness over 10 years. A study of community-based social psychiatric care in the 1980s, Social Psychiatry & Psychiatric EpidemiologySoc Psychiatry Psychiatr Epidemiol, 30, 171-84, 1995	Practice has changed somewhat since 1980s - not a cost effectiveness study.
Garrido, G., Penades, R., Barrios, M., Aragay, N., Ramos, I., Valles, V., Faixa, C., Vendrell, J. M., Computer-assisted cognitive remediation therapy in schizophrenia: Durability of the effects and cost-utility analysis, Psychiatry ResearchPsychiatry Res, 254, 198-204, 2017	Cost effectiveness study, but population of interest is not focussed on rehabilitation for people with complex psychosis.
Hallam, A., Beecham, J., Knapp, M., Fenyo, A., The costs of accommodation and care. Community provision for former long-stay psychiatric hospital patients, European Archives of Psychiatry & Clinical NeuroscienceEur Arch Psychiatry Clin Neurosci, 243, 304-10, 1994	Economic evaluation predates 2000. Organisation and provision of care may have changed by some degree.

Study	Reason for Exclusion
Hu, T. W., Jerrell, J., Cost-effectiveness of alternative approaches in treating severely mentally ill in California, Schizophrenia BulletinSchizophr Bull, 17, 461-8, 1991	A United States costing analysis. Outcomes which relate to the Welfare system differs in substantial ways to a UK context.
Jaeger, J., Berns, S., Douglas, E., Creech, B., Glick, B., Kane, J., Community-based vocational rehabilitation: effectiveness and cost impact of a proposed program model.[Erratum appears in Aust N Z J Psychiatry. 2006 Jun-Jul;40(6-7):611], Australian & New Zealand Journal of PsychiatryAust N Z J Psychiatry, 40, 452-61, 2006	Study is a New Zealand based costing analysis of limited applicability to the UK.
Jonsson, D., Walinder, J., Cost-effectiveness of clozapine treatment in therapy-refractory schizophrenia, Acta Psychiatrica ScandinavicaActa Psychiatr Scand, 92, 199-201, 1995	Costing analysis which predates year 2000.
Knapp, M, Patel, A, Curran, C, Latimer, E, Catty, J, Becker, T, Drake, Re, Fioritti, A, Kilian, R, Lauber, C, Rossler, W, Tomov, T, Busschbach, J, Comas-Herrera, A, White, S, Wiersma, D, Burns, T, Supported employment: cost-effectiveness across six European sites (Structured abstract), World Psychiatry, 12, 60-68, 2013	Available as abstract only.
Lazar, S. G., The cost-effectiveness of psychotherapy for the major psychiatric diagnoses, Psychodynamic psychiatry, 42, 2014	Review of clinical and cost studies on psychotherapy. Studies cited do not match population for relevant review question.
Leff, J, Sharpley, M, Chisholm, D, Bell, R, Gamble, C, Training community psychiatric nurses in schizophrenia family work: a study of clinical and economic outcomes for patients and relatives (Structured abstract), Journal of Mental HealthJ Ment Health, 10, 189-197, 2001	Structured abstract. Not a cost effectiveness study.
Liffick, E., Mehdiyoun, N. F., Vohs, J. L., Francis, M. M., Breier, A., Utilization and Cost of Health Care Services During the First Episode of Psychosis, Psychiatric ServicesPsychiatr Serv, 68, 131-136, 2017	A United States costing analysis. Outcomes which relate to the Welfare system differs in substantial ways to a UK context.
Mihalopoulos, C., Harris, M., Henry, L., Harrigan, S., McGorry, P., Is early intervention in psychosis cost-effective over the long term?, Schizophrenia BulletinSchizophr Bull, 35, 909-18, 2009	Not a cost utility analysis. Australian costing analysis.
Perlis, R H, Ganz, D A, Avorn, J, Schneeweiss, S, Glynn, R J, Smoller, J W, Wang, P S, Pharmacogenetic testing in the clinical management of schizophrenia: a decision-analytic model (Structured abstract), Journal of Clinical Psychopharmacology, 25, 427-434, 2005	Structured abstract. Does not match any review question considered in this guideline.
Quinlivan, R., Hough, R., Crowell, A., Beach, C., Hofstetter, R., Kenworthy, K., Service utilization and costs of care for severely mentally ill clients in an intensive case management program,	A United States costing analysis. Outcomes which relate to the Welfare system differs in substantial ways to a UK context.

Study	Reason for Exclusion
Psychiatric ServicesPsychiatr Serv, 46, 365-71, 1995	
Roine, E., Roine, R. P., Rasanen, P., Vuori, I., Sintonen, H., Saarto, T., Cost-effectiveness of interventions based on physical exercise in the treatment of various diseases: a systematic literature review, International Journal of Technology Assessment in Health CareInt J Technol Assess Health Care, 25, 427-54, 2009	Literature review on cost effectiveness studies based on physical exercise for various diseases and population groups - none of which are for complex psychosis.
Rosenheck, R A, Evaluating the cost-effectiveness of reduced tardive dyskinesia with second-generation antipsychotics (Structured abstract), British Journal of PsychiatryBr J Psychiatry, 191, 238-245, 2007	Structured abstract. Does not match any review question considered in this guideline.
Rund, B. R., Moe, L., Sollien, T., Fjell, A., Borchgrevink, T., Hallert, M., Naess, P. O., The Psychosis Project: outcome and cost-effectiveness of a psychoeducational treatment programme for schizophrenic adolescents, Acta Psychiatrica ScandinavicaActa Psychiatr Scand, 89, 211-8, 1994	Not an economic evaluation. Cost effectiveness discussed in narrative only, with a few short sentences.
Sacristan, J A, Gomez, J C, Salvador-Carulla, L, Cost effectiveness analysis of olanzapine versus haloperidol in the treatment of schizophrenia in Spain (Structured abstract), Actas Luso-espanolas de Neurologia, Psiquiatria y Ciencias Afines, 25, 225-234, 1997	Available as abstract only.
Torres-Carbajo, A, Olivares, J M, Merino, H, Vazquez, H, Diaz, A, Cruz, E, Efficacy and effectiveness of an exercise program as community support for schizophrenic patients (Structured abstract), American Journal of Recreation Therapy, 4, 41-47, 2005	Available as abstract only
Wang, P S, Ganz, D A, Benner, J S, Glynn, R J, Avorn, J, Should clozapine continue to be restricted to third-line status for schizophrenia: a decision-analytic model (Structured abstract), Journal of Mental Health Policy and Economics, 7, 77-85, 2004	Available as abstract only.
Yang, Y K, Tarn, Y H, Wang, T Y, Liu, C Y, Laio, Y C, Chou, Y H, Lee, S M, Chen, C C, Pharmacoeconomic evaluation of schizophrenia in Taiwan: model comparison of long-acting risperidone versus olanzapine versus depot haloperidol based on estimated costs (Structured abstract), Psychiatry and Clinical Neurosciences, 59, 385-394, 2005	Taiwan is not an OECD country.
Zhu, B., Ascher-Svanum, H., Faries, D. E., Peng, X., Salkever, D., Slade, E. P., Costs of treating patients with schizophrenia who have illness-related crisis events, BMC Psychiatry, 8, 2008	USA costing analysis. The structure of the US health system means that costs do not translate well into a UK context.

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Appendix L – Research recommendations

Research recommendations for review question 2.4: What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

No research recommendations were made for this review question.

Appendix M – Quotes extracted from qualitative papers

Quotes extracted from qualitative papers for review question 2.4: What are the barriers and facilitators to integrated rehabilitation care pathways involving multiple providers (including health, social care, non-statutory, independent and voluntary services)?

Table 8: Quotes extracted from the qualitative papers

Author	Finding	Quote
Bejerholm 2011	IPS and welfare regulations	My client has social phobia and is restricted to her living area. This means that she has failed to go through the PES/SIA rehabilitation before (. . .) In IPS, we work with her. So I invited a professional from the PES to come to where the client is, both regarding process and actual location (. . .) and today, with all that tailored IPS support, he is employed part time
	Interpreting and communicating rules and regulations	You need to approach situations differently, in a unique way for each client . . . You need to talk a lot with the ES.
	Neglected When Needing Help: seeking collaboration	We were in touch with the social services and with some psychiatry doctor but all we were told was that since she [the tenant] didn't request help herself, there was nothing they could do. She had to request help herself in order to get any assistance and that seems insane to us. Nobody wanted to deal with this situation.
Berry 2017	Improved staff team working	Getting everyone's ideas and then realizing people had different ideas and how we can tweak the different angles on them so it benefits the service users. [S915]
	Overcoming initial anxiety	I did feel anxious about it, actually saying that you can't work with certain clients and the way that they make you feel. [S507]
Chen 2014	Developing a Worker–Primary Support Relationship	I always keep the caseworkers informed of [what clients told me]…. Let them know [that] yes I'm here, but I don't want them feeling like I'm taking everything from them, because that's not my purpose – I'm just the added support.
		The best thing you can do is [to] engage everybody that's working with the client… be professional, talk to them, ask them when is [the best time] for me to call them, and what help they need from me.
Dadich 2013	Consumer needs, preferences and clinical considerations	We know where we're going … It makes the big picture more obvious and reduces an ad hoc approach [non-clinical case manager].
		[The two case managers] work better together. The more people, the better the brainstorming and the better the result [consumer].
		[They] said things that I didn't understand. But I'm not qualified to understand what they were talking about [consumer].
	Inclusive, active partner participation	We always work together. Her [case] plan is similar to my [care] plan. [The consumer]' s not receiving contradictory views … the reviews … give us a reason to get together [non-clinical case manager].
Drake 2003	The philosophy of mental health treatment	I regret all the years I spent counseling clients to avoid working, but that was how I was trained. I didn't appreciate that employment is an essential step in recovery for most people. Now I believe that supported employment is a central component of good mental health treatment. We try to make sure that everyone who wants it has the opportunity to work. In our agency, that means the great majority of clients.
Hansson 2010	Theme B: Psychotic symptoms.	That is a problem. I work in the council next to staff from the municipality and I do have access to our physicians' record notes. But my colleague doesn't have access to the same medical record system. I do think we should have a shared system because the risk of errors and mistakes will then be much smaller.
	Theme C: Authorities and financial issues.	We keep in touch and communicate with various authorities like lawyers for debt collection, the count administrative court and even the district court. All contacts start from our clients needs. Sometimes this is problematic due to unclear roles and boundaries. It is not always clear what to do because we have our tentacles in so many places. There is no clear cut boundary between Stockholm council and the municipality and sometimes one have to stop and ask if this really is within my area of competence.

Author	Finding	Quote
Kumar 2017	Results	Is it really Housing First if it doesn't come with rent supplements?
		The [funder] doesn't care to look at the At Home program separately. . . . If you're trying to decrease the cost per unit of service and then you introduce a model that is more costly, then you've got this inherent tension.
		We are accountable to each other by choice, because we wanted to keep the fidelity of the program in place.
McGinty 2018	Organizational fit	…you got to really wrap around people to give them the support that they need. And I feel like those wrap around supports are going to come from something like a PRP. You can't wrap around a person the same way in a community mental health center.
	Geographic proximity	What's nice about having the primary care here and the psychiatrists here is that when there is an issue we can coordinate between the two of them, and sometimes we can even get them to talk to each other
	Health IT	We use CRISP for our notifications on a daily basis, of hospitalizations, ER visits.I have not fully understood how to use [the population health management software] for population health management.It would be different if the different health IT tools spoke to each other… there's like triplicate data entry everywhere.
	Shifting staff roles to support implementation	When it comes to the majority of the actual health homes services it is the staff at the programs who do those services.
Oulvey 2013	Integration	I don't think that consumers really notice a difference (between IPS team members and the VR counselor). I think they see us working together as a team . . . So when you say VR, they think it is us.
Pogoda 2011	Paternalistic-uninformed	They [other clinicians] look at us like we're nuts because we're trying to get folks with a psychotic disorder jobs. [They think] why do we get those with 100% service-connected disability jobs, when other folks need a job? They don't see it as a valuable thing or that these patients can benefit from working. [supported employment program manager]
	Organizational barriers: Lack of education about the model	I'm not a convert at this point. Every time I hear people talk, sometimes I get irritated. I wish someone could explain the evidence base to me. I think others see this as superfluous. [psychiatrist]
	Organizational barriers: Inadequate involvement of leadership	What I want from leadership is to get some recognition. I feel like [the staff and I] work hard, we're out in the community, doing a lot of outreach and education. I feel like from leadership's point-of-view, they're there but they're not there. Sometimes it's hard for me to reach them because I don't feel like I'm getting a whole lot back. [supported employment program manager]
Rebeiro Gruhl 2012	Jurisdictional tensions	until the province decides that employment is important for persons with mental illness and flows dollars to the Local Health Integration Networks (LHINs) for that expressed purpose, little will change within the community mental health system [local decision maker]
	Funding tensions	And a lot of times this is one of those 40% cases where it just doesn't lead to anything andwe haven't seen any kind of payment for any of that work that was done
		My employer, I worked for that employer, like I worked four years to get that employer to call me first so I'm not about to, if I can't fill a position, to contact an alternate service provider. Why would they go through me next time rather than just going to that service provider, so that's unfortunately the mindset. . . Yeah, and that's the same as me going to [names an agency] with my employer to get this wage subsidy. Well, I'm giving you my employers name, the, the employers phone number, you're going to have a sit down meeting with this employer. Do you think he's going to call [names service provider] next time or do you think he's going to call [names agency] directly?
		That you know the job coaching is there before they are employed, but once they are employed over that 20 hours, they're considered employed and the services are no longer there, right? Where, with some of them, they need long-term job coaching, right? Maybe it's not, you know, maybe but it might be like 2 hours a week. . . At that point because you're considered already employed, there are no

Author	Finding	Quote
		services for an already employed applicant. So that's, that a barrier, right, so the services are not there longer term.
Vukadin 2018	Collaboration	I considered it a useful meeting (...) the lines of communication are short… and it's quite useful to have a contact person within those organizations. [MHA practitioner (IPS specialist (a)]
		You need people that are inspired (…) with an extreme level of involvement, because otherwise you won't make it; just procedures aren't enough. You need people that step up and say: I'm going to do this! [MHA decision maker (staff member/ occupational therapist)]
		I think the agreements between MHA and UWV (…) should be documented, because at the moment there is no written information available. [MHA practitioner (IPS specialist (c)]
	IPS funding	(…) it's not just one financial agreement, of course that always creates issues. Ideally, there would be one all-in package [IPS funding] for three years. [MHA decision maker (IPS program leader)]
		The municipality has ensured IPS financing for two years, but that means financing ends next year. The same goes for us, we have agreed on financing up to February 2018. In the period ahead, we will all have to discuss how we can ensure sustainable IPS funding. [HIC decision maker (mental health care adviser)]

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