National Institute for Health and Care Excellence

Final

Social work with adults experiencing complex needs

[C] Supporting changing needs

NICE guideline NG216

Evidence reviews underpinning recommendations 1.1.6 to 1.1.8, 1.2.20, 1.5.1 to 1.5.13 and research recommendation 3 in the NICE guideline

May 2022

Final

These evidence reviews were developed by the National Guideline Alliance

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Contents

This evidence report contains information on 2 reviews relating to planning for the future, the first an effectiveness review and the second, a qualitative review.

- What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?
- Based on the views and experiences of everyone involved, what works well and what could be improved about case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Supporting changing needs

Review questions

- What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?
- Based on the views and experiences of everyone involved, what works well and what can be improved about case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Introduction

Case management and care planning to support changing needs was identified as a topic of key relevance for this guideline because adults with complex needs may experience an increase in difficulties over time or their needs and strengths may fluctuate from day to day. Social work plays an important role in responding promptly and flexibly and ensuring that people's support plans accommodate changing needs, in particular ensuring services and support are carefully coordinated to avoid duplication or gaps. The aim of this review was to establish the most effective approaches to social work case management and care planning and to understand what works well and what could be improved in this context from the perspective of the person being supported, their families and relevant professionals.

Summary of the protocol

Please see Table 1 for a summary of the Population, Intervention, Comparison and Outcome (PICO) characteristics of the effectiveness review question.

Please see Table 2 for a summary of the Population and Phenomenon of interest for the qualitative review question.

Table 1: Summary of the protocol (PICO table) - effectiveness question

Population	• People aged 18 or older with complex needs*. * Studies involving adults who require a high level of support with many aspects of their daily lives will be considered for inclusion. The emphasis is on complex needs, which rely on a range of health and social care services.
Intervention	Social work case management or care planning, which is individualised, collaborative, strengths focused and considers professional and informal supporters, and environment. Includes advance care planning and planning to prevent future escalation of need.
Comparison	Studies using the following comparisons will be included: • 'Standard' care planning, which is more service focused and less individualised, strengths based and focused on professional or informal support networks. • Different types of the specified intervention.
Outcome	**Critical outcomes** Person focused outcomes: • Personal goal attainment – measured using a validated tool (for example, GAS). • Subjective satisfaction with home setting (for example, whether independent, supported, group living or residential). • Subjective quality of life – measured using a validated tool such as ASCOT, ICECAP-A, MANSA or the EQ-5D.

	Service focused outcomes: • Access to appropriate support measured, for example, by the establishment of a care plan, agreement of an advanced care plan, or provision of support for the required duration (subjectively or objectively measured). **Important outcomes** Person focused outcomes: • Unplanned care contacts, for example, emergency or unplanned admission to hospital, contact with community mental health crisis team or unplanned care home admission (either long term or as respite). Service focused outcomes: • Continuity of care and support – measured by contact with the same practitioner or small group of practitioners.

ASCOT: Adult Social Care Outcomes Toolkit; EQ-5D: EuroQol-Five Dimension; GAS: Goal Attainment Scaling; ICECAP-A: ICEpop CAPability measure for adults; MANSA: Manchester Short Assessment.

Table 2: Summary of the protocol (population and phenomenon of interest) – qualitative question

Population	• People aged 18 or older with complex needs*. • Families and supporters of adults with complex needs. • Relevant social-/health-care and other practitioners involved in needs assessment and review for adults with complex needs. * Studies involving adults who require a high level of support with many aspects of their daily lives will be considered for inclusion. The emphasis is on complex needs, which rely on a range of health and social care services.
Phenomenon of interest	Social work case management or care planning, which is individualised, collaborative, strengths focused and considers professional and informal supporters, and environment. Includes advance care planning and planning to prevent future escalation of need. In order to understand what works and what does not work well, from the perspective of everyone involved, the committee want to locate data about the following aspects of case management and care planning: • Issues related to accessing case management and care planning including ongoing review. • Positive aspects of case management and care planning and what works well. • The extent to which case management and care planning consider professional and informal supporters and environment. • Negative aspects of case management and care planning and what improvements could be made. • Perception about the impact of case management and care planning in meeting needs. • Case management and care planning with adults with learning disabilities and complex needs. • Different experiences/ views about various models of case management. • Carers satisfaction with case management and care planning. • Practitioner satisfaction with case management and care planning.

For further details see the review protocol in appendix A.

Methods and process

This is a mixed-methods review using parallel synthesis. Effectiveness and qualitative data were analysed and synthesised separately and integrated through the committee's interpretation of results, described in the committee's discussion of the evidence. This was supported by a further layer of interpretation by the review team, which is set out in table 5 and shows how some of the qualitative themes helped to explain or contextualise the quantitative finings. This table was presented to the committee along with all the effectiveness and qualitative data to help them to integrate the two data types and make recommendations.

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual 2014. Methods specific to these review questions are described in the review protocols in appendix A and the methods document (supplementary document 1).

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

Effectiveness evidence

Included studies

For the effectiveness review, no relevant UK studies were located so, as per the protocol, studies from high income countries in Europe, Australia, New Zealand, South Africa and Canada were considered for inclusion. Six studies were identified which met the inclusion criteria. These were conducted in Canada (Chung 2018), The Netherlands (Creemers 2014, de Vet 2017, Ruchlewska 2014), Sweden (Lindahl 2013) and Switzerland (Bonsack 2016).

The included studies are summarised in Table 3.

Five randomised controlled trials (RCTs) (Bonsack 2016, Chung 2018, de Vet 2017, Lindahl 2013, Ruchlewska 2014) and 1 cluster RCT (Creemers 2014) were included. Two RCTs (Bonsack 2016, de Vet 2017) assessed time-limited interventions which were developed to support vulnerable people during times of transition, focusing on strengthening support systems and co-ordinating care provision, in addition to representing the patient's viewpoints. Bonsack (2016) used questionnaires and hospital records to assess whether a transitional case management intervention compared with treatment as usual improved participant engagement with ambulatory care and reduced the rate of readmission during the follow-up after transfer from a psychiatric hospital. De Vet (2017) used questionnaires to assess whether a critical time intervention compared with care as usual improved quality of life and increased the level of family and social support provided to homeless participants transitioning to community living. Chung (2018) reported subgroup analysis comparing older (50 years old) and younger (18 to 49 years old) homeless adults with mental illness who used Housing First (intensive case management or assertive community treatment) versus usual care. Ruchlewska (2014) compared a Patient Advocate Crisis Plan (PACP) with a Clinician facilitated Crisis Plan (CCP) or no crisis plan to determine whether the different types of crisis plan reduced voluntary or involuntary admissions to a psychiatric hospital, and reduced rates of outpatient emergency visits. The remaining 2 RCTs (Creemers 2014, Lindahl 2013) used questionnaires to assess whether different intensity case management interventions compared with treatment as usual promoted access to social- and health-care services or improved quality of life (QoL).

The study populations included adults being transferred from psychiatric hospitals, adults living with mental and/or substance use disorders (including court committed adults), adults experiencing homeless and mental illness or transitioning to community living, and adults living with amyotrophic lateral sclerosis.

Data on the following outcomes were identified through analysis of the included effectiveness studies:

- Generic and/or condition-specific QoL.
- Access to appropriate support (including family and social support).
- Unplanned care contacts (including ambulatory care contact and rate of hospital admission/readmission).

No meta-analyses were conducted on the studies because, although all interventions were case-management based, none of the interventions were similar enough in their specific components to compare to each other.

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

Excluded studies

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

Summary of included studies

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

Table 3: Summary of included studies

Study	Population	Intervention	Comparison	Outcomes
Bonsack 2016 RCT Switzerland	N=102 adults discharged from psychiatric hospital Intervention, n=51 Control, n=51 Age (years) - mean (±SD) TCM (n=51): 40.0 (11.9) TAU (n=51): 41.3 (10.6) Gender (female) - n (%) TCM: 34 (66.7); TAU: 27 (52.9)	Transitional Case Management (TCM) • Treatment as usual plus input from a case manager, nurse, or a social worker to co-ordinate care provision and represent the patient's viewpoint.	Treatment as Usual (TAU) • Referral to a GP or private psychiatrist after discharge.	• Ambulatory care contact at 1, 3, 6 and 12 months. • Rate of hospital readmission at 12 months.
Chung 2018 RCT Canada	N=2148 homeless adults with mental illness Intervention, n=470 Control, n=1678 Age (years) - mean (±SD): **≥50 years old**	Housing First (HF) • ICM for participants with moderate needs. • ACT for participants with high needs. Case managers	Treatment as Usual (TAU) • Existing services available in participants respective communities	• Generic QoL (EQ-5D) at 12 and 24 months. • Condition-specific QoL (QoLI-20 total score) at 12 and 24 months.

Study	Population	Intervention	Comparison	Outcomes
	HF: 55.4 (4.6); TAU: 56.22 (5.1) **18 to 49 years old** HF: 36.8 (8.7); TAU: 36.8 (8.6) <u>Gender - n (%)</u> **≥50 years old** HF: Male: 176 (69.6); Female or other: 77 (30.4) TAU: Male: 156 (71.9); Female or other: 61 (28.1) **18 to 49 years old** HF: Male: 593 (65.5); Female or other: 312 (34.5) TAU: Male: 519 (67.1); Female or other: 254 (32.9)	develop individualised care plans with participants		
Creemers 2014 RCT The Netherlands	N=31 Amyotrophic Lateral Sclerosis (ALS) teams Intervention, n=16 Control, n=15 N=298 participants with ALS (n=155 case management; n=143 usual care) <u>Patient age (years) - mean (±SD)</u> Case management + usual care: 63 (11); usual care: 62 (11) <u>Sex (male) - %</u> Case management + usual care: 57; usual care: 64	<u>Case management + usual care</u> • Client-centred approach provided by 2 experienced occupational therapists. • Case managers provided participants with information to enable them to make decisions on how they would prefer their needs to be met (in relation to somatic, psychosocial, environmental or care issues)	<u>Usual care</u> Neuropalliative care provided by multi-disciplinary team (including rehabilitation medicine consultant, occupational therapist, physical therapist, speech pathologist, dietician, social worker, psychologist, and consultant physicians). Community and social services (including general practitioners, district nurses, home care services, paramedics, social workers, and voluntary	• Emotional Functioning (Measured using the ALSAQ-40 scale, 0 to 100) at 4, 8 and 12 months.

Study	Population	Intervention	Comparison	Outcomes
			workers) play an important role in care for participants with ALS and their caregivers.	
de Vet 2017 RCT The Netherlands	N=183 homeless adults transitioning to community living Intervention, n=94 Control, n=89 Age (years) - mean (±SD) CTI (n=94): 41.42 (11.27); CAU (n=89): 39.72 (11.87) Gender (female) - n (%) CTI: 51 (54); CAU: 34 (38); p=0.03	Critical Time Intervention (CTI) • Includes different timings: Phase I (transition to the community between discharge and 3 months post-discharge); Phase II (try-out between 3 and 6 months post-discharge); Phase III (transfer of care between 6 and 9 months post-discharge) • In each shelter organisation, 2 or 3 case managers (with a degree in social work or related field) from community service teams delivered the intervention	Care As Usual (CAU) • Provision of services after discharge, but type, approach, intensity, and duration differed depending on the shelter organisation, clients' needs, and funds available, and frequency, intensity and duration were less compared to CTI.	• General QoL at 9 months • Family support at 9 months • Social support at 9 months
Lindahl 2013 Multi-centre RCT Sweden	N=36 adults committed to treatment by an administrative court because of substance abuse Intervention, n=13 Control, n=23 Gender (female) - n (%) Case management: 3 (23); TAU: 6 (26) Age (years) - mean (±SD) Case management (n=13): 34 (12.26);	Case manager • Patient, staff at participating institution, social worker and case manager agree service plan (physical and mental health, legal status, relationship-family, relationship-friends, occupation, substance abuse, housing, budget and skills), and patients short-	Treatment as Usual (TAU) • Conference at the participating institution with a social worker, staff at the institution and the patient with the aim of deciding on a service plan.	• Use of health and social care at 6 months • Use of medical assisted treatment at 6 months • Use of institutional/inpatient care at 6 months

Study	Population	Intervention	Comparison	Outcomes
	TAU (n=23): 40 (11.31)	and long-term goals		
Ruchlewska 2014 RCT The Netherlands	N=211 adults living with schizophrenia or other psychotic disorder Intervention, n=69 Control (CCP), n=70 Control group, n=73 <u>Gender (male) - n (%)</u> PACP: 50 (72.5); CCP: 46 (65.7); control: 49 (67.1) <u>Age in years (SD)</u> PACP: 40.3 (10.9); CCP: 40.6 (11.6); control: 39.4 (11.6)	<u>Patient Advocate Crisis Plan (PACP)</u> • Patient advocates (n=2 social workers) work with service user to develop and agree crisis plan	<u>Clinician facilitated Crisis Plan (CCP)</u> • Clinician (mostly psychiatric nurses) work with service user to develop and agree crisis plan <u>Control group</u> • No crisis plan	• Psychiatric hospital admissions at 18 months (including voluntary and involuntary admissions) • Hospital admissions (voluntary) at 18 months' • Emergency visits • Emergency admission at 18 months • Admission under court order

ACT: assertive community treatment; ALS: amyotrophic lateral sclerosis; ALSAQ-40: Amyotrophic Lateral Sclerosis Assessment Questionnaire 40 item; CAU: care as usual; CCP: Clinician facilitated Crisis Plan; CTI: critical time intervention; EQ-5D: EuroQol-5 Dimension; HF: Housing First; ICM: intensive case management; NA: not applicable; PACP: Patient Advocate Crisis Plan; QoL: quality of life; QoLI-20: Lehman Quality of Life Interview 20 Index; RCT: randomised controlled trial; SD: standard deviation; TAU: treatment as usual; TCM: transitional case management.

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

Qualitative evidence

Included studies

A systematic review of the literature was conducted using a combined search for all qualitative questions. Eleven studies were included (Abendstern 2019, Archard 2015, Biringer 2017, Carver 2012, Dadich 2013, de Lange 2018, Donnelly 2019, Goodridge 2019, O'Donnell 2015, Redfern 2016, Uittenbroek 2018).

The included studies are summarised in Table 4.

The data provided evidence on the views and experiences of social work approaches to case management and care planning (Abendstern 2019, Archard 2015, Carver 2012). These studies were judged to be an insufficient basis for the purpose of decision making so as per the protocol, studies from high income countries in Europe (including the Republic of Ireland), Australia, New Zealand, South Africa and Canada were also considered for inclusion. Eight such studies were identified which met all other inclusion criteria. These were conducted in Australia (Dadich 2013, Redfern 2016), Canada (Goodridge 2019), the Republic of Ireland (Donnelly 2019, O'Donnell 2015), Norway (Biringer 2017), and The Netherlands (de Lange 2018, Uittenbroek 2018).

Data collection methods included face-to-face or telephone interviews and focus groups (or a combination of both).

Study populations included service users (including people with chronic illness or mental illness and complex needs); practitioners providing support to older people with low level or complex needs, working within adult social care, brokerage, hospital discharge support, and specialist dementia advice and support services; social worker case managers providing care to frail older adults, adults living with dementia, adults hospitalised with a disability, and older adults at risk of abuse and mistreatment; and outreach workers providing support to service users living in deprived areas and with individual needs for a variety of issues (from physical activity to alcoholism).

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

Excluded studies

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

Summary of included studies

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

Table 4: Summary of included studies

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Abendstern 2019 General qualitative inquiry England **Aim of study** To increase the understanding of the role of the non-statutory sector in the provision of care coordination for older people in England	N=13 practitioners in 13 fieldwork sites, grouped into four types Practitioners working within adult social care, brokerage, hospital discharge support, and specialist dementia advice and support services Providing short- or long-term support to older adults with low level needs or complex needs	**Data collection:** Semi-structured interviews (lasting approximately 1 hour) were audio recorded and transcribed. **Data analysis:** Deductive and inductive data analysis	The extent to which case management and care planning consider professional and informal supporters and environment: • environment. Perception about the impact of case management and care planning in meeting needs: • assessments • professional roles • continuity of care • choice and flexibility • advocacy.

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Archard 2015 General qualitative inquiry United Kingdom **Aim of study** To examine experiences of the support work programme by people using services in supported housing for people experiencing homelessness, and to explore the worker-service user engagement and influence of context on positive outcomes	N=4 people using a specialist traumatic stress service Gender (male) - n (%) 4 (100) Age (years) – range 45 to 58 N=2 Social support workers	**Data collection:** Narrative interviews, which were conducted on service premises and participants' residences and lasted between 50 and 80 minutes. **Data analysis:** Thematic analysis	Positive aspects of case management and care planning and what works well: • relationships • respect and dignity Negative aspects of case management and care planning and what improvements could be made: • relationships Practitioner satisfaction with case management and care planning: • working arrangements
Biringer 2017 Hermeneutic-phenomenological design Norway **Aim of study** To explore the experiences and perceptions of people with mental health in continuity of care within and across services in relation to recovery	N=10 people referred to the community mental health centre Follow-up at 2 years: n=8 Age (years) - mean (range) 33 (18 to 54) Gender - n Male: n=6 Female: n=4	**Data collection:** Interviews, which lasted approximately 1 hour at baseline and follow-up and took place in a setting of the participant's choice. **Data analysis:** A data-driven stepwise approach, in line with thematic analysis. For the 8 participants with follow-up data, data were analysed longitudinally to identify changes in insights and perceptions	Positive aspects of case management and care planning and what works well: • relationships • knowledge Negative aspects of case management and care planning and what improvements could be made: • relationships • knowledge and communication Perception about the impact of case management and care planning in meeting needs: • meeting needs • choice and flexibility

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Carver 2012 General qualitative inquiry Scotland **Aim of study** To improve the understanding of the views of staff and people using services in terms of the Keep Well outreach worker role	N=4 people using support from a Keep Well outreach worker Keep Well Staff: N=12 (Outreach Worker [OW]: n=4)	**Data collection:** Interviews conducted mainly by telephone; lasting for approximately 24 minutes with Keep Well Staff and 7 minutes with service users **Data analysis:** Thematic analysis	Perception about the impact of case management and care planning in meeting needs: • meeting needs Practitioner satisfaction with case management and care planning: • professional roles • resources
Dadich 2013 General qualitative inquiry and document analysis Australia **Aim of study** To examine how clinical and non-clinical case managers work together in care planning and explore the perceived influence of support	N=20 people using the Housing and Accommodation Support Initiative (HASI) with a poor housing history and chronic mental illness: <u>Sex (males) - n/N (% calculated)</u> 13/20 (65) <u>Age (years)</u> 37	**Data collection:** Semi-structured, open-ended interviews. **Data analysis:** Triangulation using constant comparison analysis.	Issues related to accessing case management and care planning including ongoing review: • relationships Positive aspects of case management and care planning and what works well: • collaboration Perception about the impact of case management and care planning in meeting needs: • meeting needs Practitioner satisfaction with case management and care planning: • collaboration
de Lange 2018 Grounded theory design The Netherlands **Aim of study** To identify facilitating factors for case management in dementia care	N=13 regional dementia care networks N=99 practitioners(including n=42 case managers)	**Data collection:** One focus group was conducted for each participating regional dementia care network using a web-based application. A topic guide with discussion questions and statements were developed and participants could log in, read others' comments and respond at any	Positive aspects of case management and care planning and what works well: • collaboration Practitioner satisfaction with case management and care planning: • collaboration • resources • professional roles

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
from the perspectives of professionals involved in dementia care		point within a 2-week period **Data analysis:** Grounded theory and thematic analysis	
Donnelly 2019 Phenomenological study Ireland **Aim of study** To assess older people's involvement in decision-making relating to care planning, focusing on people with a cognitive impairment and dementia	N=21 social workers <u>Setting</u> Primary Community and Continuing Care (PCCC); Adult Safeguarding; Medical, Psychiatry of Later Life; and Adult Mental Health services	**Data collection:** In-depth telephone interviews lasting between 40 and 90 minutes **Data analysis:** An interpretive inductionist framework	The extent to which case management and care planning consider professional and informal supporters and environment: • level of support • advocacy • family support • environment Perception about the impact of case management and care planning in meeting needs: • capacity and decision-making • choice and flexibility Practitioner satisfaction with case management and care planning: • professional roles
Goodridge 2019 General qualitative inquiry Canada **Aim of study** To identify challenges relating to availability, accessibility, and acceptability faced by socially complex patients with COPD who were eligible for a traditional CDMP, but declined participation	N=37 people with chronic disease and complex social needs Interviewed Participants: N=4 patients (9 agreed to be interviewed, but 5 were lost to follow-up); N=2 Managers; N=1 social work Case Manager <u>Age (years) - median (range)</u> 53 (28 to 78) <u>Gender (male) - n (%)</u>	**Data collection:** Interviews were conducted in their homes or another location of their choice **Data analysis:** Theory-driven thematic analysis	Issues related to accessing case management and care planning including ongoing review: • accessibility • relationships Negative aspects of case management and care planning and what improvements could be made: • knowledge and communication • relationships • respect and dignity Perception about the impact of case management and care

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	19 (51.4)		planning in meeting needs: • Meeting needs
O'Donnell 2015 General qualitative inquiry Ireland **Aim of study** To explore the experiences of social care workers who are responsible for managing case of elder abuse in Ireland, to inform practice	N=16 Senior case managers with over 10 years of social work experience	**Data collection:** Interviews were conducted using a topic guide, at a convenient time and place to the participant (usually their place of work). **Data analysis:** Inductive thematic analysis	Positive aspects of case management and care planning and what works well: • collaboration • respect and dignity • relationships The extent to which case management and care planning consider professional and informal supporters and environment: • advocacy • family support Perception about the impact of case management and care planning in meeting needs: • assessments • continuity of care • capacity and decision-making. • Practitioner satisfaction with case management and care planning: • collaboration • resources
Redfern 2016 General qualitative inquiry Australia **Aim of study** To explore how transitions from acute hospital care to the next-level-of-care could be more effective and efficient in patients with disabilities under the age of 65 years	N=5 Social workers experienced in working with adults living with disabilities	**Data collection:** Participants were interviewed for approximately 45 minutes using a semi-structured interview schedule **Data analysis:** Thematic analysis	Issues related to accessing case management and care planning including ongoing review: • accessibility The extent to which case management and care planning consider professional and informal supporters and environment: • level of support • advocacy Perception about the impact of care management and care

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
			planning in meeting needs: • meeting needs Practitioner satisfaction with case management and care planning: • collaboration • resources
Uittenbroek 2018 Grounded theory design The Netherlands **Aim of study** To assess how district nurses and social workers experience their roles as case managers within Embrace, a person-centred and integrated-care service for community-living older adults	N=5 Case managers (district nurses: n=6; social workers: n=5). <u>Age (years) - mean (range)</u> 57 (49 to 61) <u>Gender (female) - n (%)</u> 5 (100)	**Data collection:** Face-to-face, in-depth interviews, lasting approximately 107 minutes **Data analysis:** Grounded theory	• Positive aspects of case management and care planning and what works well: • relationships Perception about the impact of care management and care planning in meeting needs: • assessments • continuity of care • choice and flexibility Practitioner satisfaction with case management and care planning: • collaboration • professional roles • working arrangements

CDMP; Chronic Disease Management Programs; COPD: Chronic obstructive pulmonary disease; HASI: Housing and Accommodation Support Initiative; OW: outreach worker; PCCC: Primary Community and Continuing Care.

See the full evidence tables in appendix D.

The following themes were identified through analysis of the included studies:

- What works well:
  - Positive aspects of case management and care planning and what works well.
    - Relationships
    - Respect and dignity
    - Collaboration
    - Knowledge
  - The extent to which case management and care planning consider professional and informal supporters and environment.
    - Family support
    - Advocacy
  - Perception about the impact of case management and care planning in meeting needs.
    - Assessments
    - Choice and flexibility
    - Continuity of care
    - Identifying needs
  - Practitioner satisfaction with case management and care planning.

    - Collaboration
    - The key roles of case managers
    - Working arrangements

- What could be improved:
    - Issues related to accessing case management and care planning including ongoing review.
        - Barriers to involvement
        - Influence of subjective feelings and experiences
    - The extent to which case management and care planning consider professional and informal supporters and environment.
        - Role of family and wiser support
        - Importance of the right environment
    - Negative aspects of case management and care planning and what improvements could be made
        - Knowledge and communication
        - Relationships
        - Respect and dignity
    - Perception about the impact of case management and care planning in meeting needs.
        - Choice and flexibility
        - Changing needs
        - Capacity decision making and involvement
    - Practitioner satisfaction with case management and care planning.
        - Difficulties arising from collaboration
        - Professional competencies
        - Resource restrictions

The theme maps (Figure 1and Figure 2) illustrate these overarching themes, their related themes and sub-themes. Overarching themes are shown below in orange, related themes in blue and sub-themes in green.

Figure 1: theme map – what works well

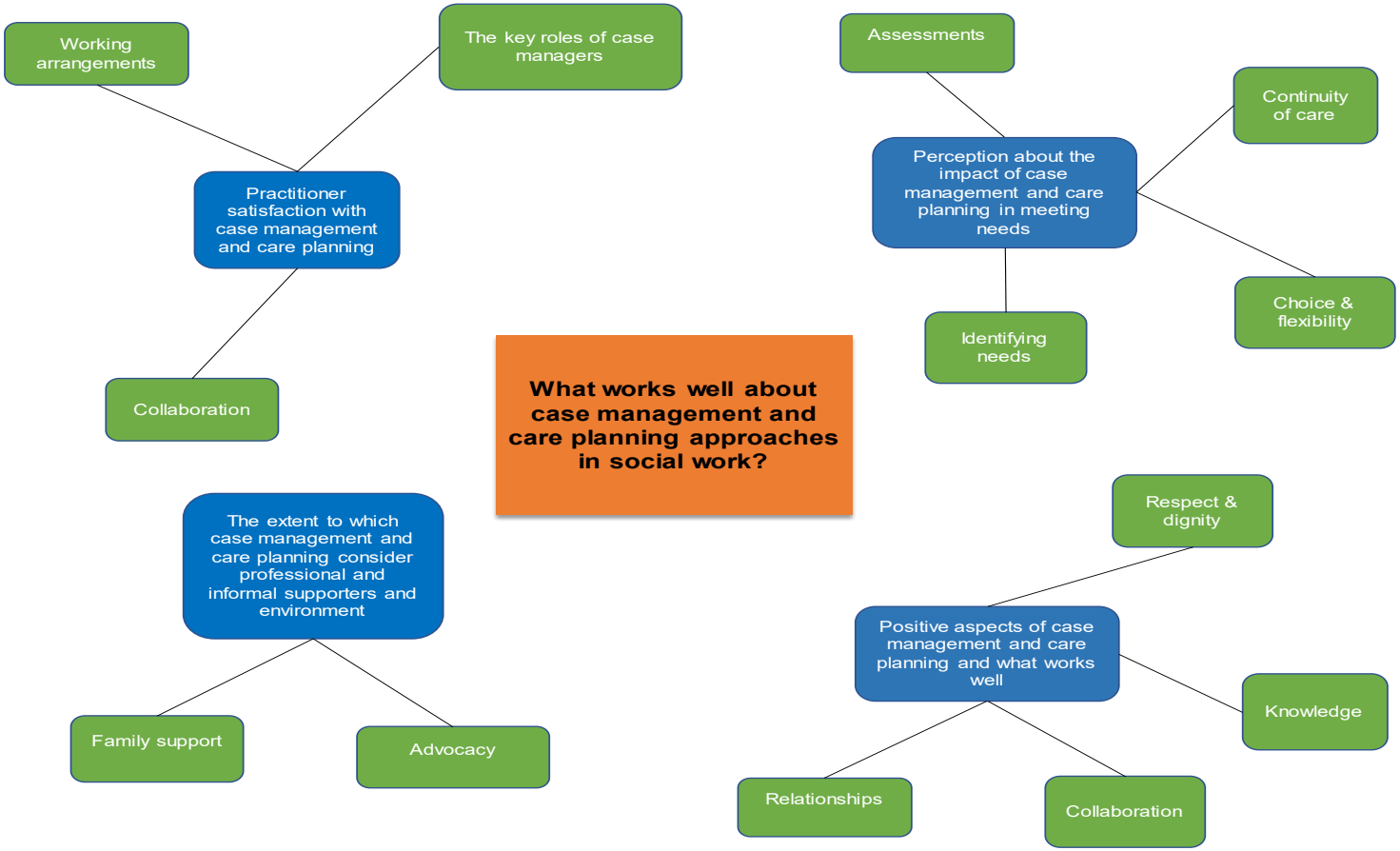
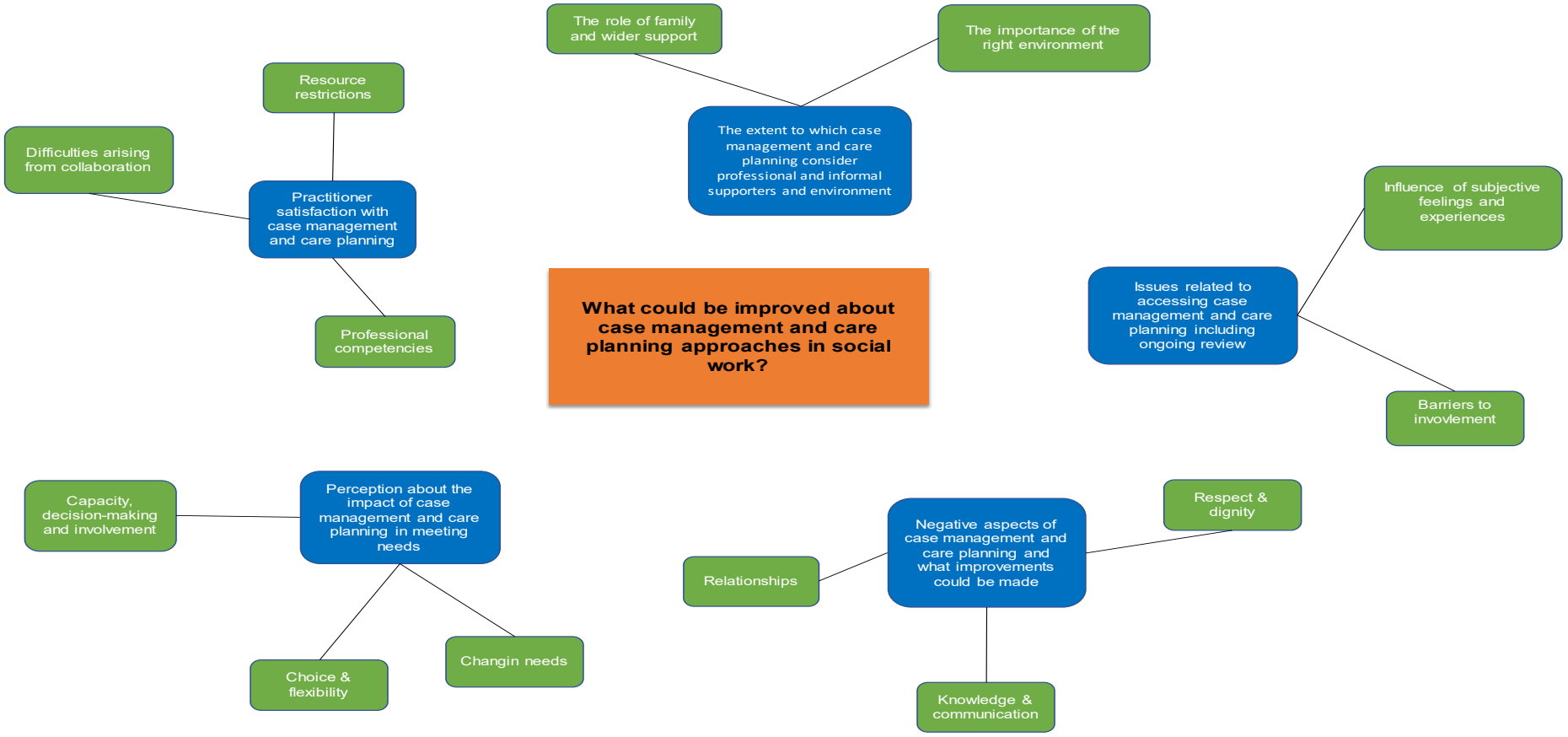


Figure 2: Theme map – what could be improved



Summary of the evidence

Effectiveness evidence

One RCT, comparing housing first to treatment as usual, identified data for the critical outcome, subjective quality of life. The evidence showed no important difference between groups for changes from baseline for generic quality of life, or condition specific quality of life, at 12 or 24 months follow up.

One RCT compared a critical time intervention to care as usual, and data were identified for the critical outcomes quality of life and access to appropriate support. The evidence showed no important difference between groups for quality of life at 9 months follow up. There was also no important difference between groups for access to appropriate support, assessed by access to family support or social support at 9 months follow up.

One cluster RCT compared case management to usual care. Data were identified for the critical outcome, subjective quality of life, which was assessed using amyotrophic lateral sclerosis assessment questionnaire (ALSAQ-40), for emotional functioning. The evidence showed no important differences between the groups for this outcome at 4, 8 or 12 months follow up.

One RCT, comparing transitional case management to treatment as usual, identified data for the important outcome, unplanned care contacts. When assessed using ambulatory care contacts, the evidence showed no statistically significant difference at 1 month follow up, but an important benefit favouring transitional case management at 3 months follow up. There was no important difference between the groups for unplanned care contacts when assessed with rate of hospital admission at 12 months follow up.

One RCT compared case management to treatment as usual. Data were identified for the critical outcome access to appropriate support, assessed by use of health and social care, and the important outcome unplanned care contacts, assessed by use of medical assisted treatment and use of institutional/inpatient care. The evidence showed that there was no important difference between case management and treatment as usual for use of health and social care. There was also no statistically significant difference between groups for medical assisted treatment or institutional/inpatient care. However, the effect size was neither reported nor calculable.

One RCT compared a Patient Advocate Crisis Plan (PACP) to no crisis plan, and to a Clinician facilitated Crisis Plan (CCP). Data were identified for the important outcome unplanned care contacts, assessed by rate of psychiatric hospital admissions (both voluntary and involuntary) and emergency visits at 18 months. The evidence showed no important difference between PACP and no crisis plan for all outcomes, and also no important difference between PACP and CCP for all outcomes.

See appendix F for full GRADE tables.

Qualitative evidence

Ten qualitative studies provided evidence relating to the overarching theme of ‘what works well’ in social work case management and care planning. Six studies provided data for themes relevant to the positive aspects of case management and care planning, such as building good relationships. Four studies contributed data for themes relevant to the extent to which case management and care planning consider professional and informal supporters and environment. Seven studies provided data for themes relevant to perception about the impact of case management and care planning in meeting needs, which included benefits around undertaking comprehensive assessments to focus on people’s strengths, and tailoring support plans to include continuity of care and availability of support. Data from 5

studies generated themes related to practitioner satisfaction with case management and care planning.

Eleven qualitative studies provided evidence relating to the overarching theme of 'what could be improved' about social work case management and care planning. Data from 2 studies generated themes around issues related to accessing case management and care planning including ongoing review. Three studies provided data for themes relevant to the extent to which case management and care planning consider professional and informal supporters and the environment. Three studies provided data around the negative aspects and what improvements could be made. Data around what could be improved about the impact of case management and care planning on meeting needs, was supported by 5 studies. Six studies provided data for themes around what could be improved about practitioner satisfaction, which included lack of collaboration and cooperation between professionals.

See appendix F for full GRADE CERQual tables.

Synthesis of effectiveness and qualitative data

Although the effectiveness and qualitative syntheses were conducted in parallel, some of the qualitative evidence did help to explain or contextualise some of the effectiveness findings. In Table 5 relevant themes are listed from the qualitative evidence and are matched to the effectiveness evidence. The final column of the table provides a possible explanation for the effectiveness results based on the qualitative findings. The contents of Table 5 are therefore limited to the effectiveness results for which there was a qualitative explanation. For the complete results of the effectiveness synthesis and qualitative synthesis see the GRADE and GRADE-CERQual tables in appendix F.

Table 5: Evidence synthesis (effectiveness and qualitative data)

Qualitative Themes	Overall confidence in the findings	Effectiveness evidence	Quality	Explanatory contribution of qualitative findings on effectiveness results
C1.3 Perception about the impact of case management and care planning in meeting needs: C1.3.1: Assessments Data from 4 studies (Abendstern 2019, O'Donnell 2015, Redfern 2016 and Uittenbroek 2018) highlighted the importance of undertaking comprehensive assessments to gain an in-depth insight into people's circumstances and complexity of needs, in order to tailor a support plan to their needs and set of circumstances, particularly if there are significant intellectual capacity issues. However, the focus of assessments varied dependent on the target	LOW	*Person focused outcomes: Access to appropriate support* Social work case management or care planning (transitional case management[1]) appeared to have an important benefit over 'standard' care planning (treatment as usual) in terms of ambulatory care contact measured at 3 months after hospital discharge, but this benefit did not remain at 3 to 12 months. There was no important difference between social work case management or care planning (case management[2] or critical time intervention[3]) and 'standard' care planning (treatment as usual/care as usual) for contact with	LOW TO VERY LOW (3 RCTs)	The evidence indicating no important difference between case management or care planning intervention and 'standard' care planning perhaps suggests that case management/care planning may not have been tailored to meet the different needs of the person, and therefore didn't show benefit over 'standard' care planning.

Qualitative Themes	Overall confidence in the findings	Effectiveness evidence	Quality	Explanatory contribution of qualitative findings on effectiveness results
group of different service providers.		health and/or social care, or access to family and social support.		
C1.3 Perception about the impact of case management and care planning in meeting needs: C1.3.3: Continuity of care Data from 3 studies (Abendstern 2019, O'Donnell 2015 and Uittenbroek 2018) reported that continuity of care in terms of monitoring and reviewing peoples' care plans and situations through regular communications were essential. However, this could vary across different types of services and depended on the length of contact with service providers. Longer term services were more likely than shorter term ones to have a monitoring role.	MODERATE			Again, the absence of benefit over 'standard' care planning perhaps suggests that case management/care planning may not have provided sufficient contact with case managers and/or insufficient monitoring and reviewing – CTI reduced the intensity of contact over the 9-month intervention? Also note that the intensity of care as usual in The Netherlands was reported by the authors to be quite high during the study period (with about a quarter of participants continuing to receive services frequently

Qualitative Themes	Overall confidence in the findings	Effectiveness evidence	Quality	Explanatory contribution of qualitative findings on effectiveness results
C2.4 Perception about the impact of case management and care planning in meeting needs: C2.4.2 Changing needs Data from 3 studies (Biringer 2017, Dadich 2013, Goodridge 2019) highlighted negative views in relation to certain aspects of case management and care planning, including variation in the care planning process (for example, frequency of meetings and monitoring plans). Although most people were happy with the frequency of review meetings, others preferred it to be more or less often to "speed things up" (person using services).	LOW			throughout follow-up). NB: n=12 participants allocated to CTI deviated from the protocol (n=4 in the care as usual group). Also, the paper reported statistically significant effect on family support, but we didn't find any benefit as per NGA criteria.

[1] Bonsack 2016 – a case manager (nurse or social worker) added to treatment as usual to coordinate care provision and represent the patient's viewpoint. To improve continuity of care (system coordination, engagement in psychiatric care, continuation of substance abuse treatment, medication adherence, family involvement and social support network, life skills training and support, integration of medical care, establishment of community linkage, and practical needs assistance).
[2] Lindahl 2013 – meeting between person using services, staff at the institution, social worker and case manager (had a degree in social work and long-term experience of fieldwork with individuals with substance abuse) to agree on service plan (physical and mental health, legal status, relationship-family, relationship-friends, occupation, substance abuse, housing, budget and skills. Person using services decides on short- and long-term goals and how to achieve these.
[3] de Vet 2017 – time-limited, strengths-based intervention which links services during times of transition. The critical time intervention (CTI) worker (had a bachelor's degree in social work or related field) bridges gaps between services and engage services users early on; helping people through enlisting help from key figures in their support networks to complete tasks and reach their goals; spend more time with clients at most critical time; decrease intensity over time but continue monitoring and contact in the meantime; set goals in all life areas for people; map out the social and professional support network of client.

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.

A single economic search was undertaken for all topics included in the scope of this guideline. See supplementary material 2 for details.

Excluded studies

Economic studies not included in this review are listed, and reasons for their exclusion are provided in appendix J.

Summary of included economic evidence

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

Economic model

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

The committee's discussion and interpretation of the evidence

The outcomes that matter most

For the effectiveness review, personal goal attainment, satisfaction with home setting, quality of life (person focused outcomes) and access to appropriate support (service focused outcomes) were considered to be critical outcomes. Identification of the rate of unplanned care contacts (person focused outcomes) and continuity of care and support (service focused outcomes) were considered to be important outcomes. The committee selected these outcomes because achieving positive results in these areas would suggest that the person's overall quality of life and wellbeing would be enhanced as a result of the case management and care planning. They also reflect the outcomes that people who use services would identify as important. Successful access to appropriate support would indicate that an assessment had achieved its objectives in identifying support needs and developing personal care/support plans. It could also be an indication of successful multi-agency collaboration.

Given the nature of 'complexity', the committee anticipated that unplanned and unexpected incidents would occur and these were identified as important outcomes. Identifying the rate of unplanned care contacts would give an indication of the response to these incidents. It would assess the extent to which emergency/crisis plans were in place and the level of service provider success in responding proactively. The committee also considered the extent to which people experiencing emergency or unplanned events are offered support appropriate to their needs or in line with their wishes and aspirations (for example, admission to a care home) as an important outcome, along with continuity of support, which is a very regularly identified aspiration for people who use services.

To address the issue of what works well and what could be improved about case management, the second part of the review was designed to include qualitative data and as a result the committee could not specify in advance the data that would be located. Instead, they agreed, by consensus, on the following main themes to guide the review, although the list was not exhaustive and the committee were aware that additional themes could be identified.

- Issues related to accessing case management and care planning including ongoing review.
- Positive and negative aspects of case management and care planning.
- The extent to which case management and care planning consider professional and informal supporters and environment.
- Perception about the impact of case management and care planning in meeting needs.
- Case management and care planning with adults with learning disabilities and complex needs.
- Different experiences/views about various models of case management.
- Carers satisfaction with case management and care planning.
- Practitioner satisfaction with case management and care planning.

These themes were chosen as they cover aspects of what works and what could be improved about case management and care planning approaches in social work from perspectives of everyone involved.

The quality of the evidence

Effectiveness evidence

The quality of the evidence for effectiveness outcomes was assessed using GRADE and was rated as very low to moderate, with most of the evidence being of very low quality. This was predominately because of serious overall risk of bias in some outcomes including, for example, insufficient methodological detail on blinding or deviations from the intended intervention. In addition, in some outcomes there was imprecision around the effect estimate. None of the studies were downgraded on the basis of indirectness, and inconsistency was not applicable because only 1 study reported data for each outcome.

In terms of population subgroups specified in the protocol, it was not possible to report findings separately because the studies did not provide this level of detail.

No evidence was identified for the following outcome: continuity of care and support.

See appendix F for full GRADE tables with quality ratings of all outcomes.

Qualitative evidence

The quality of evidence was assessed using GRADE-CERQual methodology and the overall confidence in the findings for the qualitative review ranged from low to moderate quality. This was predominately because of methodological limitations, including, for example, insufficient information on data analysis and recruitment strategy. The review findings were also downgraded for relevance because the study context in some instances was slightly different to the review protocol. Finally, the findings were also downgraded for adequacy because relevant studies did not offer rich data.

No evidence was identified for the following anticipated themes: case management and care planning with adults with learning disabilities and complex needs, different experiences/views about various models of case management and carers satisfaction with case management and care planning.

See appendix F for full GRADE-CERQual tables with quality ratings of all review findings.

Benefits and harms

The committee discussed the quantitative evidence which showed no important benefits of the interventions on most of the outcomes. They acknowledged the limitations of the quantitative evidence, in particular the quality, and decided they could not confidently make recommendations based on this evidence. The committee also discussed that the quantitative findings did not reflect their practice experience, where contrary to the quantitative evidence, in the committee's experience case management and care planning interventions can achieve benefits for adults with complex needs. They also discussed that most of the included studies were not conducted in the UK (although the committee agreed that the evidence did seem relevant to social work practices in the UK); and, although a diverse range of participants and circumstances were included in the studies, there appeared to be a focus on mental health, which may make it difficult to generalise the findings to groups with other complex needs. The committee agreed that the qualitative findings provided some explanation for the absence of a benefit of the interventions in the quantitative data, and agreed that they could use these findings to make recommendations to address this.

<u>Principles of social work for adults with complex needs - for social workers</u>

The committee discussed the evidence (C2.3.2 Relationships; low quality) that highlighted some of the negative experiences people have faced during contact with health professionals, such as still being treated as a drug user even after they had quit. The

evidence (C2.1.2 The influence of subject feelings and experiences; low quality; C2.3.3 Respect and dignity; low quality) also highlighted that a person's circumstances, such as poverty, could influence access to and participation with services. The evidence also described that some service providers were judgemental and did not consider a person's circumstances, such as poverty, when organising their appointments. On the basis of this evidence, the committee acknowledged the impact a person's previous experiences and protected characteristics can have when planning care, particularly in regard to discrimination and disadvantage and used this evidence to support recommendations for social workers to avoid making assumptions, and also to consider whether reasonable adjustments can be made to protect against or help the person deal with discrimination arising from a person's protected characteristics of the Equality Act 2010, or from other life circumstance and experiences in order to advance equality in access to care or care provision.

Assessments

Risk assessment – conducting the assessment

The committee discussed the evidence (C1.3.1: Assessments; low quality) related to assessing risk when a person lacks capacity and noted that it highlighted the importance of a comprehensive assessment to gain in-depth insight into the person's circumstances and complexity of needs in order to manage risk and take account of personal preferences. They agreed that this would lead to better outcomes, since any risky situation can be managed in line with the person's preferences even if they are later assessed as lacking capacity to make a decision. The committee agreed that the recommendation they had made, using the evidence in review B, for the social worker to support the person to engage in advanced care planning would be a way of taking into account personal preferences of the person. They agreed that the evidence from this review would support this recommendation.

Supporting people to plan for the future, including considering changing needs, wishes and capabilities

The evidence (C1.1.4: Knowledge; low quality) suggested that when people have information and support in advance and understand the care planning process, this helps them to participate in planning for the future with their social worker. Although the evidence was limited and confidence was low, the committee drew upon their own expertise to support a recommendation that highlighted the key role that social workers play in communicating relevant information to people with complex needs, as well as to their support network, in a timely manner throughout the whole process. The committee emphasised that this would also include information and support for carers which would have a positive impact on their own wellbeing as well as the person they are supporting. Aware of published NICE guidance on support for adult carers, including carers assessments, the committee agreed to sign post to this guideline. The committee agreed that providing people with relevant information and care options should result in protecting their basic human rights and empowering them to make their own decisions about their care and treatment preferences.

The committee discussed the evidence (C2.2.2 The importance of the right environment; low quality) that highlighted the importance of environment and service location in decision making, and the role it can play creating a relaxed environment. The committee agreed with the evidence and felt this was a reflection of their practice experience. They therefore agreed to make a recommendation that where possible and practical, these meetings should take place in the person's preferred location. They discussed that this would be beneficial to professionals and adults with complex needs, as it would be a way of enabling engagement during care due to feeling more relaxed in a familiar or comfortable environment. This allows the person to feel empowered and is therefore more likely to be engaged with the process and care plan.

The committee discussed the evidence (C1.3 Perception about the impact of case management and care planning in meeting needs; low to moderate quality) which highlighted a number of things that worked well in case management and care planning. In particular the committee discussed the evidence (C1.3.1 Assessments; low quality) which emphasised the importance of undertaking comprehensive and holistic assessments in order to tailor a support plan to specific needs. The committee agreed with the evidence and discussed that a holistic approach to care would achieve positive outcomes for the person such as improved quality of life because their overall needs are being considered and addressed. In addition, the committee discussed the evidence (C1.3.2 Choice and flexibility; moderate quality) that highlighted the importance of approaches that enhanced a person's self-determination, as these approaches enable people to improve their own support plan. Drawing on their own expertise, the committee agreed that these important approaches highlighted in the evidence, were components of a rights-based approach. They therefore agreed to make a recommendation to support social workers to use a rights-based approach to case management and care planning, focusing on the individual's rights according to the principles of the Human Rights Act. They specified the principles of a rights based approach using the evidence and their expertise. The committee agreed that this recommendation would improve people's outcomes by promoting their dignity and wellbeing, building on their strengths and supporting both their participation in the community and engagement with services. The benefits achieved from the recommendations include openness and honesty between social workers and people using services and their families and supporters, promoting relationships built on trust and understanding. Such approaches to case management and care planning should enhance the person's independence and self-determination to understand their rights, their own strengths and the support available to them.

The committee discussed the qualitative evidence (C1.2: The extent to which case management and care planning consider professional and informal supporters and environment; low to moderate quality) that highlighted the importance of existing relationships between adults with complex needs and their family members and carers, and also the wider community. Promoting such relationships may enhance the support networks available to adults with complex needs, which may in turn help minimise the potential for isolation. They discussed the importance of both paid and unpaid support networks (for example, family and personal assistants) and support obtained through personal budgets, and agreed that their input should be reflected in the care plan where appropriate. This is reflected in the recommendation that social workers should, when appropriate and wanted, include input from key support networks in the person's care plan.

Based on evidence (C2.4.2: Changing needs; Low quality) that highlighted that a barrier to successfully planning for the future was not recognising quickly enough when needs change, the committee recognised the benefits of a flexible and responsive approach. This would require regular review so that plans can be adjusted to ensure the person's safety and wellbeing. They highlighted that a person's needs can change fluctuate between assessment and provision of support. They agreed that this recommendation would ensure that a flexible approach to changing needs is taken so that new support needs are not left unmet. The evidence (C1.3.2: Choice and flexibility; moderate quality) also emphasised the importance of taking person-centred and strength-based approaches to understanding people's needs and strengths and enhance independence and self-determination. The committee recognised that the choices available to people using services are often limited. They were keen to highlight the benefits that may be gained by moving away from the idea that the only option available to people is statutory services, instead taking a more creative approach and opening up available options. These benefits include promoting choice and control and, enabling people to draw on their own strengths to improve their health and wellbeing. Involving the wider community should also broaden the support options available to people and help reduce health inequalities (such as inequalities in access to care or care provision). The committee therefore recommended that social workers should respond to the person and their changing circumstances, through a number of means including developing a

flexible, responsive plan and reviewing and revising care plans in response to fluctuating changes.

Based on the evidence (C1.3.1: Assessments; low quality) about the challenges of planning and addressing all of the person's needs, and supported by their own knowledge and experience, the committee were aware that services may not always successfully meet the whole range of identified needs. However, the committee highlighted the importance of a care plan reflecting all of a person's needs rather than only those that would be met under resource availability. They agreed on a recommendation that would allow the social worker to consider all of a person's needs, eligible and non-eligible, and provide information on how they can be best met, and the arrangements required to meet them. The committee recognised that a social worker will not know in advanced of submitting a care plan, whether a person's needs will be met as this would depend on the current state of resources at the time. However, they recognised the importance of recording any eligible needs that appeared to be unlikely to be met. The committee also acknowledged and recommended that in order for social workers to be notified of changing circumstances it is important that the person with complex needs has their work contact details and that this is documented in the person's care plan.

In relation to this, the committee cited the Care and support statutory guidance (Chapter 13) which describes the routes to reviewing care and support plans. A review should be planned with the person and take place at least once a year but the statutory guidance highlights that there can be situations where an unplanned review is necessary (for example if needs change or if it is requested by the person or other people important to them).

The committee discussed the evidence (C1.2.2: Advocacy; moderate quality) in combination with the relevant legislation, in particular the Care Act 2014 and Mental Capacity Act (MCA) 2005 in regard to the capacity to make care planning decisions. The committee discussed the need for social workers to use professional judgement when deciding on the most appropriate legislation to follow based on the circumstances of the person with complex needs. For example, arranging for an independent Care Act advocate under the Care Act if the person has been assessed as having a significant difficulty in participating in the care planning process and they do not have appropriate support (for example, family members); or instructing a mental capacity act advocate under the MCA where a person has been assessed as lacking capacity to make decisions in relation to their care plan and there are no other appropriate persons able to represent them. However, the committee acknowledged the need for good practice in terms of offering generic (non-statutory) independent advocacy to individuals who are able to make decisions unaided, but do not have access to other support networks of their decision making capacity. However, based on the evidence (C2.5.2: Professional competencies; low quality) and their own expertise, the committee recognised the potential variation in practice and the difficulties that social workers may face in providing advocacy. For example, social workers may not always be encouraged to develop their advocacy role, despite their training which suggests that this should be an important part of their role.

The committee discussed evidence (C1.4.3: Working arrangements; low quality) around working arrangements which identified certain conditions that enabled social workers to fulfil their roles more successfully, including autonomy, training, and support and supervision. However, the evidence (C1.4.3: Working arrangements; low quality) also suggested that most social workers reported a lack of support from managers from their own organisations. The committee were keen to emphasise the importance of supporting social workers in their role so that in turn, adults with complex needs would be effectively supported. This was reflected in the committee's recommendation and in line with Social Work England's Professional Standards that organisations should provide social workers: with regular, practice-based supervision and support so they can be responsive to people's complex and fluctuating needs; keep their knowledge and practice up to date; and contribute to an open, creative, learning culture in the workplace to discuss, reflect on and share best practice.

The committee discussed the evidence (C1.3.3: Continuity of care; moderate quality) showing that continuity was valued in care planning which would in turn enhance health and wellbeing and this was consistent with their experience. However, the committee were aware of the variation in practice and that the relationship between the person and the named social worker would only work if the relationship was a positive one (for example, non-judgemental and built on trust). This is also supported by other qualitative evidence (C1.1.1: Relationships; low quality). The qualitative evidence (C2.3.2 Relationships; low quality) highlighted the difficulties people using services face when they don't have continuity with social workers and having to repeat life stories to new people. The evidence also described the frustrations of social workers at the difficulties of being able to gain enough understanding of a person's situations due to not being involved in their care for long enough. The committee agreed that this was in line with their practice experience, and highlighted that in current practice people would be assigned a named social worker whenever this was feasible. They agreed that having a named social worker would be a way of alleviating these issues, and agreed on a recommendation to reflect this.

The committee identified situations where the needs of adults with complex needs may change such as when growing older, or transitioning out of hospital. They agreed it was important to provide social workers with relevant and up to date guidance in these specific areas and made recommendations to sign-post to relevant NICE guidance.

The committee made a research recommendation to address the gap in the effectiveness evidence relating to the evaluation of specific models of social work case management to inform future guidelines. The committee were particularly interested in the effectiveness and cost-effectiveness of early, preventative case management and care planning for adults with complex needs (see appendix K for full details).

Cost effectiveness and resource use

No economic evidence was identified which was relevant to this review question.

The recommendations will reinforce and standardise current practice. The provision of a named social worker varies nationally so recommending all people with complex needs have one may have some resource impact. This however is already largely undertaken where possible so any increase is likely to be small. Having a named social worker will facilitate continuity of care and may prevent unnecessary repetition of tasks such as assessments and identifying risks. A named social worker may also improve trust and communication with a person allowing for more effective and targeted care improving quality of life and preventing wasted resources from less effective or unneeded interventions. The committee agreed that this was already common practice.

Other factors the committee took into account

When making the recommendations, the committee also aimed to respect individual choice and uphold fundamental human rights in relation to decision-making as well as important legal requirements. They therefore took into account relevant legislation, including, the: Mental Capacity Act 2005, Mental Health Act 2007, Human Rights Act 1998 as well as the Equality Act 2010 when making the recommendations. The committee also cross-referred to the following NICE guidance to signpost readers to relevant information to help support people to plan for the future when they transitioning between services, settings or between levels of care:

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs NG27 (2015)
- Transition between inpatient mental health settings and community or care home settings NG53 (2016)

- Transition from children's to adults' services for young people using health or social care services NG43 (2016)
- Intermediate care including reablement NG74 (2017)

The committee also agreed that it useful to cross-refer to recommendations 1.4.5 to 1.4.7 in the NICE guideline on care and support for people growing older with learning disabilities in relation to support people growing older with learning disabilities to plan for the future.

The committee also referred to the Care and support statutory guidance to support recommendations regarding when care plans should be reviewed.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.1.6 to 1.1.8, 1.2.20, 1.5.1 to 1.5.13. It also supports research recommendation 3 on supporting people to plan for the future.

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Effectiveness evidence

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Appendices

Appendix A Review protocols

Review protocol for review question C1: What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Table 6: Review protocol – effectiveness review

Field	Content
PROSPERO registration number	CRD42020202378
Review title	Supporting people to consider changing needs, wishes and capabilities.
Review question	C1. What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)? *Note that this review is linked with C2, which is described in a separate review protocol:* *Based on the views and experiences of everyone involved, what works well and what could be improved about case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?*
Objective	To assess the effectiveness of case management and care planning to support changing needs, wishes and capabilities.
Searches	The following databases will be searched: • Cochrane Database of Systematic Reviews (CDSR) • Cochrane Central Register of Controlled Trials (CENTRAL) • MEDLINE & Medline in Process • Embase • Applied Social Science Index and Abstracts (ASSIA) • International Bibliography of the Social Sciences (IBSS) • Social Policy and Practice • Social Services Abstracts

Field	Content
	• Sociological Abstracts • Social Care Online Searches will be restricted by: • Date limit: 2010 onwards (see rationale under Section 10) • English language • Human studies • Systematic reviews filter The full search strategies will be published in the final review. Other searches: • Additional searching may be undertaken if required. For each search (including economic searches), the principal database search strategy is quality assured by a second information specialist using an adaption of the PRESS 2015 Guideline Evidence-Based Checklist. With the agreement of the guideline committee the searches will be re-run 6 weeks before final submission of the review and further studies retrieved for inclusion.
Condition or domain being studied	Case management and care planning in social work to support changing needs, wishes and capabilities including preventing an escalation of needs. Includes advance care planning.
Population	• People aged 18 or older with complex needs*. * Studies involving adults who require a high level of support with many aspects of their daily lives will be considered for inclusion. The emphasis is on complex needs, which rely on a range of health and social care services.
Intervention	Social work case management or care planning, which is individualised, collaborative, strengths focused and considers professional and informal supporters, and environment. Includes advance care planning and planning to prevent future escalation of need.
Comparator	Studies using the following comparisons will be included:

Field	Content
	• 'Standard' care planning, which is more service focused and less individualised, strengths based and focused on professional or informal support networks. • Different types of the specified intervention.

Types of study to be included	• Experimental studies (where the investigator assigned intervention or control) including:
	  ○ Randomised or quasi-randomised controlled trials.
	  ○ Non-randomised controlled trials.
	• Systematic reviews/meta-analyses of controlled trials.
	
	In the absence of controlled trials reporting critical outcomes, studies using the following designs will be included if they report data on critical outcomes:
	• Other non-randomised studies (where neither control nor intervention were assigned by the investigator) including:
	  ○ Prospective and retrospective cohort studies (studies with multivariate analyses will be prioritised over those using univariate methods of analysis).
	  ○ Case control studies.
	  ○ Before-and-after study or interrupted time series.
	  ○ Systematic reviews of observational studies.

Other exclusion criteria	Inclusion: • Full text papers. • Only studies conducted in the UK will be included. However, if insufficient UK based studies are available for the purposes of decision making about recommendations then studies from the following high income countries (as defined by the World Bank) from Europe, plus Australia, New Zealand, Canada and South Africa, will be included. Exclusion: • Observational studies that do not report critical outcomes. • Conference abstracts. • Articles published before 2010.

Field	Content
	• Papers that do not include methodological details will not be included as they do not provide sufficient information to evaluate risk of bias/ study quality. • Non-English language articles.
Context	No previous guidelines will be updated by this review question.
Primary outcomes **(critical outcomes)**	Person focused outcomes: • Personal goal attainment – measured using a validated tool, for example, Goal attainment scaling (GAS). • Subjective satisfaction with home setting (for example, whether independent, supported, group living or residential). • Subjective quality of life – measured using a validated tool such as ASCOT, ICECAP-A, MANSA or the EQ-5D. Service focused outcomes: • Access to appropriate support measured for example by the establishment of a care plan, agreement of an advanced care plan or provision of support for the required duration (subjectively or objectively measured).
Secondary outcomes **(important outcomes)**	Person focused outcomes: • Unplanned care contacts, for example, emergency or unplanned admission to hospital, contact with community mental health crisis team or unplanned care home admission (either long term or as respite). Service focused outcomes: • Continuity of care and support, measured by contact with the same practitioner or small group of practitioners.
Data extraction (selection and coding)	• All references identified by the searches and from other sources will be uploaded into STAR and de-duplicated. Titles and abstracts of the retrieved citations will be screened to identify studies that potentially meet the inclusion criteria outlined in the review protocol. • Duplicate screening will be undertaken for 10% of items. • Full versions of the selected studies will be obtained for assessment. Studies that fail to meet the inclusion criteria once the full version has been checked will be excluded at this stage. Each study excluded after checking the full version will be listed, along with the reason for its exclusion. • Draft excluded studies will be circulated to the Topic Group for their comments. Resolution of disputes will be by discussion between the senior reviewer, Topic Advisor and Chair.

Field	Content	
	• A standardised form will be used to extract data from included studies. One reviewer will extract relevant data into a standardised form, and this will be quality assessed by a senior reviewer.	
Risk of bias (quality) assessment	Risk of bias of individual studies will be assessed using the preferred checklist as described in Developing NICE guidelines: the manual.	
Strategy for data synthesis	NGA STAR software will be used for generating bibliographies/citations, study sifting and data extraction. If pairwise meta-analyses are undertaken, they will be performed using Cochrane Review Manager (RevMan). 'GRADEpro' will be used to assess the quality of evidence for each outcome. Being a parallel review to C2, the NGA technical team will present findings from this review together with qualitative evidence (C2), where data allow. The committee will be supported to complete the synthesis of these mixed data through their discussions of the evidence. Their interpretation of the relationship between the effectiveness and qualitative data will be described in the committee discussion of the evidence section of the evidence report.	
Analysis of sub-groups	Subgroup analysis will be conducted wherever possible if the issue of heterogeneity appears relevant, for example in relation to: • Different approaches to social work case management and care planning. • All groups highlighted in the Equality Impact Assessment. • People entitled to section 117 aftercare following discharge from hospital under the Mental Health Act 1983.	
Type and method of review	☒	Intervention
	☐	Diagnostic
	☐	Prognostic
	☐	Qualitative
	☐	Epidemiologic
	☐	Service Delivery
	☒	Other (please specify) This intervention review is linked with a qualitative review [C2] on the same issue.

Field	Content		
Language	English		
Country	England		
Anticipated or actual start date	February		
Anticipated completion date	November 2021		
Stage of review at time of this submission	Review stage	Started	Completed
	Preliminary searches	☑	☑
	Piloting of the study selection process	☑	☑
	Formal screening of search results against eligibility criteria	☑	☑
	Data extraction	☑	☑
	Risk of bias (quality) assessment	☑	☑
	Data analysis	☑	☑
Named contact	5a. Named contact National Guideline Alliance 5b. Named contact e-mail SWIadults@nice.org.uk 5c Organisational affiliation of the review National Institute for Health and Care Excellence (NICE) and National Guideline Alliance.		
Review team members	NGA Technical Team		
Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance, which receives funding from NICE.		

Field	Content	
Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.	
Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10145/documents.	
Other registration details	Not applicable.	
Reference/URL for published protocol	https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=202378	
Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: • Notifying registered stakeholders of publication. • Publicising the guideline through NICE's newsletter and alerts. • Issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE.	
Keywords	Social work, complex needs, future planning, care management.	
Details of existing review of same topic by same authors	Not applicable.	
Current review status	☒	Ongoing
	☒	Completed but not published
	☐	Completed and published
	☐	Completed, published and being updated

Field	Content	
	☐	Discontinued
Additional information	Not applicable.	
Details of final publication	www.nice.org.uk	

ASCOT: Adult Social Care Outcomes Toolkit; ASSIA: Applied Social Science Index and Abstracts; CCTR: Cochrane Controlled Trials Register; CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; CG: clinical guideline; DARE: Database of Abstracts of Reviews of Effects; EQ-5D: EuroQol 5 Dimensions; GAS: goal attainment scaling; GP: general practitioner; GRADE: Grading of Recommendations Assessment, Development and Evaluation; HTA: Health Technology Assessment; IBSS: International Bibliography of the Social Sciences; ICECAP-A: ICEpop CAPability measure for adults; NGA: National Guideline Alliance; MANSA: Manchester Short Assessment; NICE: National Institute for Health and Care Excellence.

Review protocol for review question C2: Based on the views and experiences of everyone involved, what works well and what can be improved about case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Table 7: Review protocol – qualitative review

Field	Content
PROSPERO registration number	CRD42020207549
Review title	Supporting people to consider changing needs, wishes and capabilities (views and experiences).
Review question	C2. Based on the views and experiences of everyone involved, what works well and what can be improved about case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)? *Note that this review is linked with C1, which is described in a separate review protocol:* *What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?*
Objective	• To establish what people with complex care needs, their families and carers believe works well and what could be improved about social work case management and care planning to support changing needs, wishes and capabilities. • To establish what practitioners believe works well and what could be improved about social work case management and care planning to support changing needs, wishes and capabilities.
Searches	The following databases will be searched: • Cochrane Database of Systematic Reviews (CDSR) • Cochrane Central Register of Controlled Trials (CENTRAL) • MEDLINE & Medline in Process • Embase • Emcare • CINAHL • PsycINFO • Applied Social Science Index and Abstracts (ASSIA) • International Bibliography of the Social Sciences (IBSS)

Field	Content
	• Social Policy and Practice • Social Science Database • Social Services Abstracts • Sociological Abstracts • Social Care Online Searches will be restricted by: • Date limit: 2010 onwards (see rationale under Section 10) • English language • Human studies • Qualitative studies filter Other searches: • Additional searching may be undertaken if required. One search will be conducted to cover all qualitative questions. For each search (including economic searches), the principal database search strategy is quality assured by a second information specialist using an adaption of the PRESS 2015 Guideline Evidence-Based Checklist. With the agreement of the guideline committee the searches will be re-run 6 weeks before final submission of the review and further studies retrieved for inclusion. The full search strategies will be published in the final review.
Condition or domain being studied	Views, perceptions and/or lived experiences of case management and care planning in social work to support changing needs, wishes and capabilities. Includes advance care planning.
Population	• People aged 18 or older with complex needs*. • Families and supporters of adults with complex needs

Field	Content
	• Relevant social-/health- care and other practitioners involved in needs assessment and review for adults with complex needs. *Studies involving adults who require a high level of support with many aspects of their daily lives will be considered for inclusion. The emphasis is on complex needs, which rely on a range of health and social care services.
Phenomenon of interest	Social work case management and care planning, which is individualised, collaborative, strengths focussed and considers professional and informal supporters, and environment. Includes advance care planning and planning to prevent future escalation of need. In order to understand what works and what does not work well, from the perspective of everyone involved, the committee want to locate data about the following aspects of case management and care planning: • **Issues related to accessing case management and care planning including ongoing review.** Problems can arise even before the case management and care planning process, not least difficulties with access including a lack of internet or telephone availability and no single point of contact. There may also be subsequent difficulties in accessing reviews of ongoing needs including around changes in circumstances, for example if a carer moves away or for another reason is unable to provide support. Interim reviews are known to take place in some areas but this is not consistent and people are often unaware that they can also request reviews. • **Positive aspects of case management and care planning and what works well.** The committee would like to locate data which provide an overall picture of the key characteristics of good case management and care planning. At the heart of this they expect to find descriptions of person centred approaches and case management and care planning which feature clear communication and the promotion of respect and dignity. They expect examples to include family led conferences and advance care planning which place the person at the centre. The committee believe that descriptions of this kind of approach will demonstrate the critical importance of involving a practitioner with the required expertise, professional experience and attitude. • **The extent to which case management and care planning consider professional and informal supporters and environment.** The committee would like to understand whether and to what extent carers and other advocates are included in case management and care planning, particularly in terms of the insight and added information they can provide about the person they're supporting. There is a concern that this crucial

Field	Content
	contribution is often overlooked in the context of case management and care planning and that the same applies to contributions from others (such as care workers or the person's wider support network), which are also overlooked. There are also concerns that case management and care planning are sometimes conducted with little reference to wider circumstances or existing care plans. For example, a care plan to support transfer from hospital having no regard to already established arrangements. • **Negative aspects of case management and care planning and what improvements could be made.** If there is evidence about other negative aspects of case management and care planning this may provide support for the committee to make recommendations about what improvements could be made. When case management and care planning are perceived not to be working complaints are sometimes made relating to people's rights under the Care Act, for instance that the full spread of needs and circumstances are not being thoroughly identified and understood. Data about other negative experiences might highlight a lack of continuity and consistency or dissatisfaction with practitioners who appear more interested in fulfilling targets than meeting needs or who lack understanding about key legal or legislative details. • **Perception about the impact of case management and care planning in meeting needs.** Another anticipated theme is a perception that the initial assessment is the most important stage whereas the case management and care planning which ensue are equally or even more important for ensuring ongoing person centred support. • **Case management and care planning with adults with learning disabilities and complex needs.** The committee believe that data about the experiences of people with learning disabilities and complex needs are particularly important because their views are often lost during the process of case management and care planning and this is sometimes owing to issues linked with mental capacity. • **Different experiences/ views about various models of case management.** The committee are particularly interested in data about views and experiences which clearly link to the different approaches to case management and care planning reported in the related effectiveness review (C1). • **Carers satisfaction with case management and care planning.** The committee believe it is important to triangulate data by including carers' views and experiences of case management and care planning. As well as having views about the experience of the person they're supporting, views about their own experiences are also

Field	Content
	important and this is a key distinction. Their needs are sometimes at odds with those of the person they support and the challenge for case management and care planning is navigating these differences. Carers might report a lack of support and information (for example about their rights under the Care Act) and this can be felt acutely during challenging periods, for example when the person's needs are changing. Difficult relationships between practitioners and carers sometimes stem from incorrect assumptions about carers' willingness and ability to continue in their role. This will be compounded by carers' uncertainty about potential time scales, for example how long they're likely to need to provide support. • **Practitioner satisfaction with case management and care planning.** This is another way in which the committee wish to triangulate qualitative data. Given that they aim to locate people's views about the experience of case management and care planning, including whether they feel their needs, wishes and circumstances are recognised, the committee wish to understand whether practitioners feel they have the resources or working arrangements to enable this to happen. For example, a lack of inter-agency or inter professional collaboration can be a barrier to providing supportive case management and care planning. Ongoing concerns about limited resources might lead to a focus on people without family or other supporters although this overlooks the fact that if people with carers are marginalised then care arrangements can break down and crises ensue. Finally, the committee also wish to locate data about practitioner's experiences of different models of case management and care planning.
Comparator	Not applicable as this is a qualitative review.
Types of study to be included	• Systematic reviews of qualitative studies • Studies using qualitative methods: focus groups, semi-structured and structured interviews, observations • Surveys conducted using open ended questions and a qualitative analysis of responses Note: Mixed methods studies will be included but only qualitative data will be extracted and risk of bias assessed
Other exclusion criteria	Inclusion: • Full text papers. • Only studies conducted in the UK will be included. However, if insufficient UK based studies are available for the purposes of decision making about recommendations then studies from the following high income countries (as defined by the World Bank) from Europe, plus Australia, New Zealand, Canada and South Africa, will be included. Exclusion:

Field	Content
	• Articles published before 2010 • Papers that do not include methodological details will not be included as they do not provide sufficient information to evaluate risk of bias/ study quality. • Studies using effectiveness methods only (including surveys that report only effectiveness data) • Surveys using mainly closed questions or which quantify open ended answers for analysis. • Non-English language articles Thematic saturation: 1. Data or theme(s) from included studies will not be extracted for particular theme(s) if thematic saturation is reached. 2. Papers included on full text will subsequently be excluded when the whole anticipated framework of phenomena (x anticipated themes listed in row 7) has reached thematic saturation. That is, when evidence synthesis and the application of GRADE-CERQual show that data about all 10 aspects of the phenomenon of interest are 'adequate' and 'coherent'. See row 7 above for details of the anticipated framework of phenomenon and associated rationale.
Context	No previous guidelines will be updated by this review question.
Primary outcomes (critical outcomes)	Outcomes not applicable as this is a qualitative review. For anticipated themes, see row 7 above. 'Phenomenon of interest'.
Secondary outcomes (important outcomes)	Not applicable.
Data extraction (selection and coding)	• All references identified by the searches and from other sources will be uploaded into STAR and de-duplicated. Titles and abstracts of the retrieved citations will be screened to identify studies that potentially meet the inclusion criteria outlined in the review protocol. • Duplicate screening will be undertaken for 10% of items. • Full versions of the selected studies will be obtained for assessment. Studies that fail to meet the inclusion criteria once the full version has been checked will be excluded at this stage. Each study excluded after checking the full version will be listed along with the reason for its exclusion.

Field	Content	
	• The excluded studies list will be circulated to the Topic Group for their comments. Resolution of disputes will be by discussion between the senior reviewer, Topic Advisor and Chair. • A standardised form will be used to extract data from included studies, providing study reference, research question, data collection and analysis methods used, participant characteristics, second-order themes, and relevant first-order themes (that is, supporting quotes). One reviewer will extract relevant data into a standardised form. This will be quality assessed by the senior reviewer.	
Risk of bias (quality) assessment	Risk of bias of individual qualitative studies will be assessed using the CASP (Critical Skills Appraisal Programme) qualitative checklist, and for systematic reviews of qualitative studies will be assessed using the CASP Systematic Review checklist. See appendix H in Developing NICE guidelines: the manual for further details. The quality assessment will be performed by one reviewer and this will be quality assessed by the senior reviewer.	
Strategy for data synthesis	• Extracted second-order study themes and related first-order quotes will be synthesised by the reviewer into third-order themes and related sub-themes as 'review findings'. • The GRADE-CERQual approach will be used to summarise the confidence in the review findings synthesized from the qualitative evidence ('Using qualitative evidence in decision making for health and social interventions'; Lewin 2015). The overall confidence in evidence about each review finding will be rated on four dimensions: methodological limitations, coherence, adequacy, and relevance. • Being a parallel review to C1, the effectiveness of case management and care planning, the NGA technical team will present findings from the effectiveness (C1) and qualitative (C2) reviews together, where data allow. The committee will be supported to complete the synthesis of these mixed data through their discussions of the evidence. Their interpretation of the relationship between the effectiveness and qualitative data will be described in the committee discussion of the evidence section of the evidence report.	
Analysis of sub-groups	As this is a qualitative review sub group analysis is not possible. However, if data allow, the review will include information regarding differences in views held between certain groups or about different approaches to social work case management and care planning, focused on different groups and delivered via different modes.	
Type and method of review	☐	Intervention
	☐	Diagnostic
	☐	Prognostic
	☒	Qualitative
	☐	Epidemiologic

Field	Content		
	☐	Service Delivery	
	☒	Other (please specify) This qualitative review is linked with an intervention review [C1] on the same issue.	
Language	English		
Country	England		
Anticipated or actual start date	August 2020		
Anticipated completion date	November 2021		
Stage of review at time of this submission	Review stage	Started	Completed
	Preliminary searches	☑	☑
	Piloting of the study selection process	☑	☑
	Formal screening of search results against eligibility criteria	☑	☑
	Data extraction	☑	☑
	Risk of bias (quality) assessment	☑	☑
	Data analysis	☑	☑
Named contact	5a. Named contact National Guideline Alliance 5b. Named contact e-mail SWIadults@nice/org.uk 5c Organisational affiliation of the review National Institute for Health and Care Excellence (NICE) and National Guideline Alliance.		
Review team members	NGA Technical Team		

Field	Content	
Funding sources/sponsor	This systematic review is being completed by the National Guideline Alliance, which receives funding from NICE.	
Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.	
Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10145/documents.	
Other registration details	Not applicable.	
Reference/URL for published protocol	https://www.crd.york.ac.uk/prospero/display_record.php?RecordID=207549	
Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: • Notifying registered stakeholders of publication. • Publicising the guideline through NICE's newsletter and alerts. • Issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE.	
Keywords	Social work, complex needs, future planning, care management.	
Details of existing review of same topic by same authors	Not applicable.	
Current review status	☐	Ongoing

Field	Content	
	☒	Completed but not published
	☐	Completed and published
	☐	Completed, published and being updated
	☐	Discontinued
Additional information	Not applicable.	
Details of final publication	www.nice.org.uk	

ASCOT: Adult Social Care Outcomes Toolkit; ASSIA: Applied Social Science Index and Abstracts; CASP: Critical Skills Appraisal Programme; CCTR: Cochrane Controlled Trials Register; CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; GP: general practitioner; IBSS: International Bibliography of the Social Sciences; NGA: National Guideline Alliance; NICE: National Institute for Health and Care Excellence.

Appendix B Literature search strategies

Literature search strategies for review question C: What is the effectiveness of social work approaches to assessing and reviewing complex care and support needs (including strengths-based approaches)?

Database(s): Embase 1980 to 2020 Week 24, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to June 15, 2020

Multifile database codes: emez= Embase 1980 to 2020 Week 42; ppez= Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to June 15, 2020

#	Searches
1	(exp Social Work/ or Social Work, Psychiatric/ or Social Workers/ or Social Welfare/ or Case Management/ or Accountable Care Organizations/ or (Mental Health Services/ and (Professional Role/ or Professional Standard/ or exp Workforce/))) use ppez
2	(social care/ or social welfare/ or social work/ or social work practice/ or social worker/ or case management/ or case manager/ or national health service/ or accountable care organization/ or mental health care personnel/) use emez
3	((social* or case* or outreach or personal or relief or support) adj3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi?ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*)).ti,ab.
4	(care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?).ti,ab.
5	(("approved mental health" adj (professional? or personnel or staff or team* or worker?)) or AMHP).ti,ab.
6	(social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?).ti,ab.
7	or/1-6
8	exp Comorbidity/ use ppez
9	comorbidity/ use emez
10	((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special*) adj4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*)).ti,ab.
11	SHCN.ti,ab.
12	complex case?.ti,ab.
13	(dual diagnos?s or multi* diagnos?s).ti,ab.
14	(impact adj3 daily adj (life or lives or living or activit* or experienc*)).ti,ab.
15	or/8-14
16	exp *Social Problems/ use ppez
17	exp *social problem/ use emez
18	16 or 17
19	(exp Human Activities/ or exp Life Style/) use ppez
20	(exp human activities/ or exp "lifestyle and related phenomena"/) use emez
21	18 and (19 or 20)
22	(Employment/ or Employment, Supported/ or Return to Work/ or Rehabilitation, Vocational/ or Unemployment/) use ppez
23	(unemployment/ or employment status/ or supported employment/ or sheltered workshop/ or vocational rehabilitation/ or absenteeism/ or job security/ or return to work/) use emez
24	((chang* or develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or target*) adj3 (employment or unemployment or unemploy*)).ti,ab.
25	(support* adj3 (employment? or work or vocational)).ti,ab.
26	(employment or unemploy* or underemploy* or under employ*).ti.
27	individual placement?.ti,ab.
28	((finding or gaining or obtaining or keeping or sustaining) adj3 (work or job or employment)).ti,ab.
29	(social firms or (sheltered adj (employment or work))).ti,ab.
30	(precar* adj1 (employment or work)).ti,ab.
31	(paid work or paid employment).ti,ab.
32	(voluntary work or volunteering or unpaid work or un paid work).ti,ab.
33	(meaningful adj (activit* or employment or work)).ti,ab.
34	("return to work" or "back to work" or absenteeism).ti,ab.
35	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj (work* or disabilit*)).ti,ab.
36	((labo?r force or employment or unemployment) adj status).ti,ab.
37	or/22-36
38	(Family Conflict/ or Family Relations/ or Intergenerational Relations/) use ppez

#	Searches
39	family functioning/ or family conflict/ use emez
40	((family or families or intergenerat* or inter-generat*) adj (relation* or breakdown or conflict?)).ti,ab.
41	((sexual or intimate or partner?) adj (relation* or conflict?)).ti,ab.
42	((develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or promot* or target*) adj2 relationship?).ti,ab.
43	((carer? or partner or relationship?) adj support*).ti,ab.
44	or/38-43
45	(Housing/ or Homeless Persons/ or Independent Living/ or Assisted Living Facilities/ or Group Homes/ or Halfway Houses/ or Housing for the Elderly/ or Poverty Areas/ or Public Housing/ or Residence Characteristics/) use ppez
46	(housing/ or assisted living facility/ or community living/ or emergency shelter/ or homelessness/ or exp homeless person/ or deinstitutionalization/ or halfway house/) use emez
47	housing.ti.
48	((housing or accommodation or neighbo?rhood? or residence*) adj3 (chang* or address* or condition* or develop* or enhanc* or improv* or initiative? or instability or intervention? or mitigat* or program* or stability or target*)).ti,ab.
49	homeless*.ti,ab.
50	(permanent housing or social housing).ti,ab.
51	((assisted or autonomous or independent or secur* or sheltered or support* or sustain*) adj3 (housing or accommodat* or dwelling? or residen* or tenanc* or tenure?)).ti,ab.
52	((halfway or satellite) adj (accommodat* or dwelling? or home? or house?)).ti,ab.
53	(neighbo?rhood? adj (characteristic* or intervention* or program*)).ti,ab.
54	((environment* or housing or neighbo?rhood?) and infrastructure).ti,ab.
55	or/45-54
56	(*Economic Status/ or *Financing, Personal/ or exp *Income/ or Poverty/ or Working Poor/ or *Social Welfare/) use ppez
57	(*money/ or *economic status/ or household economic status/ or *social welfare/ or *socioeconomics/ or household income/ or personal income/ or family income/ or *financial management/ or "salary and fringe benefit"/ or *pension/ or *salary/ or poverty/ or exp lowest income group/) use emez
58	money.ti.
59	((access* or improv* or manag* or supplement*) adj2 (cash or money or financ* or income? or savings)).ti,ab.
60	((financial adj (autonomy or security or insecurity)) or loans or borrowing or budgeting or microcredit or microfinance or social fund*).ti,ab.
61	(extreme poverty or high poverty).ti,ab. or poverty.ti.
62	((address* or escap* or improv* or "out of" or support* or target*) adj2 (depriv* or poor or poverty)).ti,ab.
63	(((food or fuel) adj (insecurity or poverty)) or food bank?).ti,ab.
64	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj2 (debt? or poverty or ((economic or financial) adj hardship?))).ti,ab.
65	((basic or low or minimum) adj3 (wage? or income?)).ti,ab.
66	(family adj (income? or tax credit?)).ti,ab.
67	welfare benefit?.ti,ab.
68	or/56-67
69	(Criminals/ or Prisoners/ or Recidivism/) use ppez
70	(offender/ or exp maladjustment/ or prisoner/) use emez
71	((crime? or criminal* or offend* or offence? or recidiv*) adj3 (initiative? or intervention? or program* or mitigat* or address* or diver* or prevent* or rehabilitat*)).ti,ab.
72	((inmate? or prisoner? or convict? or felon?) adj3 (rehabilitat* or releas*)).ti,ab.
73	(community adj2 (reentry or re-entry)).ti,ab.
74	or/69-73
75	("Social Determinants of Health"/ or exp Social Isolation/ or Social Marginalization/ or Social Stigma/) use ppez
76	("social determinants of health"/ or social disability/ or loneliness/ or social isolation/ or social alienation/ or community involvement/ or *social support/ or *social network/ or *psychosocial environment/ or psychosocial rehabilitation/) use emez
77	(community involvement or community network* or loneliness or social* alienat* or social connect* or social inclusion or social* isolat* or social network* or social participation or social stigma*).ti,ab.
78	or/75-77
79	Civil Rights/ or Human Rights/ or Personal Autonomy/ or Personhood/ or Public Policy/ or Social Justice/
80	Minority Groups/ or "Transients and Migrants"/ or Refugees/ or Vulnerable Populations/
81	(or/79-80) use ppez
82	human rights/ or civil rights/ or human dignity/ or personal autonomy/ or social justice/
83	exp migrant/ or minority group/ or vulnerable population/
84	(or/82-83) use emez
85	(((civil* or human or legal or social) adj rights) or (social justice or equal protection or social protection)).ti,ab.
86	((social or community or neighbo?rhood?) adj3 (equit* or inequit* or inequalit*)).ti,ab.
87	(digital adj (inclusion or exclusion or divide or equit* or inequit* or inequalit*)).ti,ab.
88	((disadvantaged or underserved or under served or vulnerab* or at risk or high risk) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
89	((minorit* or emigra* or immigra* or migra* or foreigner* or refugee* or transient*) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
90	or/81,84-89
91	(Crime Victims/ or "Adult Survivors of Child Abuse"/ or Alcoholism/ or Drug Users/ or Domestic Violence/ or Battered Women/ or Elder Abuse/ or Spouse Abuse/ or Human Trafficking/) use ppez
92	(crime victim/ or exp childhood trauma survivor/ or exp domestic violence/ or human trafficking/ or sex trafficking/ or exp drug dependence/ or injection drug user/) use emez

#	Searches
93	(crime victim? or revictimi* or ((victim* or crime?) and survivor*)).ti,ab.
94	((domestic or marital or partner? or spous* or surviv*) adj3 (abus* or rape? or sex* assault* or violence)).ti,ab.
95	coercive control.ti,ab.
96	((female? or women?) adj (refuge? or shelter?)).ti,ab.
97	(exploitation or safe guarding or safeguarding).ti,ab.
98	(((substance or drug or alcohol) adj (abuse or misuse?)) or "substance use" or "illegal drug use*" or addict* or alcoholi* or (problem* adj1 drinking)).tw.
99	or/91-98
100	or/21,37,44,55,68,74,78,90,99
101	(exp Communication Disorders/ or exp Sensory Disorders/ or exp Cognition Disorders/ or Cognitive Dysfunction/ or exp Disabled Persons/ or exp Intellectual Disability/ or Mental Competency/ or exp Mental Disorders/ or Mental Health/ or exp Brain Diseases/) use ppez
102	(exp disabled person/ or exp disability/ or exp sensory dysfunction/ or exp cognitive defect/ or exp mental capacity/ or exp mental disease/ or exp intellectual impairment/ or exp mental health care/ or exp brain disease/) use emez
103	(disable? or disabilit* or handicap* or retard* or disorder? or impair* or condition? or illness* or capacity or competen* or incompeten* or difficulty or difficulties or deficit? or dysfunct*).ti.
104	or/101-103
105	(Health Services/ or exp Community Health Services/ or exp Community Psychiatry/ or Custodial Care/ or Health Services for the Aged/ or Health Services for Persons with Disabilities/ or Long-Term Care/ or exp Mental Health Services/ or Palliative Care/ or Personal Health Services/ or exp Rehabilitation/ or Terminal Care/) use ppez
106	(health service/ or exp community care/ or exp elderly care/ or exp mental health service/ or long term care/ or custodial care/ or social psychiatry/ or palliative therapy/ or occupational health service/ or exp rehabilitation/ or terminal care/) use emez
107	((communit* or elder* or mental* or long term or custod* or psychosocial* or palliative or terminal or reabl* or rehabilitat*) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
108	((allied health professional? or AHP? or clinical or clinician? or consultant? or family doctor? or general practi* or GP? or medical or medic? or nurse? or occupational therapist? or physician? or ((speech or language) adj2 therapist?) or SLT?) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
109	or/105-108
110	100 and (104 or 109)
111	7 and 15 and 110
112	advance care planning/
113	capacity building/
114	patient care planning/
115	case management/
116	long-term care/
117	(or/112-116) use emez,ppez
118	((advance* or ahead or anticipat* or future or long term) adj5 (decision* or directive* or plan* or statement*)).ti,ab.
119	((care adj2 model*) and (decision* or plan*)).ti,ab.
120	(case? manag* and plan*).ti,ab.
121	(("best interests" or capacity or safeguard* or wellness) and (decision* or plan*)).ti,ab.
122	capacity building.ti,ab.
123	power of attorney.ti,ab.
124	(((person* or patient* or resident* or client* or service user*) adj1 (centred or centered)) and (decision* or plan* or review*)).ti,ab.
125	((strength* based or recover* or rehabilitat* or resilien* or restorat*) adj3 plan*).ti,ab.
126	((crisis or emergenc* or escalat*) and plan*).ti,ab.
127	((chang* or anticipat* or delay* or prevent* or reduc*) adj2 (capability* or need* or support* or wish*)).ti,ab.
128	or/117-127
129	111 and 128
130	Letter/ use ppez
131	letter.pt. or letter/ use emez
132	note.pt.
133	editorial.pt.
134	Editorial/ use ppez
135	News/ use ppez
136	exp Historical Article/ use ppez
137	Anecdotes as Topic/ use ppez
138	Comment/ use ppez
139	Case Report/ use ppez
140	case report/ or case study/ use emez
141	(letter or comment*).ti.
142	or/130-141
143	randomized controlled trial/ use ppez
144	randomized controlled trial/ use emez
145	random*.ti,ab.
146	or/143-145
147	142 not 146
148	animals/ not humans/ use ppez

#	Searches
149	animal/ not human/ use emez
150	nonhuman/ use emez
151	exp Animals, Laboratory/ use ppez
152	exp Animal Experimentation/ use ppez
153	exp Animal Experiment/ use emez
154	exp Experimental Animal/ use emez
155	exp Models, Animal/ use ppez
156	animal model/ use emez
157	exp Rodentia/ use ppez
158	exp Rodent/ use emez
159	(rat or rats or mouse or mice).ti.
160	or/147-159
161	129 not 160
162	limit 161 to (conference abstract or conference paper or conference review or conference proceeding) [Limit not valid in Ovid MEDLINE(R),Ovid MEDLINE(R) Daily Update,Ovid MEDLINE(R) In-Process,Ovid MEDLINE(R) Publisher; records were retained]
163	162 use emez
164	161 not 163
165	limit 164 to english language
166	limit 165 to yr="2010 -Current"

The Cochrane Library: Cochrane Database of Systematic Reviews, Issue 6 of 12, June 2020; Cochrane Central Register of Controlled Trials, Issue 6 of 12, June 2020

ID	Search
#1	MeSH descriptor: [Social Work] explode all trees
#2	MeSH descriptor: [Social Work, Psychiatric] this term only
#3	MeSH descriptor: [Social Workers] this term only
#4	MeSH descriptor: [Social Work Department, Hospital] this term only
#5	MeSH descriptor: [Social Welfare] this term only
#6	MeSH descriptor: [Case Management] this term only
#7	MeSH descriptor: [Case Managers] this term only
#8	MeSH descriptor: [Accountable Care Organizations] this term only
#9	MeSH descriptor: [Mental Health Services] explode all trees
#10	((social* or case* or outreach or personal or relief or support) next/3 (advisor* or agenc* or assistan* or care* or department* or deliver* or institution* or intervention* or lead* or manager* or organisation* or organization* or personnel or planning or practi* or profession* or program* or provider* or provision or sector* or service* or setting* or staff or supervi* or system* or team* or unit* or work*)):ti,ab
#11	("care coordinator*" or "care co ordinator*" or "case manager*" or caseworker* or "case worker*" or "best interest* assessor*"):ti,ab
#12	(("approved mental health" next/3 (professional or personnel or staff or team* or worker*)) or AMHP):ti,ab
#13	("social welfare" or "social assistance" or "local authorit*" or "local council*" or "state support" or "social prescribing" or "welfare service*"):ti,ab
#14	{or #1-#13}
#15	MeSH descriptor: [Comorbidity] explode all trees
#16	((complex* or chang* or chronic or coexist* or "co exist*" or combin* or concomitant or comorbid* or "co morbid*" or cooccur* or "co occur*" or develop* or "high support" or (intellectual* and physical*) or "life limiting" or "long standing" or longstanding or "long term" or (mental* and physical*) or multi* or ongoing or "on-going" or persistent or priorit* or serious* or severe or several or simultaneous or special*) next/4 (need* or care or circumstance* or condition* or existence* or experience* or initiative* or intervention* or issue* or live* or mitigat* or patient* or person* or people? or problem* or realit* or situation* or "social factor*" or support or target*)):ti,ab
#17	(SHCN or "complex* case*"):ti,ab
#18	("dual diagnosis" or "dual diagnoses" or "multi* diagnosis" or "multi* diagnoses"):ti,ab
#19	(impact next/3 daily next (life or living or activit* or experienc*)):ti,ab
#20	{or #15-#19}
#21	#14 and #20 with Cochrane Library publication date Between Jan 2010 and Dec 2020
#22	MeSH descriptor: [Advance Care Planning] explode all trees
#23	MeSH descriptor: [Capacity Building] this term only
#24	MeSH descriptor: [Patient Care Planning] explode all trees
#25	MeSH descriptor: [Case Management] explode all trees
#26	MeSH descriptor: [Long-Term Care] this term only
#27	((advance* or ahead or anticipat* or future or long term) next/5 (decision* or directive* or plan* or statement*)):ti,ab
#28	((care next/2 model*) and (decision* or plan*)):ti,ab
#29	(case? manag* and plan*):ti,ab
#30	(("best interests" or capacity or safeguard* or wellness) and (decision* or plan*)):ti,ab
#31	capacity building:ti,ab
#32	power of attorney:ti,ab
#33	(((person* or patient* or resident* or client* or service user*) next (centred or centered)) and (decision* or plan* or review*)):ti,ab
#34	((strength* based or recover* or rehabilitat* or resilien* or restorat*) next/3 plan*):ti,ab
#35	((crisis or emergenc* or escalat*) near plan*):ti,ab
#36	((chang* or anticipat* or delay* or prevent* or reduc*) next/2 (capability* or need* or support* or wish*)):ti,ab

ID	Search
#37	{or #22-#36}
#38	#21 and #37 with Cochrane Library publication date Between Jan 2010 and Jun 2020

Database(s): Applied Social Sciences Index & Abstracts (ASSIA) (1987 - current) [via Proquest]; International Bibliography of the Social Sciences (IBSS) (1951 - current); Sociological Abstracts (1952 - current) [via Proquest]; Social Services Abstracts [via Proquest]

Set#	Searched for
S1	(AB,TI((social* OR case* OR communit* OR outreach OR personal OR relief OR support) NEAR/3 (advisor? OR agenc* OR assistant? OR care* OR department* OR deliver* OR institution* OR intervention? OR lead* OR manager? OR organi?ation* OR personnel OR planning OR practi* OR profession* OR program* OR provider? OR provision OR sector* OR service? OR setting? OR staff OR supervi* OR system* OR team* OR unit? OR work*)) OR (AB,TI (care coordinator? OR care co-coordinator? OR case manager* OR caseworker* OR case-worker* OR case worker* OR best interest? assessor?)) OR (AB,TI (social welfare OR social assistance OR local authorit* OR state support OR social prescribing welfare service? OR approved mental health profession* OR AMHP*))) AND pd(20100101-20201231) AND la.exact("ENG"))
S2	(AB,TI(complex* OR chang* OR chronic OR coexist* OR co exist* OR combin* OR concomitant OR comorbid* OR co morbid* OR cooccur* OR co occur* OR develop* OR high support OR life limiting OR long standing OR longstanding OR long term OR multi* OR ongoing OR on going OR persistent OR priorit* OR serious* OR severe OR several OR simultaneous OR special*) AND pd(20100101-20201231) AND la.exact("ENG"))
S3	(AB,TI(need? OR care OR circumstance* OR condition? OR existence? OR experience? OR initiative? OR intervention? OR impact* OR issue* OR life OR lives OR living OR mitigat* OR patient? OR person? OR people OR problem* OR realit* OR situation? OR social factor* OR support OR target*) AND pd(20100101-20201231) AND la.exact("ENG"))
S4	(((AB,TI((advance* OR ahead OR anticipat* OR future OR long term) NEXT (decision* OR directive* OR plan* OR statement*))) AND la.exact("ENG")) OR ((AB,TI((care model* OR case manag* OR best interests OR capacity OR safeguard* OR wellness) NEXT (decision* OR plan*))) AND la.exact("ENG")) OR ((AB,TI(capacity building OR power of attorney)) AND la.exact("ENG")) OR ((AB,TI((person* OR patient* OR resident* OR client* OR service user*) NEXT/2 (decision* OR plan* OR review*))) AND la.exact("ENG")) OR ((AB,TI((strength* based OR recover* OR rehabilitat* OR resilien* OR restorat* OR cris* OR emergenc* OR escalat*) NEXT plan*)) AND la.exact("ENG")) OR ((AB,TI((chang* OR anticipat* OR delay* OR prevent* OR reduc*) NEXT (capability* OR need* OR support* OR wish*))) AND pd(20100101-20201231) AND la.exact("ENG")))
S5	2 and 3
S6	1 and 5
S7	4 and 6

Social Care Online: https://www.scie-socialcareonline.org.uk/

Titles search:
- PublicationTitle:'social work* or social care*'
- OR PublicationTitle:'care coordinator* or care co-ordinator* or case manager* or caseworker* or case-worker* or case worker* or best interest* assessor*'
- OR PublicationTitle:'"approved mental health professional*" or AMHP'
- OR PublicationTitle:'social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service*'
- AND PublicationTitle:'advance* or ahead or anticipat* or chang* or future or long term and decision* or care model* or case* manag* or directive* or plan* or statement* or "best interests" or capacity or safeguard* or wellness or strength* based or recover* or rehabilitat* or resilien* or restorat* or crisis or emergenc* or escalat* or capability* or need* or support or wish*'
- AND PublicationYear:'2010 2020'

OR

Abstracts search:
- AbstractOmitNorms:'social work* or social care*'
- OR AbstractOmitNorms:'care coordinator* or care co-ordinator* or case manager* or caseworker* or case-worker* or case worker* or best interest* assessor*'
- OR AbstractOmitNorms:'"approved mental health professional*" or AMHP'
- OR AbstractOmitNorms:'social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service*'
- AND AbstractOmitNorms:'advance* or ahead or anticipat* or chang* or future or long term and decision* or care model* or case* manag* or directive* or plan* or statement* or "best interests" or capacity or safeguard* or wellness or strength* based or recover* or rehabilitat* or resilien* or restorat* or crisis or emergenc* or escalat* or capability* or need* or support or wish*'
- AND PublicationYear:'2010 2020'

Database(s): Social Policy and Practice 202004

#	Searches
1	((social* or case* or outreach or personal or relief or support) adj3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi?ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*)).ti,ab.
2	(care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?).ti,ab.
3	(("approved mental health" adj (professional? or personnel or staff or team* or worker?)) or AMHP).ti,ab.

#	Searches
4	(social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?).ti,ab.
5	or/1-4
6	((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special*) adj4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*)).ti,ab.
7	SHCN.ti,ab.
8	complex case?.ti,ab.
9	(dual diagnos?s or multi* diagnos?s).ti,ab.
10	(impact adj3 daily adj (life or lives or living or activit* or experienc*)).ti,ab.
11	or/6-10
12	((chang* or develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or target*) adj3 (employment or unemployment or unemploy*)).ti,ab.
13	(support* adj3 (employment? or work or vocational)).ti,ab.
14	(employment or unemploy* or underemploy* or under employ*).ti.
15	individual placement?.ti,ab.
16	((finding or gaining or obtaining or keeping or sustaining) adj3 (work or job or employment)).ti,ab.
17	(social firms or (sheltered adj (employment or work))).ti,ab.
18	(precar* adj1 (employment or work)).ti,ab.
19	(paid work or paid employment).ti,ab.
20	(voluntary work or volunteering or unpaid work or un paid work).ti,ab.
21	(meaningful adj (activit* or employment or work)).ti,ab.
22	("return to work" or "back to work" or absenteeism).ti,ab.
23	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj (work* or disabilit*)).ti,ab.
24	((labo?r force or employment or unemployment) adj status).ti,ab.
25	or/12-24
26	((family or families or intergenerat* or inter-generat*) adj (relation* or breakdown or conflict?)).ti,ab.
27	((sexual or intimate or partner?) adj (relation* or conflict?)).ti,ab.
28	((develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or promot* or target*) adj2 relationship?).ti,ab.
29	((carer? or partner or relationship?) adj support*).ti,ab.
30	or/26-29
31	housing.ti.
32	((housing or accommodation or neighbo?rhood? or residence*) adj3 (chang* or address* or condition* or develop* or enhanc* or improv* or initiative? or instability or intervention? or mitigat* or program* or stability or target*)).ti,ab.
33	homeless*.ti,ab.
34	(permanent housing or social housing).ti,ab.
35	((assisted or autonomous or independent or secur* or sheltered or support* or sustain*) adj3 (housing or accommodat* or dwelling? or residen* or tenanc* or tenure?)).ti,ab.
36	((halfway or satellite) adj (accommodat* or dwelling? or home? or house?)).ti,ab.
37	(neighbo?rhood? adj (characteristic* or intervention* or program*)).ti,ab.
38	((environment* or housing or neighbo?rhood?) and infrastructure).ti,ab.
39	or/31-38
40	money.ti.
41	((access* or improv* or manag* or supplement*) adj2 (cash or money or financ* or income? or savings)).ti,ab.
42	((financial adj (autonomy or security or insecurity)) or loans or borrowing or budgeting or microcredit or microfinance or social fund*).ti,ab.
43	(extreme poverty or high poverty).ti,ab. or poverty.ti.
44	((address* or escap* or improv* or "out of" or support* or target*) adj2 (depriv* or poor or poverty)).ti,ab.
45	(((food or fuel) adj (insecurity or poverty)) or food bank?).ti,ab.
46	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj2 (debt? or poverty or ((economic or financial) adj hardship?))).ti,ab.
47	((basic or low or minimum) adj3 (wage? or income?)).ti,ab.
48	(family adj (income? or tax credit?)).ti,ab.
49	welfare benefit?.ti,ab.
50	or/40-49
51	((crime? or criminal* or offend* or offence? or recidiv*) adj3 (initiative? or intervention? or program* or mitigat* or address* or diver* or prevent* or rehabilitat*)).ti,ab.
52	((inmate? or prisoner? or convict? or felon?) adj3 (rehabilitat* or releas*)).ti,ab.
53	(community adj2 (reentry or re-entry)).ti,ab.
54	or/51-53
55	(community involvement or community network* or loneliness or social* alienat* or social connect* or social inclusion or social* isolat* or social network* or social participation or social stigma*).ti,ab.
56	(((civil* or human or legal or social) adj rights) or (social justice or equal protection or social protection)).ti,ab.
57	((social or community or neighbo?rhood?) adj3 (equit* or inequit* or inequalit*)).ti,ab.
58	(digital adj (inclusion or exclusion or divide or equit* or inequit* or inequalit*)).ti,ab.
59	((disadvantaged or underserved or under served or vulnerab* or at risk or high risk) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.

#	Searches
60	((minorit* or emigra* or immigra* or migra* or foreigner* or refugee* or transient*) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
61	or/56-60
62	(crime victim? or revictimi* or ((victim* or crime?) and survivor*)).ti,ab.
63	((domestic or marital or partner? or spous* or surviv*) adj3 (abus* or rape? or sex* assault* or violence)).ti,ab.
64	coercive control.ti,ab.
65	((female? or women?) adj (refuge? or shelter?)).ti,ab.
66	(exploitation or safe guarding or safeguarding).ti,ab.
67	(((substance or drug or alcohol) adj (abuse or misuse?)) or "substance use" or "illegal drug use*" or addict* or alcoholi* or (problem* adj1 drinking)).ti,ab.
68	or/62-67
69	or/25,30,39,50,54-55,61,68
70	(disable? or disabilit* or handicap* or retard* or disorder? or impair* or condition? or illness* or capacity or competen* or difficulty or difficulties or deficit? or dysfunct*).ti.
71	((communit* or elder* or mental* or long term or custod* or psychosocial* or palliative or terminal or reable* or rehabilitat*) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
72	((allied health professional? or AHP? or clinical or clinician? or consultant? or family doctor? or general practi* or GP? or medical or medic? or nurse? or occupational therapist? or physician? or ((speech or language) adj2 therapist?) or SLT?) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
73	71 or 72
74	5 and 11 and 69 and (70 or 73)
75	((advance* or ahead or anticipat* or future or long term) adj5 (decision* or directive* or plan* or statement*)).ti,ab.
76	((care adj2 model*) and (decision* or plan*)).ti,ab.
77	(case? manag* and plan*).ti,ab.
78	(("best interests" or capacity or safeguard* or wellness) and (decision* or plan*)).ti,ab.
79	capacity building.ti,ab.
80	power of attorney.ti,ab.
81	(((person* or patient* or resident* or client* or service user*) adj1 (centred or centered)) and (decision* or plan* or review*)).ti,ab.
82	((strength* based or recover* or rehabilitat* or resilien* or restorat*) adj3 plan*).ti,ab.
83	((crisis or emergenc* or escalat*) and plan*).ti,ab.
84	((chang* or anticipat* or delay* or prevent* or reduc*) adj2 (capability* or need* or support* or wish*)).ti,ab.
85	or/75-84
86	74 and 85
87	(animal* or rat or rats or mouse or mice).ti.
88	86 not 87
89	limit 88 to yr="2010 -Current"

Literature search strategies for review question C: Based on the views and experiences of everyone involved, what works well and what can be improved about case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

A combined search was used for all qualitative questions.

Database(s): Embase 1980 to 2020 Week 11, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to March 17, 2020

Multifile database codes: emez= Embase 1980 to 2020 Week 11; ppez= Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to March 17, 2020

#	Searches
1	(exp Social Work/ or Social Work, Psychiatric/ or Social Workers/ or Social Welfare/ or Case Management/ or Accountable Care Organizations/ or (Mental Health Services/ and (Professional Role/ or Professional Standard/ or exp Workforce/))) use ppez
2	(social care/ or social welfare/ or social work/ or social work practice/ or social worker/ or case management/ or case manager/ or national health service/ or accountable care organization/ or mental health care personnel/) use emez
3	((social* or case* or outreach or personal or relief or support) adj3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi?ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*)).ti,ab.

#	Searches
4	(care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?).ti,ab.
5	(("approved mental health" adj (professional? or personnel or staff or team* or worker?)) or AMHP).ti,ab.
6	(social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?).ti,ab.
7	or/1-6
8	exp Comorbidity/ use ppez
9	comorbidity/ use emez
10	((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special*) adj4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*)).ti,ab.
11	SHCN.ti,ab.
12	complex case?.ti,ab.
13	(dual diagnos?s or multi* diagnos?s).ti,ab.
14	(impact adj3 daily adj (life or lives or living or activit* or experienc*)).ti,ab.
15	or/8-14
16	exp *Social Problems/ use ppez
17	exp *social problem/ use emez
18	16 or 17
19	(exp Human Activities/ or exp Life Style/) use ppez
20	(exp human activities/ or exp "lifestyle and related phenomena"/) use emez
21	18 and (19 or 20)
22	(Employment/ or Employment, Supported/ or Return to Work/ or Rehabilitation, Vocational/ or Unemployment/) use ppez
23	(unemployment/ or employment status/ or supported employment/ or sheltered workshop/ or vocational rehabilitation/ or absenteeism/ or job security/ or return to work/) use emez
24	((chang* or develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or target*) adj3 (employment or unemployment or unemploy*)).ti,ab.
25	(support* adj3 (employment? or work or vocational)).ti,ab.
26	(employment or unemploy* or underemploy* or under employ*).ti.
27	individual placement?.ti,ab.
28	((finding or gaining or obtaining or keeping or sustaining) adj3 (work or job or employment)).ti,ab.
29	(social firms or (sheltered adj (employment or work))).ti,ab.
30	(precar* adj1 (employment or work)).ti,ab.
31	(paid work or paid employment).ti,ab.
32	(voluntary work or volunteering or unpaid work).ti,ab.
33	(meaningful adj (activit* or employment or work)).ti,ab.
34	("return to work" or "back to work" or absenteeism).ti,ab.
35	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj (work* or disabilit*)).ti,ab.
36	((labo?r force or employment or unemployment) adj status).ti,ab.
37	or/22-36
38	(Family Conflict/ or Family Relations/ or Intergenerational Relations/) use ppez
39	family functioning/ or family conflict/ use emez
40	((family or families or intergenerat* or inter-generat*) adj (relation* or breakdown or conflict?)).ti,ab.
41	((sexual or intimate or partner?) adj (relation* or conflict?)).ti,ab.
42	((develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or promot* or target*) adj2 relationship?).ti,ab.
43	((carer? or partner or relationship?) adj support*).ti,ab.
44	or/38-43
45	(Housing/ or Homeless Persons/ or Independent Living/ or Assisted Living Facilities/ or Group Homes/ or Halfway Houses/ or Housing for the Elderly/ or Poverty Areas/ or Public Housing/ or Residence Characteristics/) use ppez
46	(housing/ or assisted living facility/ or community living/ or emergency shelter/ or homelessness/ or exp homeless person/ or deinstitutionalization/ or halfway house/) use emez
47	housing.ti.
48	((housing or accommodation or neighbo?rhood? or residence*) adj3 (chang* or address* or condition* or develop* or enhanc* or improv* or initiative? or instability or intervention? or mitigat* or program* or stability or target*)).ti,ab.
49	homeless*.ti,ab.
50	(permanent housing or social housing).ti,ab.
51	((assisted or autonomous or independent or secur* or sheltered or support* or sustain*) adj3 (housing or accommodat* or dwelling? or residen* or tenanc* or tenure?)).ti,ab.
52	((halfway or satellite) adj (accommodat* or dwelling? or home? or house?)).ti,ab.
53	(neighbo?rhood? adj (characteristic* or intervention* or program*)).ti,ab.
54	((environment* or housing or neighbo?rhood?) and infrastructure).ti,ab.
55	or/45-54
56	(*Economic Status/ or *Financing, Personal/ or exp *Income/ or Poverty/ or Working Poor/ or *Social Welfare/) use ppez
57	(*money/ or *economic status/ or household economic status/ or *social welfare/ or *socioeconomics/ or household income/ or personal income/ or family income/ or *financial management/ or "salary and fringe benefit"/ or *pension/ or *salary/ or poverty/ or exp lowest income group/) use emez

#	Searches
58	money.ti.
59	((access* or improv* or manag* or supplement*) adj2 (cash or money or financ* or income? or savings)).ti,ab.
60	((financial adj (autonomy or security or insecurity)) or loans or borrowing or budgeting or microcredit or microfinance or social fund*).ti,ab.
61	(extreme poverty or high poverty).ti,ab. or poverty.ti.
62	((address* or escap* or improv* or "out of" or support* or target*) adj2 (depriv* or poor or poverty)).ti,ab.
63	(((food or fuel) adj (insecurity or poverty)) or food bank?).ti,ab.
64	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj2 (debt? or poverty or ((economic or financial) adj hardship?))).ti,ab.
65	((basic or low or minimum) adj3 (wage? or income?)).ti,ab.
66	(family adj (income? or tax credit?)).ti,ab.
67	welfare benefit?.ti,ab.
68	or/56-67
69	(Criminals/ or Prisoners/ or Recidivism/) use ppez
70	(offender/ or exp maladjustment/ or prisoner/) use emez
71	((crime? or criminal* or offend* or offence? or recidiv*) adj3 (initiative? or intervention? or program* or mitigat* or address* or diver* or prevent* or rehabilitat*)).ti,ab.
72	((inmate? or prisoner? or convict? or felon?) adj3 (rehabilitat* or releas*)).ti,ab.
73	(community adj2 (reentry or re-entry)).ti,ab.
74	or/69-73
75	("Social Determinants of Health"/ or exp Social Isolation/ or Social Marginalization/ or Social Stigma/) use ppez
76	("social determinants of health"/ or social disability/ or loneliness/ or social isolation/ or social alienation/ or community involvement/ or *social support/ or *social network/ or *psychosocial environment/ or psychosocial rehabilitation/) use emez
77	(community involvement or community network* or loneliness or social* alienat* or social connect* or social inclusion or social* isolat* or social network* or social participation or social stigma*).ti,ab.
78	or/75-77
79	Civil Rights/ or Human Rights/ or Personal Autonomy/ or Personhood/ or Public Policy/ or Social Justice/
80	Minority Groups/ or "Transients and Migrants"/ or Refugees/ or Vulnerable Populations/
81	(or/79-80) use ppez
82	human rights/ or civil rights/ or human dignity/ or personal autonomy/ or social justice/
83	exp migrant/ or minority group/ or vulnerable population/
84	(or/82-83) use emez
85	(((civil* or human or legal or social) adj rights) or (social justice or equal protection or social protection)).ti,ab.
86	((social or community or neighbo?rhood?) adj3 (equit* or inequit* or inequalit*)).ti,ab.
87	(digital adj (inclusion or exclusion or divide or equit* or inequit* or inequalit*)).ti,ab.
88	((disadvantaged or underserved or under served or vulnerab* or at risk or high risk) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
89	((minorit* or emigra* or immigra* or migra* or foreigner* or refugee* or transient*) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
90	or/81,84-89
91	(Crime Victims/ or "Adult Survivors of Child Abuse"/ or Alcoholism/ or Drug Users/ or Domestic Violence/ or Battered Women/ or Elder Abuse/ or Spouse Abuse/ or Human Trafficking/) use ppez
92	(crime victim/ or exp childhood trauma survivor/ or exp domestic violence/ or human trafficking/ or sex trafficking/ or exp drug dependence/ or injection drug user/) use emez
93	(crime victim? or revictimi* or ((victim* or crime?) and survivor*)).ti,ab.
94	((domestic or marital or partner? or spous* or surviv*) adj3 (abus* or rape? or sex* assault* or violence)).ti,ab.
95	coercive control.ti,ab.
96	((female? or women?) adj (refuge? or shelter?)).ti,ab.
97	(exploitation or safe guarding or safeguarding).ti,ab.
98	(((substance or drug or alcohol) adj (abuse or misuse?)) or "substance use" or "illegal drug use*" or addict* or alcoholi* or (problem* adj1 drinking)).tw.
99	or/91-98
100	or/21,37,44,55,68,74,78,90,99
101	(exp Communication Disorders/ or exp Sensory Disorders/ or exp Cognition Disorders/ or Cognitive Dysfunction/ or exp Disabled Persons/ or exp Intellectual Disability/ or Mental Competency/ or exp Mental Disorders/ or Mental Health/ or exp Brain Diseases/) use ppez
102	(exp disabled person/ or exp disability/ or exp sensory dysfunction/ or exp cognitive defect/ or exp mental capacity/ or exp mental disease/ or exp intellectual impairment/ or exp mental health care/ or exp brain disease/) use emez
103	(disable? or disabilit* or handicap* or retard* or disorder? or impair* or condition? or illness* or capacity or competen* or incompeten* or difficulty or difficulties or deficit? or dysfunct*).ti.
104	or/101-103
105	(Health Services/ or exp Community Health Services/ or exp Community Psychiatry/ or Custodial Care/ or Health Services for the Aged/ or Health Services for Persons with Disabilities/ or Long-Term Care/ or exp Mental Health Services/ or Palliative Care/ or Personal Health Services/ or exp Rehabilitation/ or Terminal Care/) use ppez
106	(health service/ or exp community care/ or exp elderly care/ or exp mental health service/ or long term care/ or custodial care/ or social psychiatry/ or palliative therapy/ or occupational health service/ or exp rehabilitation/ or terminal care/) use emez
107	((communit* or elder* or mental* or long term or custod* or psychosocial* or palliative or terminal or reabl* or rehabilitat*) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.

#	Searches
108	((allied health professional? or AHP? or clinical or clinician? or consultant? or family doctor? or general practi* or GP? or medical or medic? or nurse? or occupational therapist? or physician? or ((speech or language) adj2 therapist?) or SLT?) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
109	or/105-108
110	100 and (104 or 109)
111	7 and 15 and 110
112	(Qualitative Research/ or Nursing Methodology Research/ or Interviews as Topic/ or Interview/ or Interview, Psychological/ or Narration/ or "Surveys and Questionnaires"/) use ppez
113	(qualitative research/ or nursing methodology research/ or exp interview/ or narrative/ or questionnaire/ or qualitative analysis/) use emez
114	(qualitative or theme* or thematic or ethnograph* or hermeneutic* or heuristic* or semiotic* or humanistic or existential or experiential or paradigm* or narrative* or questionnaire*).mp.
115	((discourse* or discurs* or conversation* or content) adj analys?s).mp.
116	((lived or life or personal) adj experience*).mp.
117	(focus adj group*).ti,ab.
118	(grounded adj (theor* or study or studies or research or analys?s)).mp.
119	action research.ti,ab.
120	(field adj (study or studies or research)).ti,ab.
121	descriptive study.ti,ab.
122	or/112-121
123	((Letter/ or Editorial/ or News/ or exp Historical Article/ or Anecdotes as Topic/ or Comment/ or Case Report/ or (letter or comment*).ti.) not (Randomized Controlled Trial/ or random*.ti,ab.)) or (Animals not Humans).sh. or exp Animals, Laboratory/ or exp Animal Experimentation/ or exp Models, Animal/ or exp Rodentia/ or (rat or rats or mouse or mice).ti.
124	123 use ppez
125	((letter.pt. or letter/ or note.pt. or editorial.pt. or case report/ or case study/ or (letter or comment*).ti.) not (randomized controlled trial/ or random*.ti,ab.)) or ((animal/ not human/) or nonhuman/ or exp animal experiment/ or exp experimental animal/ or animal model/ or exp rodent/ or (rat or rats or mouse or mice).ti.)
126	125 use emez
127	124 or 126
128	limit 122 to (conference abstract or conference paper or conference review or conference proceeding) [Limit not valid in Ovid MEDLINE(R),Ovid MEDLINE(R) Daily Update,Ovid MEDLINE(R) In-Process,Ovid MEDLINE(R) Publisher; records were retained]
129	128 use emez
130	122 not (127 or 129)
131	111 and 130
132	limit 131 to english language
133	limit 132 to yr="2010 -Current"

Database(s): EBSCO Host CINAHL Plus

#	Query	Limiters/Expanders
S22	S17 AND S21	Limiters - Publication Year: 2010-2020; English Language; Exclude MEDLINE records Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S21	S18 OR S19 OR S20	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S20	TX (qualitative or "action research" OR "descriptive study" OR ethnogra* OR existential OR experiential OR experience* OR "field research" OR "field study" OR "field studies" OR "focus group?" OR grounded OR hermeneutic* OR heuristic* OR humanistic OR interview* OR "mixed method?" OR narrative OR paradigm* OR semiotic* OR thematic)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S19	(MH "Interviews+") OR (MH "Narratives+") OR (MH "Questionnaires+") OR (MH "Surveys")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S18	(MH "Qualitative Studies+")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S17	S9 AND S16	Limiters - Publication Year: 2010-2020; English Language; Exclude MEDLINE records Expanders - Apply equivalent subjects

#	Query	Limiters/Expanders
		Search modes - Boolean/Phrase
S16	S10 OR S11 OR S12 OR S13 OR S14 OR S15	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S15	TX (impact adj3 daily W2 (life or lives or living or activit* or experienc*))	Expanders - Apply equivalent subjects Search modes - SmartText Searching
S14	TX (dual diagnos#s or multi* diagnos#s)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S13	TX complex case?	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S12	TX SHCN	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S11	TX ((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special*) W4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*))	Expanders - Apply equivalent subjects Search modes - SmartText Searching
S10	(MH "Comorbidity")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S9	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S8	TX (social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S7	TX (("approved mental health" W2 (professional? or personnel or staff or team* or worker?)) or AMHP)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S6	TX (care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S5	TX ((social* or case* or outreach or personal or relief or support) W3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi#ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*))	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S4	((MH "Mental Health Services+") AND ((MH "Accountability") OR (MH "Professional Practice") OR (MH "Professional Role")))	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S3	(MH "Accountable Care Organizations")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S2	(MH "Case Management") OR (MH "Case Managers")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S1	(MH "Social Welfare") OR (MH "Social Work") OR (MH "Social Work Practice") OR (MH "Social Work Service") OR (MH "Social Worker Attitudes") OR (MH "Social Workers")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase

Database(s): Emcare 1995 to present

#	Searches
1	social care/ or social welfare/ or social work/ or social work practice/ or social worker/ or case management/ or case manager/ or national health service/ or accountable care organization/ or mental health care personnel/
2	((social* or case* or outreach or personal or relief or support) adj3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi?ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*)).ti,ab.
3	(care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?).ti,ab.
4	(("approved mental health" adj (professional? or personnel or staff or team* or worker?)) or AMHP).ti,ab.
5	(social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?).ti,ab.
6	or/1-5
7	comorbidity/
8	((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special*) adj4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*)).ti,ab.
9	SHCN.ti,ab.
10	complex case?.ti,ab.
11	(dual diagnos?s or multi* diagnos?s).ti,ab.
12	(impact adj3 daily adj (life or lives or living or activit* or experienc*)).ti,ab.
13	or/7-12
14	exp *social problem/
15	exp human activities/ or exp "lifestyle and related phenomena"/
16	14 and 15
17	unemployment/ or employment status/ or supported employment/ or sheltered workshop/ or vocational rehabilitation/ or absenteeism/ or job security/ or return to work/
18	((chang* or develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or target*) adj3 (employment or unemployment or unemploy*)).ti,ab.
19	(support* adj3 (employment? or work or vocational)).ti,ab.
20	(employment or unemploy* or underemploy* or under employ*).ti.
21	individual placement?.ti,ab.
22	((finding or gaining or obtaining or keeping or sustaining) adj3 (work or job or employment)).ti,ab.
23	(social firms or (sheltered adj (employment or work))).ti,ab.
24	(precar* adj1 (employment or work)).ti,ab.
25	(paid work or paid employment).ti,ab.
26	(voluntary work or volunteering or unpaid work).ti,ab.
27	(meaningful adj (activit* or employment or work)).ti,ab.
28	("return to work" or "back to work" or absenteeism).ti,ab.
29	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj (work* or disabilit*)).ti,ab.
30	((labo?r force or employment or unemployment) adj status).ti,ab.
31	or/17-30
32	family functioning/ or family conflict/
33	((family or families or intergenerat* or inter-generat*) adj (relation* or breakdown or conflict?)).ti,ab.
34	((sexual or intimate or partner?) adj (relation* or conflict?)).ti,ab.
35	((develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or promot* or target*) adj2 relationship?).ti,ab.
36	((carer? or partner or relationship?) adj support*).ti,ab.
37	or/32-36
38	housing/ or assisted living facility/ or community living/ or emergency shelter/ or homelessness/ or exp homeless person/ or deinstitutionalization/ or halfway house/
39	housing.ti.
40	((housing or accommodation or neighbo?rhood? or residence*) adj3 (chang* or address* or condition* or develop* or enhanc* or improv* or initiative? or instability or intervention? or mitigat* or program* or stability or target*)).ti,ab.
41	homeless*.ti,ab.
42	(permanent housing or social housing).ti,ab.
43	((assisted or autonomous or independent or secur* or sheltered or support* or sustain*) adj3 (housing or accommodat* or dwelling? or residen* or tenanc* or tenure?)).ti,ab.
44	((halfway or satellite) adj (accommodat* or dwelling? or home? or house?)).ti,ab.
45	(neighbo?rhood? adj (characteristic* or intervention* or program*)).ti,ab.
46	((environment* or housing or neighbo?rhood?) and infrastructure).ti,ab.
47	or/38-46
48	*money/ or *economic status/ or household economic status/ or *social welfare/ or *socioeconomics/ or household income/ or personal income/ or family income/ or *financial management/ or "salary and fringe benefit"/ or *pension/ or *salary/ or poverty/ or exp lowest income group/
49	money.ti.
50	((access* or improv* or manag* or supplement*) adj2 (cash or money or financ* or income? or savings)).ti,ab.
51	((financial adj (autonomy or security or insecurity)) or loans or borrowing or budgeting or microcredit or microfinance or social fund*).ti,ab.
52	(extreme poverty or high poverty).ti,ab. or poverty.ti.

#	Searches
53	((address* or escap* or improv* or "out of" or support* or target*) adj2 (depriv* or poor or poverty)).ti,ab.
54	(((food or fuel) adj (insecurity or poverty)) or food bank?).ti,ab.
55	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj2 (debt? or poverty or ((economic or financial) adj hardship?))).ti,ab.
56	((basic or low or minimum) adj3 (wage? or income?)).ti,ab.
57	(family adj (income? or tax credit?)).ti,ab.
58	welfare benefit?.ti,ab.
59	or/48-58
60	offender/ or exp maladjustment/ or prisoner/
61	((crime? or criminal* or offend* or offence? or recidiv*) adj3 (initiative? or intervention? or program* or mitigat* or address* or diver* or prevent* or rehabilitat*)).ti,ab.
62	((inmate? or prisoner? or convict? or felon?) adj3 (rehabilitat* or releas*)).ti,ab.
63	(community adj2 (reentry or re-entry)).ti,ab.
64	or/60-63
65	"social determinants of health"/ or social disability/ or loneliness/ or social isolation/ or social alienation/ or community involvement/ or *social support/ or *social network/ or *psychosocial environment/ or psychosocial rehabilitation/
66	(community involvement or community network* or loneliness or social* alienat* or social connect* or social inclusion or social* isolat* or social network* or social participation or social stigma*).ti,ab.
67	or/65-66
68	human rights/ or civil rights/ or human dignity/ or personal autonomy/ or social justice/
69	exp migrant/ or minority group/ or vulnerable population/
70	(((civil* or human or legal or social) adj rights) or (social justice or equal protection or social protection)).ti,ab.
71	((social or community or neighbo?rhood?) adj3 (equit* or inequit* or inequalit*)).ti,ab.
72	(digital adj (inclusion or exclusion or divide or equit* or inequit* or inequalit*)).ti,ab.
73	((disadvantaged or underserved or under served or vulnerab* or at risk or high risk) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
74	((minorit* or emigra* or immigra* or migra* or foreigner* or refugee* or transient*) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
75	or/68-74
76	crime victim/ or exp childhood trauma survivor/ or exp domestic violence/ or human trafficking/ or sex trafficking/ or exp drug dependence/ or injection drug user/
77	(crime victim? or revictimi* or ((victim* or crime?) and survivor*)).ti,ab.
78	((domestic or marital or partner? or spous* or surviv*) adj3 (abus* or rape? or sex* assault* or violence)).ti,ab.
79	coercive control.ti,ab.
80	((female? or women?) adj (refuge? or shelter?)).ti,ab.
81	(exploitation or safe guarding or safeguarding).ti,ab.
82	(((substance or drug or alcohol) adj (abuse or misuse?)) or "substance use" or "illegal drug use*" or addict* or alcoholi* or (problem* adj1 drinking)).tw.
83	or/76-82
84	or/16,31,37,47,59,64,67,75,83
85	exp disabled person/ or exp disability/ or exp sensory dysfunction/ or exp cognitive defect/ or exp mental capacity/ or exp mental disease/ or exp intellectual impairment/ or exp mental health care/ or exp brain disease/
86	(disable? or disabilit* or handicap* or retard* or disorder? or impair* or condition? or illness* or capacity or competen* or incompeten* or difficulty or difficulties or deficit? or dysfunct*).ti.
87	or/85-86
88	health service/ or exp community care/ or exp elderly care/ or exp mental health service/ or long term care/ or custodial care/ or social psychiatry/ or palliative therapy/ or occupational health service/ or exp rehabilitation/ or terminal care/
89	((communit* or elder* or mental* or long term or custod* or psychosocial* or palliative or terminal or reabl* or rehabilitat*) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
90	((allied health professional? or AHP? or clinical or clinician? or consultant? or family doctor? or general practi* or GP? or medical or medic? or nurse? or occupational therapist? or physician? or ((speech or language) adj2 therapist?) or SLT?) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
91	or/88-90
92	84 and (87 or 91)
93	6 and 13 and 92
94	qualitative research/ or nursing methodology research/ or exp interview/ or narrative/ or questionnaire/ or qualitative analysis/
95	(qualitative or theme* or thematic or ethnograph* or hermeneutic* or heuristic* or semiotic* or humanistic or existential or experiential or paradigm* or narrative* or questionnaire*).mp.
96	((discourse* or discurs* or conversation* or content) adj analys?s).mp.
97	((lived or life or personal) adj experience*).mp.
98	(focus adj group*).ti,ab.
99	(grounded adj (theor* or study or studies or research or analys?s)).mp.
100	action research.ti,ab.
101	(field adj (study or studies or research)).ti,ab.
102	descriptive study.ti,ab.
103	or/94-102

#	Searches
104	((letter.pt. or letter/ or note.pt. or editorial.pt. or case report/ or case study/ or (letter or comment*).ti.) not (randomized controlled trial/ or random*.ti,ab.)) or ((animal/ not human/) or nonhuman/ or exp animal experiment/ or exp experimental animal/ or animal model/ or exp rodent/ or (rat or rats or mouse or mice).ti.)
105	limit 103 to (conference abstract or conference paper or conference review or conference proceeding)
106	103 not (104 or 105)
107	93 and 106
108	limit 107 to english language
109	limit 108 to yr="2010 -Current"

Database(s): Applied Social Sciences Index & Abstracts (ASSIA) (1987 - current) [via Proquest]; International Bibliography of the Social Sciences (IBSS) (1951 - current); Sociological Abstracts (1952 - current) [via Proquest]; Social Services Abstracts [via Proquest]

Set#	Searched for
S1	(AB,TI((social* OR case* OR communit* OR outreach OR personal OR relief OR support) NEAR/3 (advisor? OR agenc* OR assistant? OR care* OR department* OR deliver* OR institution* OR intervention? OR lead* OR manager? OR organi?ation* OR personnel OR planning OR practi* OR profession* OR program* OR provider? OR provision OR sector* OR service? OR setting? OR staff OR supervi* OR system* OR team* OR unit? OR work*)) OR (AB,TI (care coordinator? OR care co-coordinator? OR case manager* OR caseworker* OR case-worker* OR case worker* OR best interest? assessor?)) OR (AB,TI (social welfare OR social assistance OR local authorit* OR state support OR social prescribing welfare service? OR approved mental health profession* OR AMHP*))) AND pd(20100101-20201231) AND la.exact("ENG")
S2	AB,TI(complex* OR chang* OR chronic OR coexist* OR co exist* OR combin* OR concomitant OR comorbid* OR co morbid* OR cooccur* OR co occur* OR develop* OR high support OR life limiting OR long standing OR longstanding OR long term OR multi* OR ongoing OR on going OR persistent OR priorit* OR serious* OR severe OR several OR simultaneous OR special*) AND pd(20100101-20201231) AND la.exact("ENG")
S3	AB,TI(need? OR care OR circumstance* OR condition? OR existence? OR experience? OR initiative? OR intervention? OR impact* OR issue* OR life OR lives OR living OR mitigat* OR patient? OR person? OR people OR problem* OR realit* OR situation? OR social factor* OR support OR target*) AND pd(20100101-20201231) AND la.exact("ENG")
S4	(AB,TI (qualitative OR interview* OR ("mixed method" OR "mixed methods") OR questionnaire* OR survey*) AND pd(20100101-20201231)) AND la.exact("ENG")
S5	2 and 3
S6	1 and 6
S7	4 and 6

Database(s): APA PsycInfo 1806 to March Week 2 2020

#	Searches
1	exp social workers/ or exp social services/ or exp social casework/ or case management/ or social security/ or "welfare services (government)"/ or community welfare services/ or government agencies/
2	((social* or case* or outreach or personal or relief or support) adj3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi?ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*)).ti,ab.
3	(care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?).ti,ab.
4	(("approved mental health" adj (professional? or personnel or staff or team* or worker?)) or AMHP).ti,ab.
5	(social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?).ti,ab.
6	or/1-5
7	comorbidity/
8	((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special*) adj4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*)).ti,ab.
9	SHCN.ti,ab.
10	complex case?.ti,ab.
11	(dual diagnos?s or multi* diagnos?s).ti,ab.
12	(impact adj3 daily adj (life or lives or living or activit* or experienc*)).ti,ab.
13	or/7-12
14	exp social issues/
15	"activities of daily living"/ or exp lifestyle/
16	14 and 15
17	employment status/ or employability/ or occupational tenure/ or occupational status/ or job security/ or job search/ or supported employment/ or vocational rehabilitation/ or vocational evaluation/ or work adjustment training/ or sheltered workshops/ or unemployment/ or personnel termination/ or employee layoffs/
18	((chang* or develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or target*) adj3 (employment or unemployment or unemploy*)).ti,ab.
19	(support* adj3 (employment? or work or vocational)).ti,ab.

#	Searches
20	(employment or unemploy* or underemploy* or under employ*).ti.
21	individual placement?.ti,ab.
22	((finding or gaining or obtaining or keeping or sustaining) adj3 (work or job or employment)).ti,ab.
23	(social firms or (sheltered adj (employment or work))).ti,ab.
24	(precar* adj1 (employment or work)).ti,ab.
25	(paid work or paid employment).ti,ab.
26	(voluntary work or volunteering or unpaid work).ti,ab.
27	(meaningful adj (activit* or employment or work)).ti,ab.
28	("return to work" or "back to work" or absenteeism).ti,ab.
29	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj (work* or disabilit*)).ti,ab.
30	((labo?r force or employment or unemployment) adj status).ti,ab.
31	or/17-30
32	family relations/ or intergenerational relations/ or exp marital relations/ or family conflict/ or marital conflict/ or home environment/ or living alone/ or family reunification/ or living arrangements/
33	((family or families or intergenerat* or inter-generat*) adj (relation* or breakdown or conflict?)).ti,ab.
34	((sexual or intimate or partner?) adj (relation* or conflict?)).ti,ab.
35	((develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or promot* or target*) adj2 relationship?).ti,ab.
36	((carer? or partner or relationship?) adj support*).ti,ab.
37	or/32-36
38	housing/ or assisted living/ or group homes/ or shelters/ or homeless/ or homeless mentally ill/ or deinstitutionalization/ or independent living programs/ or living arrangements/ or residential care institutions/ or halfway houses/ or independent living programs/ or living arrangements/ or residential care institutions/ or poverty areas/ or social environments/ or therapeutic social clubs/ or built environment/ or urban planning/
39	housing.ti.
40	((housing or accommodation or neighbo?rhood? or residence*) adj3 (chang* or address* or condition* or develop* or enhanc* or improv* or initiative? or instability or intervention? or mitigat* or program* or stability or target*)).ti,ab.
41	homeless*.ti,ab.
42	(permanent housing or social housing).ti,ab.
43	((assisted or autonomous or independent or secur* or sheltered or support* or sustain*) adj3 (housing or accommodat* or dwelling? or residen* or tenanc* or tenure?)).ti,ab.
44	((halfway or satellite) adj (accommodat* or dwelling? or home? or house?)).ti,ab.
45	(neighbo?rhood? adj (characteristic* or intervention* or program*)).ti,ab.
46	((environment* or housing or neighbo?rhood?) and infrastructure).ti,ab.
47	or/38-46
48	socioeconomic status/ or "income (economic)"/ or budgets/ or economic security/ or financial strain/ or exp employee benefits/ or *disadvantaged/ or *social deprivation/
49	money.ti.
50	((access* or improv* or manag* or supplement*) adj2 (cash or money or financ* or income? or savings)).ti,ab.
51	((financial adj (autonomy or security or insecurity)) or loans or borrowing or budgeting or microcredit or microfinance or social fund*).ti,ab.
52	(extreme poverty or high poverty).ti,ab. or poverty.ti.
53	((address* or escap* or improv* or "out of" or support* or target*) adj2 (depriv* or poor or poverty)).ti,ab.
54	(((food or fuel) adj (insecurity or poverty)) or food bank?).ti,ab.
55	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj2 (debt? or poverty or ((economic or financial) adj hardship?))).ti,ab.
56	((basic or low or minimum) adj3 (wage? or income?)).ti,ab.
57	(family adj (income? or tax credit?)).ti,ab.
58	welfare benefit?.ti,ab.
59	or/48-58
60	exp criminal offenders/ or criminal record/ or prisoners/ or criminal rehabilitation/ or reintegration/
61	((crime? or criminal* or offend* or offence? or recidiv*) adj3 (initiative? or intervention? or program* or mitigat* or address* or diver* or prevent* or rehabilitat*)).ti,ab.
62	((inmate? or prisoner? or convict? or felon?) adj3 (rehabilitat* or releas*)).ti,ab.
63	(community adj2 (reentry or re-entry)).ti,ab.
64	or/60-63
65	social isolation/ or loneliness/ or abandonment/ or alienation/ or exp social discrimination/ or stigma/ or health disparities/
66	(community involvement or community network* or loneliness or social* alienat* or social connect* or social inclusion or social* isolat* or social network* or social participation or social stigma*).ti,ab.
67	or/65-66
68	human rights/ or exp civil rights/ or exp freedom/ or government policy making/ or digital divide/ or information literacy/
69	exp minority groups/ or exp "racial and ethnic groups"/ or asylum seeking/ or immigration/ or refugees/ or at risk populations/ or disadvantaged/
70	(((civil* or human or legal or social) adj rights) or (social justice or equal protection or social protection)).ti,ab.
71	((social or community or neighbo?rhood?) adj3 (equit* or inequit* or inequalit*)).ti,ab.
72	(digital adj (inclusion or exclusion or divide or equit* or inequit* or inequalit*)).ti,ab.
73	((disadvantaged or underserved or under served or vulnerab* or at risk or high risk) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
74	((minorit* or emigra* or immigra* or migra* or foreigner* or refugee* or transient*) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.

#	Searches
75	or/68-74
76	crime victims/ or elder abuse/ or domestic violence/ or battered females/ or exposure to violence/ or intimate partner violence/ or physical abuse/ or exp sexual abuse/ or shelters/ or interpersonal control/ or coercion/ or slavery/ or human trafficking/ or *freedom/ or exp alcohol abuse/ or exp drug abuse/
77	(crime victim? or revictimi* or ((victim* or crime?) and survivor*)).ti,ab.
78	((domestic or marital or partner? or spous* or surviv*) adj3 (abus* or rape? or sex* assault* or violence)).ti,ab.
79	coercive control.ti,ab.
80	((female? or women?) adj (refuge? or shelter?)).ti,ab.
81	(exploitation or safe guarding or safeguarding).ti,ab.
82	(((substance or drug or alcohol) adj (abuse or misuse?)) or "substance use" or "illegal drug use*" or addict* or alcoholi* or (problem* adj1 drinking)).tw.
83	or/76-82
84	or/16,31,37,47,59,64,67,75,83
85	exp disabilities/ or exp chronic illness/ or cognitive impairment/ or diminished capacity/ or exp health impairments/ or exp mental disorders/ or exp sensory system disorders/ or special needs/ or exp central nervous system disorders/ or exp sense organ disorders/ or terminally ill patients/
86	(disable? or disabilit* or handicap* or retard* or disorder? or impair* or condition? or illness* or capacity or competen* or incompeten* or difficulty or difficulties or deficit? or dysfunct*).ti.
87	or/85-86
88	exp health care services/ or exp community facilities/ or exp elderly care/ or exp mental health programs/ or social psychiatry/ or exp occupational health/ or exp rehabilitation/
89	((communit* or elder* or mental* or long term or custod* or psychosocial* or palliative or terminal or reabl* or rehabilitat*) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
90	((allied health professional? or AHP? or clinical or clinician? or consultant? or family doctor? or general practi* or GP? or medical or medic? or nurse? or occupational therapist? or physician? or ((speech or language) adj2 therapist?) or SLT?) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
91	or/88-90
92	84 and (87 or 91)
93	6 and 13 and 92
94	exp qualitative methods/ or interviews/ or narratives/ or exp questionnaires/ or qualitative measures/
95	(qualitative or theme* or thematic or ethnograph* or hermeneutic* or heuristic* or semiotic* or humanistic or existential or experiential or paradigm* or narrative* or questionnaire*).mp.
96	((discourse* or discurs* or conversation* or content) adj analys?s).mp.
97	((lived or life or personal) adj experience*).mp.
98	(focus adj group*).ti,ab.
99	(grounded adj (theor* or study or studies or research or analys?s)).mp.
100	action research.ti,ab.
101	(field adj (study or studies or research)).ti,ab.
102	descriptive study.ti,ab.
103	or/94-102
104	((case report/ or (letter or comment*).ti.) not (randomized controlled trials/ or random*.ti,ab.)) or (animals/ or "primates (nonhuman)"/ or exp animal research/ or animal models/ or exp rodents/ or (rat or rats or mouse or mice).ti.)
105	103 not 104
106	93 and 105
107	limit 106 to english language
108	limit 107 to yr="2010 -Current"

Social Care Online: https://www.scie-socialcareonline.org.uk/

Search:
PublicationTitle:'complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or life limiting or long standing or longstanding or long term or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special'
- OR PublicationTitle:'need* or care or circumstance* or condition* or existence* or experience* or initiative* or intervention* or issue* or live* or mitigat* or patient* or person* or people or problem* or realit* or situation* or social factor* or support or target*'
- AND AllFields:'qualitative or interview* or mixed method* or questionnaire* or survey*'
- AND PublicationYear:'2010 2020'
- AND SubjectTerms:'"social care"' including related terms
Social work search:
AllFields:'social work* or social care* or care coordinator* or care co-ordinator*'
- OR AllFields:'case manager* or caseworker* or case-worker* or case worker* or best interest* assessor*'
- OR AllFields:'approved mental health professional* or AMHP'
- OR AllFields:'social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service*'
- AND AllFields:'qualitative or interview* or mixed method* or questionnaire* or survey*'
- AND PublicationYear:'2010 2020'

Database(s): Social Policy and Practice 202001

#	Searches
1	((social* or case* or outreach or personal or relief or support) adj3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi?ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*)).ti,ab.
2	(care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?).ti,ab.
3	(("approved mental health" adj (professional? or personnel or staff or team* or worker?)) or AMHP).ti,ab.
4	(social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?).ti,ab.
5	or/1-4
6	((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special*) adj4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*)).ti,ab.
7	SHCN.ti,ab.
8	complex case?.ti,ab.
9	(dual diagnos?s or multi* diagnos?s).ti,ab.
10	(impact adj3 daily adj (life or lives or living or activit* or experienc*)).ti,ab.
11	or/6-10
12	((chang* or develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or target*) adj3 (employment or unemployment or unemploy*)).ti,ab.
13	(support* adj3 (employment? or work or vocational)).ti,ab.
14	(employment or unemploy* or underemploy* or under employ*).ti.
15	individual placement?.ti,ab.
16	((finding or gaining or obtaining or keeping or sustaining) adj3 (work or job or employment)).ti,ab.
17	(social firms or (sheltered adj (employment or work))).ti,ab.
18	(precar* adj1 (employment or work)).ti,ab.
19	(paid work or paid employment).ti,ab.
20	(voluntary work or volunteering).ti,ab.
21	(meaningful adj (activit* or employment or work)).ti,ab.
22	("return to work" or "back to work" or absenteeism).ti,ab.
23	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj work* disabilit*).ti,ab.
24	((labo?r force or employment or unemployment) adj status).ti,ab.
25	or/12-24
26	((family or families or intergenerat* or inter-generat*) adj (relation* or breakdown or conflict?)).ti,ab.
27	((sexual or intimate or partner?) adj (relation* or conflict?)).ti,ab.
28	((develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or promot* or target*) adj2 relationship?).ti,ab.
29	((carer? or partner or relationship?) adj support*).ti,ab.
30	or/26-29
31	housing.ti.
32	((housing or accommodation or neighbo?rhood? or residence*) adj3 (chang* or address* or condition* or develop* or enhanc* or improv* or initiative? or instability or intervention? or mitigat* or program* or stability or target*)).ti,ab.
33	homeless*.ti,ab.
34	(permanent housing or social housing).ti,ab.
35	((assisted or autonomous or independent or secur* or sheltered or support* or sustain*) adj3 (housing or accommodat* or dwelling? or residen* or tenanc* or tenure?)).ti,ab.
36	((halfway or satellite) adj (accommodat* or dwelling? or home? or house?)).ti,ab.
37	(neighbo?rhood? adj (characteristic* or intervention* or program*)).ti,ab.
38	((environment* or housing or neighbo?rhood?) and infrastructure).ti,ab.
39	or/31-38
40	money.ti.
41	((access* or improv* or manag* or supplement*) adj2 (cash or money or financ* or income? or savings)).ti,ab.
42	((financial adj (autonomy or security or insecurity)) or loans or borrowing or budgeting or microcredit or microfinance or social fund*).ti,ab.
43	(extreme poverty or high poverty).ti,ab. or poverty.ti.
44	((address* or escap* or improv* or "out of" or support* or target*) adj2 (depriv* or poor or poverty)).ti,ab.
45	(((food or fuel) adj (insecurity or poverty)) or food bank?).ti,ab.
46	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj2 (debt? or poverty or ((economic or financial) adj hardship?))).ti,ab.
47	((basic or low or minimum) adj3 (wage? or income?)).ti,ab.
48	(family adj (income? or tax credit?)).ti,ab.
49	welfare benefit?.ti,ab.
50	or/40-49
51	((crime? or criminal* or offend* or offence? or recidiv*) adj3 (initiative? or intervention? or program* or mitigat* or address* or diver* or prevent* or rehabilitat*)).ti,ab.
52	((inmate? or prisoner? or convict? or felon?) adj3 (rehabilitat* or releas*)).ti,ab.
53	(community adj2 (reentry or re-entry)).ti,ab.
54	or/51-53

#	Searches
55	(community involvement or community network* or loneliness or social* alienat* or social connect* or social inclusion or social* isolat* or social network* or social participation or social stigma*).ti,ab.
56	(((civil* or human or legal or social) adj rights) or (social justice or equal protection or social protection)).ti,ab.
57	((social or community or neighbo?rhood?) adj3 (equit* or inequit* or inequalit*)).ti,ab.
58	(digital adj (inclusion or exclusion or divide or equit* or inequit* or inequalit*)).ti,ab.
59	((disadvantaged or underserved or under served or vulnerab* or at risk or high risk) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
60	((minorit* or emigra* or immigra* or migra* or foreigner* or refugee* or transient*) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
61	or/56-60
62	(crime victim? or revictimi* or ((victim* or crime?) and survivor*)).ti,ab.
63	((domestic or marital or partner? or spous* or surviv*) adj3 (abus* or rape? or sex* assault* or violence)).ti,ab.
64	coercive control.ti,ab.
65	((female? or women?) adj (refuge? or shelter?)).ti,ab.
66	(exploitation or safe guarding or safeguarding).ti,ab.
67	(((substance or drug or alcohol) adj (abuse or misuse?)) or "substance use" or "illegal drug use*" or addict* or alcoholi* or (problem* adj1 drinking)).ti,ab.
68	or/62-67
69	(disable? or disabilit* or handicap* or retard* or disorder? or impair* or condition? or illness* or capacity or competen* or difficulty or difficulties or deficit? or dysfunct*).ti.
70	or/25,30,39,50,54-55,61,68-69
71	5 and 11 and 70
72	(qualitative or theme* or thematic or ethnograph* or hermeneutic* or heuristic* or semiotic* or humanistic or existential or experiential or paradigm* or narrative* or questionnaire*).ti,ab.
73	((discourse* or discurs* or conversation* or content) adj analys?s).ti,ab.
74	((lived or life or personal) adj experience*).ti,ab.
75	focus group*.ti,ab.
76	(grounded adj (theor* or study or studies or research or analys?s)).ti,ab.
77	action research.ti,ab.
78	(field adj (study or studies or research)).ti,ab.
79	descriptive study.ti,ab.
80	or/72-79
81	71 and 80
82	limit 81 to yr="2010 -Current"

Literature search strategies for economic studies

A combined search was used for all economic questions.

Embase 1980 to 2021 Week 22, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to June 07, 2021

Multifile database codes: emez= Embase 1980 to 2021 Week 22; ppez= Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to June 07, 2021

#	Searches
1	(exp Social Work/ or Social Work, Psychiatric/ or Social Workers/ or Social Welfare/ or Case Management/ or Accountable Care Organizations/ or (Mental Health Services/ and (Professional Role/ or Professional Standard/ or exp Workforce/))) use ppez
2	(social care/ or social welfare/ or social work/ or social work practice/ or social worker/ or case management/ or case manager/ or national health service/ or accountable care organization/ or mental health care personnel/) use emez
3	((social* or case* or outreach or personal or relief or support) adj3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi?ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*)).ti,ab.
4	(care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?).ti,ab.
5	(("approved mental health" adj (professional? or personnel or staff or team* or worker?)) or AMHP).ti,ab.
6	(social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?).ti,ab.
7	or/1-6
8	exp Comorbidity/ use ppez
9	comorbidity/ use emez
10	((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or

#	Searches
	serious* or severe or several or simultaneous or special*) adj4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*)).ti,ab.
11	SHCN.ti,ab.
12	complex case?.ti,ab.
13	(dual diagnos?s or multi* diagnos?s).ti,ab.
14	(impact adj3 daily adj (life or lives or living or activit* or experienc*)).ti,ab.
15	or/8-14
16	exp *Social Problems/ use ppez
17	exp *social problem/ use emez
18	16 or 17
19	(exp Human Activities/ or exp Life Style/) use ppez
20	(exp human activities/ or exp "lifestyle and related phenomena"/) use emez
21	18 and (19 or 20)
22	(Employment/ or Employment, Supported/ or Return to Work/ or Rehabilitation, Vocational/ or Unemployment/) use ppez
23	(unemployment/ or employment status/ or supported employment/ or sheltered workshop/ or vocational rehabilitation/ or absenteeism/ or job security/ or return to work/) use emez
24	((chang* or develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or target*) adj3 (employment or unemployment or unemploy*)).ti,ab.
25	(support* adj3 (employment? or work or vocational)).ti,ab.
26	(employment or unemploy* or underemploy* or under employ*).ti.
27	individual placement?.ti,ab.
28	((finding or gaining or obtaining or keeping or sustaining) adj3 (work or job or employment)).ti,ab.
29	(social firms or (sheltered adj (employment or work))).ti,ab.
30	(precar* adj1 (employment or work)).ti,ab.
31	(paid work or paid employment).ti,ab.
32	(voluntary work or volunteering or unpaid work).ti,ab.
33	(meaningful adj (activit* or employment or work)).ti,ab.
34	("return to work" or "back to work" or absenteeism).ti,ab.
35	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj (work* or disabilit*)).ti,ab.
36	((labo?r force or employment or unemployment) adj status).ti,ab.
37	or/22-36
38	(Family Conflict/ or Family Relations/ or Intergenerational Relations/) use ppez
39	family functioning/ or family conflict/ use emez
40	((family or families or intergenerat* or inter-generat*) adj (relation* or breakdown or conflict?)).ti,ab.
41	((sexual or intimate or partner?) adj (relation* or conflict?)).ti,ab.
42	((develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or promot* or target*) adj2 relationship?).ti,ab.
43	((carer? or partner or relationship?) adj support*).ti,ab.
44	or/38-43
45	(Housing/ or Homeless Persons/ or Independent Living/ or Assisted Living Facilities/ or Group Homes/ or Halfway Houses/ or Housing for the Elderly/ or Poverty Areas/ or Public Housing/ or Residence Characteristics/) use ppez
46	(housing/ or assisted living facility/ or community living/ or emergency shelter/ or homelessness/ or exp homeless person/ or deinstitutionalization/ or halfway house/) use emez
47	housing.ti.
48	((housing or accommodation or neighbo?rhood? or residence*) adj3 (chang* or address* or condition* or develop* or enhanc* or improv* or initiative? or instability or intervention? or mitigat* or program* or stability or target*)).ti,ab.
49	homeless*.ti,ab.
50	(permanent housing or social housing).ti,ab.
51	((assisted or autonomous or independent or secur* or sheltered or support* or sustain*) adj3 (housing or accommodat* or dwelling? or residen* or tenanc* or tenure?)).ti,ab.
52	((halfway or satellite) adj (accommodat* or dwelling? or home? or house?)).ti,ab.
53	(neighbo?rhood? adj (characteristic* or intervention* or program*)).ti,ab.
54	((environment* or housing or neighbo?rhood?) and infrastructure).ti,ab.
55	or/45-54
56	(*Economic Status/ or *Financing, Personal/ or exp *Income/ or Poverty/ or Working Poor/ or *Social Welfare/) use ppez
57	(*money/ or *economic status/ or household economic status/ or *social welfare/ or *socioeconomics/ or household income/ or personal income/ or family income/ or *financial management/ or "salary and fringe benefit"/ or *pension/ or *salary/ or poverty/ or exp lowest income group/) use emez
58	money.ti.
59	((access* or improv* or manag* or supplement*) adj2 (cash or money or financ* or income? or savings)).ti,ab.
60	((financial adj (autonomy or security or insecurity)) or loans or borrowing or budgeting or microcredit or microfinance or social fund*).ti,ab.
61	(extreme poverty or high poverty).ti,ab. or poverty.ti.
62	((address* or escap* or improv* or "out of" or support* or target*) adj2 (depriv* or poor or poverty)).ti,ab.
63	(((food or fuel) adj (insecurity or poverty)) or food bank?).ti,ab.
64	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj2 (debt? or poverty or ((economic or financial) adj hardship?))).ti,ab.
65	((basic or low or minimum) adj3 (wage? or income?)).ti,ab.

#	Searches
66	(family adj (income? or tax credit?)).ti,ab.
67	welfare benefit?.ti,ab.
68	or/56-67
69	(Criminals/ or Prisoners/ or Recidivism/) use ppez
70	(offender/ or exp maladjustment/ or prisoner/) use emez
71	((crime? or criminal* or offend* or offence? or recidiv*) adj3 (initiative? or intervention? or program* or mitigat* or address* or diver* or prevent* rehabilitat*)).ti,ab.
72	((inmate? or prisoner? or convict? or felon?) adj3 (rehabilitat* or releas*)).ti,ab.
73	(community adj2 (reentry or re-entry)).ti,ab.
74	or/69-73
75	("Social Determinants of Health"/ or exp Social Isolation/ or Social Marginalization/ or Social Stigma/) use ppez
76	("social determinants of health"/ or social disability/ or loneliness/ or social isolation/ or social alienation/ or community involvement/ or *social support/ or *social network/ or *psychosocial environment/ or psychosocial rehabilitation/) use emez
77	(community involvement or community network* or loneliness or social* alienat* or social connect* or social inclusion or social* isolat* or social network* or social participation or social stigma*).ti,ab.
78	or/75-77
79	Civil Rights/ or Human Rights/ or Personal Autonomy/ or Personhood/ or Public Policy/ or Social Justice/
80	Minority Groups/ or "Transients and Migrants"/ or Refugees/ or Vulnerable Populations/
81	(or/79-80) use ppez
82	human rights/ or civil rights/ or human dignity/ or personal autonomy/ or social justice/
83	exp migrant/ or minority group/ or vulnerable population/
84	(or/82-83) use emez
85	(((civil* or human or legal or social) adj rights) or (social justice or equal protection or social protection)).ti,ab.
86	((social or community or neighbo?rhood?) adj3 (equit* or inequit* or inequalit*)).ti,ab.
87	(digital adj (inclusion or exclusion or divide or equit* or inequit* or inequalit*)).ti,ab.
88	((disadvantaged or underserved or under served or vulnerab* or at risk or high risk) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
89	((minorit* or emigra* or immigra* or migra* or foreigner* or refugee* or transient*) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
90	or/81,84-89
91	(Crime Victims/ or "Adult Survivors of Child Abuse"/ or Alcoholism/ or Drug Users/ or Domestic Violence/ or Battered Women/ or Elder Abuse/ or Spouse Abuse/ or Human Trafficking/) use ppez
92	(crime victim/ or exp childhood trauma survivor/ or exp domestic violence/ or human trafficking/ or sex trafficking/ or exp drug dependence/ or injection drug user/) use emez
93	(crime victim? or revictimi* or ((victim* or crime?) and survivor*)).ti,ab.
94	((domestic or marital or partner? or spous* or surviv*) adj3 (abus* or rape? or sex* assault* or violence)).ti,ab.
95	coercive control.ti,ab.
96	((female? or women?) adj (refuge? or shelter?)).ti,ab.
97	(exploitation or safe guarding or safeguarding).ti,ab.
98	(((substance or drug or alcohol) adj (abuse or misuse?)) or "substance use" or "illegal drug use*" or addict* or alcoholi* or (problem* adj1 drinking)).tw.
99	or/91-98
100	or/21,37,44,55,68,74,78,90,99
101	(exp Communication Disorders/ or exp Sensory Disorders/ or exp Cognition Disorders/ or Cognitive Dysfunction/ or exp Disabled Persons/ or exp Intellectual Disability/ or Mental Competency/ or exp Mental Disorders/ or Mental Health/ or exp Brain Diseases/) use ppez
102	(exp disabled person/ or exp disability/ or exp sensory dysfunction/ or exp cognitive defect/ or exp mental capacity/ or exp mental disease/ or exp intellectual impairment/ or exp mental health care/ or exp brain disease/) use emez
103	(disable? or disabilit* or handicap* or retard* or disorder? or impair* or condition? or illness* or capacity or competen* or incompeten* or difficulty or difficulties or deficit? or dysfunct*).ti.
104	or/101-103
105	(Health Services/ or exp Community Health Services/ or exp Community Psychiatry/ or Custodial Care/ or Health Services for the Aged/ or Health Services for Persons with Disabilities/ or Long-Term Care/ or exp Mental Health Services/ or Palliative Care/ or Personal Health Services/ or exp Rehabilitation/ or Terminal Care/) use ppez
106	(health service/ or exp community care/ or exp elderly care/ or exp mental health service/ or long term care/ or custodial care/ or social psychiatry/ or palliative therapy/ or occupational health service/ or exp rehabilitation/ or terminal care/) use emez
107	((communit* or elder* or mental* or long term or custod* or psychosocial* or palliative or terminal or reabl* or rehabilitat*) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
108	((allied health professional? or AHP? or clinical or clinician? or consultant? or family doctor? or general practi* or GP? or medical or medic? or nurse? or occupational therapist? or physician? or ((speech or language) adj2 therapist?) or SLT?) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
109	or/105-108
110	100 and (104 or 109)
111	7 and 15 and 110
112	Economics/
113	Value of life/
114	exp "Costs and Cost Analysis"/
115	exp Economics, Hospital/

#	Searches
116	exp Economics, Medical/
117	Economics, Nursing/
118	Economics, Pharmaceutical/
119	exp "Fees and Charges"/
120	exp Budgets/
121	(or/112-120) use ppez
122	health economics/
123	exp economic evaluation/
124	exp health care cost/
125	exp fee/
126	budget/
127	funding/
128	(or/122-127) use emez
129	budget*.ti,ab.
130	cost*.ti.
131	(economic* or pharmaco?economic*).ti.
132	(price* or pricing*).ti,ab.
133	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
134	(financ* or fee or fees).ti,ab.
135	(value adj2 (money or monetary)).ti,ab.
136	or/129-135
137	121 or 128 or 136
138	Quality-Adjusted Life Years/ use ppez
139	Sickness Impact Profile/
140	quality adjusted life year/ use emez
141	"quality of life index"/ use emez
142	(quality adjusted or quality adjusted life year*).tw.
143	(qaly* or qal or qald* or qale* or qtime* or qwb* or daly).tw.
144	(illness state* or health state*).tw.
145	(hui or hui2 or hui3).tw.
146	(multiattribute* or "multi attribute*").tw.
147	(utilit* adj3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*)).tw.
148	utilities.tw.
149	(eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol*or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol).tw.
150	(euro* adj3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5 domain* or 5domain*)).tw.
151	(sf36 or sf 36 or sf thirty six or sf thirtysix).tw.
152	(time trade off*1 or time tradeoff*1 or tto or timetradeoff*1).tw.
153	Quality of Life/ and ((quality of life or qol) adj (score*1 or measure*1)).tw.
154	Quality of Life/ and ec.fs.
155	Quality of Life/ and (health adj3 status).tw.
156	(quality of life or qol).tw. and Cost-Benefit Analysis/ use ppez
157	(quality of life or qol).tw. and cost benefit analysis/ use emez
158	((qol or hrqol or quality of life).tw. or *quality of life/) and ((qol or hrqol* or quality of life) adj2 (increas* or decreas* or improv* or declin* or reduc* or high* or low* or effect or effects or worse or score or scores or change*1 or impact*1 or impacted or deteriorat*)).ab.
159	Cost-Benefit Analysis/ use ppez and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
160	cost benefit analysis/ use emez and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
161	*quality of life/ and (quality of life or qol).ti.
162	quality of life/ and ((quality of life or qol) adj3 (improv* or chang*)).tw.
163	quality of life/ and health-related quality of life.tw.
164	Models, Economic/ use ppez
165	economic model/ use emez
166	((capabilit* or wellbeing or well-being) adj4 (measur* or index* or instrument* or tool*)).tw.
167	(subjective wellbeing or subjective well-being).tw.
168	(ASCOT or "adult social care outcomes toolkit").tw.
169	(SCRQOL or "social care- related quality of life").tw.
170	"capacity to benefit score".tw.
171	(ICECAP* or "Icepop capability measure for adults" or "Icepop capability measure for older people" or "Icecap supportive care measure" or "Icecap close person measure").tw.
172	(ASCOF or "adult social care outcomes framework").tw.
173	(Warwick Edinburgh Mental Well-being scale or WEMBS or S-WEMWBS).tw.
174	ONS-4.tw.
175	GHQ-12.tw.
176	(Personal Well-Being Index* or PWI-A).tw.
177	(OPUS* or "older people's utility scale").tw.
178	or/138-177
179	137 or 178

#	Searches
180	(((Letter/ or Editorial/ or News/ or exp Historical Article/ or Anecdotes as Topic/ or Comment/ or Case Report/ or (letter or comment*).ti.) not (Randomized Controlled Trial/ or random*.ti,ab.)) or ((Animals not Humans).sh. or exp Animals, Laboratory/ or exp Animal Experimentation/ or exp Models, Animal/ or exp Rodentia/ or (rat or rats or mouse or mice).ti.)) use ppez
181	(((letter.pt. or letter/ or note.pt. or editorial.pt. or case report/ or case study/ or (letter or comment*).ti.) not (randomized controlled trial/ or random*.ti,ab.)) or ((animal/ not human/) or nonhuman/ or exp animal experiment/ or exp experimental animal/ or animal model/ or exp rodent/ or (rat or rats or mouse or mice).ti.)) use emez
182	180 or 181
183	limit 179 to (conference abstract or conference paper or conference review or conference proceeding) [Limit not valid in Ovid MEDLINE(R),Ovid MEDLINE(R) Daily Update,Ovid MEDLINE(R) In-Process,Ovid MEDLINE(R) Publisher; records were retained]
184	183 use emez
185	179 not (182 or 184)
186	111 and 185
187	limit 186 to english language
188	limit 187 to yr="2010 -Current"

Database(s): Centre for Reviews and Dissemination (CRD): Health Technology Assessments (HTA); NHS Economic Evaluation Database (NHS EED)

Search
(complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co morbid* or cooccur* or co occur* or develop* or high support or life limiting or long standing or longstanding or long term or multi* or ongoing or on going or persistent or priorit* or serious* or severe or several or simultaneous or special"):TI AND (need* or care or circumstance* or condition* or existence* or experience* or initiative* or intervention* or issue* or live* or mitigat* or patient* or person* or people or problem* or realit* or situation* or social factor* or support or target*):TI AND (social work* or social care* or care coordinator* or care co ordinator* or case manager* or caseworker* or case worker* or best interest* assessor* or approved mental health professional* or AMHP* or social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service*) IN NHSEED, HTA FROM 2010 TO 2021

EBSCO Host CINAHL Plus

#	Query	Limiters/Expanders
S60	S17 AND S59	Limiters - Publication Year: 2010-2020; English Language; Exclude MEDLINE records Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S59	S23 OR S58	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S58	S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S57	TX (OPUS* or "older people's utility scale")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S56	TX ("Personal Well-Being Index*" or "PWI-A")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S55	TX "GHQ-12"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S54	TX "ONS-4"	Expanders - Apply equivalent subjects Search modes - SmartText Searching
S53	TX "ONS-4"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S52	TX ("Warwick Edinburgh Mental Well-being scale" or WEMBS or S-WEMWBS)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S51	TX (ASCOF or "adult social care outcomes framework")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S50	TX (ICECAP* or "Icepop capability measure for adults" or "Icepop capability measure for older people" or "Icecap supportive care measure" or "Icecap close person measure")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S49	TX "capacity to benefit score"	Expanders - Apply equivalent subjects Search modes - SmartText Searching
S48	TX "capacity to benefit score"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S47	TX (SCRQOL or "social care- related quality of life")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S46	TX (ASCOT or "adult social care outcomes toolkit")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase

#	Query	Limiters/Expanders
S45	TX ("subjective wellbeing" or "subjective well-being")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S44	TX ((capabilit* or wellbeing or well-being) N3 (measur* or index* or instrument* or tool*))	Expanders - Apply equivalent subjects Search modes - SmartText Searching
S43	TX ((capabilit* or wellbeing or well-being) N3 (measur* or index* or instrument* or tool*)).tw.	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S42	(MH "Quality of Life") AND TX (health-related quality of life)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S41	(MH "Quality of Life") AND TI (quality of life or qol)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S40	AB ((qol or hrqol or quality of life) AND ((qol or hrqol* or (quality of life N2 (increas* or decreas* or improv* or declin* or reduc* or high* or low* or effect or effects or worse or score or scores or change*1 or impact*1 or impacted or deteriorat*)))	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S39	(MH "Cost Benefit Analysis") AND TX ((quality of life or qol) or (cost-effectiveness ratio* and (perspective* or life expectanc*))	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S38	(MH "Quality of Life") AND TX (health N3 status)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S37	(MH "Quality of Life") AND TX ((quality of life or qol) N (score*1 or measure*1))	Expanders - Apply equivalent subjects Search modes - SmartText Searching
S36	(MH "Quality of Life") AND TX ((quality of life or qol) N (score*1 or measure*1))	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S35	TX (time trade off*1 or time tradeoff*1 or tto or timetradeoff*1)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S34	TX (sf36 or sf 36 or sf thirty six or sf thirtysix)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S33	TX (euro* N3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5 domain* or 5domain*))	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S32	TX (eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol* or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S31	TI utilities	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S30	TX (utilit* N3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*))	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S29	TX (multiattibute* or multi attribute*)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S28	TX (hui or hui2 or hui3)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S27	TX (illness state* or health state*)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S26	TX (quality adjusted or quality adjusted life year*or qaly* or qal or qald* or qale* or qtime* or qwb* or daly)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S25	(MH "Sickness Impact Profile")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S24	(MH "Quality-Adjusted Life Years")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S23	S18 OR S19 OR S20 OR S21 OR S22	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S22	TX (value N2 (money or monetary))	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S21	TX (cost* N2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*))	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S20	TI cost* or economic* or pharmaco?economic*	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S19	TX budget* or fee or fees or finance* or price* or pricing	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S18	(MH "Fees and Charges+") OR (MH "Costs and Cost Analysis+") OR (MH "Economics") OR (MH "Economic Value of Life") OR (MH "Economics, Pharmaceutical") OR (MH "Economic Aspects of Illness") OR (MH "Resource Allocation+")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S17	S9 AND S16	Limiters - Publication Year: 2010-2020; English Language; Exclude MEDLINE records Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S16	S10 OR S11 OR S12 OR S13 OR S14 OR S15	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S15	TX (impact adj3 daily W2 (life or lives or living or activit* or experienc*))	Expanders - Apply equivalent subjects Search modes - SmartText Searching

#	Query	Limiters/Expanders
S14	TX (dual diagnos#s or multi* diagnos#s)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S13	TX complex case?	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S12	TX SHCN	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S11	TX ((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special*) W4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*))	Expanders - Apply equivalent subjects Search modes - SmartText Searching
S10	(MH "Comorbidity")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S9	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S8	TX (social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S7	TX (("approved mental health" W2 (professional? or personnel or staff or team* or worker?)) or AMHP)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S6	TX (care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S5	TX ((social* or case* or outreach or personal or relief or support) W3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi#ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*))	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S4	((MH "Mental Health Services+") AND ((MH "Accountability") OR (MH "Professional Practice") OR (MH "Professional Role")))	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S3	(MH "Accountable Care Organizations")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S2	(MH "Case Management") OR (MH "Case Managers")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase
S1	(MH "Social Welfare") OR (MH "Social Work") OR (MH "Social Work Practice") OR (MH "Social Work Service") OR (MH "Social Worker Attitudes") OR (MH "Social Workers")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase

Cochrane Central Register of Controlled Trials, Issue 5 of 12, May 2021

ID	Search
#1	MeSH descriptor: [Social Work] explode all trees
#2	MeSH descriptor: [Social Work, Psychiatric] this term only
#3	MeSH descriptor: [Social Workers] this term only
#4	MeSH descriptor: [Social Work Department, Hospital] this term only
#5	MeSH descriptor: [Social Welfare] this term only
#6	MeSH descriptor: [Case Management] this term only
#7	MeSH descriptor: [Case Managers] this term only
#8	MeSH descriptor: [Accountable Care Organizations] this term only
#9	MeSH descriptor: [Mental Health Services] explode all trees
#10	((social* or case* or outreach or personal or relief or support) next/3 (advisor* or agenc* or assistan* or care* or department* or deliver* or institution* or intervention* or lead* or manager* or organisation* or organization* or personnel or planning or practi* or profession* or program* or provider* or provision or sector* or service* or setting* or staff or supervi* or system* or team* or unit* or work*)):ti,ab
#11	("care coordinator*" or "care co ordinator*" or "case manager*" or caseworker* or "case worker*" or "best interest assessor*" or “best interests assessor*):ti,ab
#12	(("approved mental health" next/3 (professional or personnel or staff or team* or worker*)) or AMHP):ti,ab
#13	("social welfare" or "social assistance" or "local authorit*" or "local council*" or "state support" or "social prescribing" or "welfare service*"):ti,ab
#14	{or #1-#13}
#15	MeSH descriptor: [Comorbidity] explode all trees
#16	((complex* or chang* or chronic or coexist* or "co exist*" or combin* or concomitant or comorbid* or "co morbid*" or cooccur* or "co occur*" or develop* or “high support” or (intellectual* and physical*) or "life limiting" or "long standing" or longstanding or "long term" or (mental* and physical*) or multi* or ongoing or "on going" or persistent or priorit* or serious* or severe or several or simultaneous or special*) next/4 (need* or care or circumstance* or condition* or existence* or experience* or initiative* or intervention* or issue* or live* or mitigat* or patient* or person* or people? or problem* or realit* or situation* or "social factor*" or support or target*)):ti,ab

ID	Search
#17	(SHCN or "complex* case*"):ti,ab
#18	("dual diagnosis" or "dual diagnoses" or "multi* diagnosis" or "multi* diagnoses"):ti,ab
#19	(impact next/3 daily next (life or living or activit* or experienc*)):ti,ab
#20	{or #15-#19}
#21	#14 and #20 with Cochrane Library publication date Between Jan 2010 and Dec 2020
#22	MeSH descriptor: [Economics] this term only
#23	MeSH descriptor: [Value of Life] this term only
#24	MeSH descriptor: [Costs and Cost Analysis] explode all trees
#25	MeSH descriptor: [Economics, Hospital] explode all trees
#26	MeSH descriptor: [Economics, Medical] explode all trees
#27	MeSH descriptor: [Economics, Nursing] this term only
#28	MeSH descriptor: [Economics, Pharmaceutical] this term only
#29	MeSH descriptor: [Fees and Charges] explode all trees
#30	MeSH descriptor: [Budgets] explode all trees
#31	budget*:ti,ab
#32	cost*:ti
#33	(economic* or pharmaco?economic*):ti
#34	(price* or pricing*):ti,ab
#35	(cost* next/2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)):ab
#36	(financ* or fee or fees):ti,ab
#37	(value next/2 (money or monetary)):ti,ab
#38	{or #22-#37}
#39	MeSH descriptor: [Quality-Adjusted Life Years] this term only
#40	MeSH descriptor: [Sickness Impact Profile] this term only
#41	(“quality adjusted” or “quality adjusted life year*”):ti,ab
#42	(qaly* or qal or qald* or qale* or qtime* or qwb* or daly):ti,ab
#43	(“illness state*” or “health state*”):ti,ab
#44	(hui or hui2 or hui3):ti,ab
#45	(multiattribute* or "multi attribute*"):ti,ab
#46	(utilit* next/3 (score? or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*)):ti,ab
#47	utilities:ti,ab
#48	("eq-5d*" or eq5d* or "eq-5*" or eq5* or euroqual* or "euro qual*" or "euroqual 5d*" or "euro qual 5d*" or "euro qol*" or euroqol* or "euro quol*" or euroquol* or "euro quol5d*" or euroquol5d* or "eur qol*" or eurqol* or "eur qol5d*" or eurqol5d* or eur?qul* or eur?qul5d* or "euro* quality of life" or "european qol"):ti,ab
#49	(euro* next/3 (“5 d*” or 5d* or "5 dimension*" or 5dimension* or "5 domain*" or 5domain*)):ti,ab
#50	(sf36 or "sf 36" or "sf thirty six" or "sf thirtysix"):ti,ab
#51	("time trade off?" or "time tradeoff?" or tto or timetradeoff?):ti,ab
#52	{or #39-#51}
#53	MeSH descriptor: [Quality of Life] this term only
#54	(("quality of life" or qol) next (score? or measure?)):ti,ab
#55	(health next/3 status):ti,ab
#56	(“quality of life” or qol):ti
#57	((“quality of life” or qol) next/3 (improv* or chang*)):ti,ab
#58	"health related quality of life":ti,ab
#59	#53 and {or #54-#58}
#60	MeSH descriptor: [Cost-Benefit Analysis] this term only
#61	(“cost effectiveness ratio*” and (perspective* or “life expectanc*”)):ti,ab
#62	("quality of life" or qol):ti,ab
#63	#60 and {or #61-#62}
#64	(qol or hrqol or "quality of life"):ti
#65	("quality of life" and ((qol or hrqol* or "quality of life") next/2 (increas* or decreas* or improv* or declin* or reduc* or high* or low* or effect or effects or worse or score? or change? or impact? or impacted or deteriorat*))):ab
#66	MeSH descriptor: [Models, Economic] explode all trees
#67	((capabilit* or wellbeing or "well being") next/3 (measur* or index* or instrument* or tool*)):ti,ab
#68	("subjective wellbeing" or "subjective well being"):ti,ab
#69	(ASCOT or "adult social care outcomes toolkit"):ti,ab
#70	(SCRQOL or "social care related quality of life"):ti,ab
#71	"capacity to benefit score":ti,ab
#72	(ICECAP* or "Icepop capability measure for adults" or "Icepop capability measure for older people" or "Icecap supportive care measure" or "Icecap close person measure"):ti,ab
#73	(ASCOF or "adult social care outcomes framework"):ti,ab
#74	("Warwick Edinburgh Mental Well being scale" or WEMBS or S-WEMWBS):ti,ab
#75	"ONS-4":ti,ab
#76	"GHQ-12":ti,ab
#77	("Personal Well Being Index*" or "PWI-A"):ti,ab
#78	(OPUS* or "older people's utility scale"):ti,ab
#79	{or #64-#78}
#80	#52 or #59 or #63 or #79
#81	#38 or #80
#82	#21 and #81 with Publication Year from 2010 to 2020, in Trials

EMCare 1995 to present.

#	Searches
1	social care/ or social welfare/ or social work/ or social work practice/ or social worker/ or case management/ or case manager/ or national health service/ or accountable care organization/ or mental health care personnel/
2	((social* or case* or outreach or personal or relief or support) adj3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi?ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*)).ti,ab.
3	(care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?).ti,ab.
4	(("approved mental health" adj (professional? or personnel or staff or team* or worker?)) or AMHP).ti,ab.
5	(social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?).ti,ab.
6	or/1-5
7	comorbidity/
8	((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special*) adj4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*)).ti,ab.
9	SHCN.ti,ab.
10	complex case?.ti,ab.
11	(dual diagnos?s or multi* diagnos?s).ti,ab.
12	(impact adj3 daily adj (life or lives or living or activit* or experienc*)).ti,ab.
13	or/7-12
14	exp social problem/
15	exp human activities/ or exp "lifestyle and related phenomena"/
16	14 and 15
17	unemployment/ or employment status/ or supported employment/ or sheltered workshop/ or vocational rehabilitation/ or absenteeism/ or job security/ or return to work/
18	((chang* or develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or target*) adj3 (employment or unemployment or unemploy*)).ti,ab.
19	(support* adj3 (employment? or work or vocational)).ti,ab.
20	(employment or unemploy* or underemploy* or under employ*).ti.
21	individual placement?.ti,ab.
22	((finding or gaining or obtaining or keeping or sustaining) adj3 (work or job or employment)).ti,ab.
23	(social firms or (sheltered adj (employment or work))).ti,ab.
24	(precar* adj1 (employment or work)).ti,ab.
25	(paid work or paid employment).ti,ab.
26	(voluntary work or volunteering or unpaid work).ti,ab.
27	(meaningful adj (activit* or employment or work)).ti,ab.
28	("return to work" or "back to work" or absenteeism).ti,ab.
29	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj (work* or disabilit*)).ti,ab.
30	((labo?r force or employment or unemployment) adj status).ti,ab.
31	or/17-30
32	family functioning/ or family conflict/
33	((family or families or intergenerat* or inter-generat*) adj (relation* or breakdown or conflict?)).ti,ab.
34	((sexual or intimate or partner?) adj (relation* or conflict?)).ti,ab.
35	((develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or promot* or target*) adj2 relationship?).ti,ab.
36	((carer? or partner or relationship?) adj support*).ti,ab.
37	or/32-36
38	housing/ or assisted living facility/ or community living/ or emergency shelter/ or homelessness/ or exp homeless person/ or deinstitutionalization/ or halfway house/
39	housing.ti.
40	((housing or accommodation or neighbo?rhood? or residence*) adj3 (chang* or address* or condition* or develop* or enhanc* or improv* or initiative? or instability or intervention? or mitigat* or program* or stability or target*)).ti,ab.
41	homeless*.ti,ab.
42	(permanent housing or social housing).ti,ab.
43	((assisted or autonomous or independent or secur* or sheltered or support* or sustain*) adj3 (housing or accommodat* or dwelling? or residen* or tenanc* or tenure?)).ti,ab.
44	((halfway or satellite) adj (accommodat* or dwelling? or home? or house?)).ti,ab.
45	(neighbo?rhood? adj (characteristic* or intervention* or program*)).ti,ab.
46	((environment* or housing or neighbo?rhood?) and infrastructure).ti,ab.
47	or/38-46
48	money/ or economic status/ or household economic status/ or social welfare/ or socioeconomics/ or household income/ or personal income/ or family income/ or financial management/ or "salary and fringe benefit"/ or pension/ or salary/ or poverty/ or exp lowest income group/
49	money.ti.

#	Searches
50	((access* or improv* or manag* or supplement*) adj2 (cash or money or financ* or income? or savings)).ti,ab.
51	((financial adj (autonomy or security or insecurity)) or loans or borrowing or budgeting or microcredit or microfinance or social fund*).ti,ab.
52	(extreme poverty or high poverty).ti,ab. or poverty.ti.
53	((address* or escap* or improv* or "out of" or support* or target*) adj2 (depriv* or poor or poverty)).ti,ab.
54	(((food or fuel) adj (insecurity or poverty)) or food bank?).ti,ab.
55	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj2 (debt? or poverty or ((economic or financial) adj hardship?))).ti,ab.
56	((basic or low or minimum) adj3 (wage? or income?)).ti,ab.
57	(family adj (income? or tax credit?)).ti,ab.
58	welfare benefit?.ti,ab.
59	or/48-58
60	offender/ or exp maladjustment/ or prisoner/
61	((crime? or criminal* or offend* or offence? or recidiv*) adj3 (initiative? or intervention? or program* or mitigat* or address* or diver* or prevent* rehabilitat*)).ti,ab.
62	((inmate? or prisoner? or convict? or felon?) adj3 (rehabilitat* or releas*)).ti,ab.
63	(community adj2 (reentry or re-entry)).ti,ab.
64	or/60-63
65	"social determinants of health"/ or social disability/ or loneliness/ or social isolation/ or social alienation/ or community involvement/ or *social support/ or *social network/ or *psychosocial environment/ or psychosocial rehabilitation/
66	(community involvement or community network* or loneliness or social* alienat* or social connect* or social inclusion or social* isolat* or social network* or social participation or social stigma*).ti,ab.
67	or/65-66
68	human rights/ or civil rights/ or human dignity/ or personal autonomy/ or social justice/
69	exp migrant/ or minority group/ or vulnerable population/
70	(((civil* or human or legal or social) adj rights) or (social justice or equal protection or social protection)).ti,ab.
71	((social or community or neighbo?rhood?) adj3 (equit* or inequit* or inequalit*)).ti,ab.
72	(digital adj (inclusion or exclusion or divide or equit* or inequit* or inequalit*)).ti,ab.
73	((disadvantaged or underserved or under served or vulnerab* or at risk or high risk) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
74	((minorit* or emigra* or immigra* or migra* or foreigner* or refugee* or transient*) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
75	or/68-74
76	crime victim/ or exp childhood trauma survivor/ or exp domestic violence/ or human trafficking/ or sex trafficking/ or exp drug dependence/ or injection drug user/
77	(crime victim? or revictimi* or ((victim* or crime?) and survivor*)).ti,ab.
78	((domestic or marital or partner? or spous* or surviv*) adj3 (abus* or rape? or sex* assault* or violence)).ti,ab.
79	coercive control.ti,ab.
80	((female? or women?) adj (refuge? or shelter?)).ti,ab.
81	(exploitation or safe guarding or safeguarding).ti,ab.
82	(((substance or drug or alcohol) adj (abuse or misuse?)) or "substance use" or "illegal drug use*" or addict* or alcoholi* or (problem* adj1 drinking)).tw.
83	or/76-82
84	or/16,31,37,47,59,64,67,75,83
85	exp disabled person/ or exp disability/ or exp sensory dysfunction/ or exp cognitive defect/ or exp mental capacity/ or exp mental disease/ or exp intellectual impairment/ or exp mental health care/ or exp brain disease/
86	(disable? or disabilit* or handicap* or retard* or disorder? or impair* or condition? or illness* or capacity or competen* or incompeten* or difficulty or difficulties or deficit? or dysfunct*).ti.
87	or/85-86
88	health service/ or exp community care/ or exp elderly care/ or exp mental health service/ or long term care/ or custodial care/ or social psychiatry/ or palliative therapy/ or occupational health service/ or exp rehabilitation/ or terminal care/
89	((communit* or elder* or mental* or long term or custod* or psychosocial* or palliative or terminal or reabl* or rehabilitat*) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
90	((allied health professional? or AHP? or clinical or clinician? or consultant? or family doctor? or general practi* or GP? or medical or medic? or nurse? or occupational therapist? or physician? or ((speech or language) adj2 therapist?) or SLT?) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
91	or/88-90
92	84 and (87 or 91)
93	6 and 13 and 92
94	health economics/
95	exp economic evaluation/
96	exp health care cost/
97	exp fee/
98	budget/
99	funding/
100	budget*.ti,ab.
101	cost*.ti.
102	(economic* or pharmaco?economic*).ti.

#	Searches
103	(price* or pricing*).ti,ab.
104	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
105	(financ* or fee or fees).ti,ab.
106	(value adj2 (money or monetary)).ti,ab.
107	or/94-106
108	Sickness Impact Profile/
109	quality adjusted life year/
110	"quality of life index"/
111	(quality adjusted or quality adjusted life year*).tw.
112	(qaly* or qal or qald* or qale* or qtime* or qwb* or daly).tw.
113	(illness state* or health state*).tw.
114	(hui or hui2 or hui3).tw.
115	(multiattibute* or multi attribute*).tw.
116	(utilit* adj3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*)).tw.
117	utilities.tw.
118	(eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol*or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol).tw.
119	(euro* adj3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5 domain* or 5domain*)).tw.
120	(sf36 or sf 36 or sf thirty six or sf thirtysix).tw.
121	(time trade off*1 or time tradeoff*1 or tto or timetradeoff*1).tw.
122	"quality of life"/ and ((quality of life or qol) adj (score*1 or measure*1)).tw.
123	"quality of life"/ and (health adj3 status).tw.
124	(quality of life or qol).tw. and cost benefit analysis/
125	((qol or hrqol or quality of life).tw. or "quality of life"/) and ((qol or hrqol* or quality of life) adj2 (increas* or decreas* or improv* or declin* or reduc* or high* or low* or effect or effects or worse or score or scores or change*1 or impact*1 or impacted or deteriorat*)).ab.
126	cost benefit analysis/ and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
127	"quality of life"/ and (quality of life or qol).ti.
128	"quality of life"/ and ((quality of life or qol) adj3 (improv* or chang*)).tw.
129	"quality of life"/ and health-related quality of life.tw.
130	economic model/
131	((capabilit* or wellbeing or well-being) adj4 (measur* or index* or instrument* or tool*)).tw.
132	(subjective wellbeing or subjective well-being).tw.
133	(ASCOT or "adult social care outcomes toolkit").tw.
134	(SCRQOL or "social care- related quality of life").tw.
135	"capacity to benefit score".tw.
136	(ICECAP* or "Icepop capability measure for adults" or "Icepop capability measure for older people" or "Icecap supportive care measure" or "Icecap close person measure").tw.
137	(ASCOF or "adult social care outcomes framework").tw.
138	(Warwick Edinburgh Mental Well-being scale or WEMBS or S-WEMWBS).tw.
139	ONS-4.tw.
140	GHQ-12.tw.
141	(Personal Well-Being Index* or PWI-A).tw.
142	(OPUS* or "older people's utility scale").tw.
143	or/108-142
144	107 or 143
145	((letter.pt. or letter/ or note.pt. or editorial.pt. or case report/ or case study/ or (letter or comment*).ti.) not (randomized controlled trial/ or random*.ti,ab.)) or ((animal/ not human/) or nonhuman/ or exp animal experiment/ or exp experimental animal/ or animal model/ or exp rodent/ or (rat or rats or mouse or mice).ti.)
146	limit 144 to (conference abstract or conference paper or conference review or conference proceeding)
147	144 not (145 or 146)
148	93 and 147
149	limit 148 to english language
150	limit 149 to yr="2010 -Current"

Applied Social Sciences Index & Abstracts (ASSIA) (1987 - current) [via Proquest]; International Bibliography of the Social Sciences (IBSS) (1951 - current); Sociological Abstracts (1952 - current) [via Proquest]; Social Services Abstracts [via Proquest].

Health Economics

Set	Searched for
S1	(AB,TI ('budget* or cost* or economic* or fee or fees or financ* or money or monetary or pharmacoeconomic* or price* or pricing) AND pd(20100101-20210608))
S2	AND (((AB,TI((social* OR case* OR communit* OR outreach OR personal OR relief OR support) NEAR/3 (advisor? OR agenc* OR assistant? OR care* OR department* OR deliver* OR institution* OR intervention? OR lead* OR

Set	Searched for
	manager? OR organi?ation* OR personnel OR planning OR practi* OR profession* OR program* OR provider? OR provision OR sector* OR service? OR setting? OR staff OR supervi* OR system* OR team* OR unit? OR work*)) OR (AB,TI (care coordinator? OR care co coordinator? OR case manager* OR caseworker* OR case worker* OR best interest? assessor?)) OR (AB,TI (social welfare OR social assistance OR local authorit* OR state support OR social prescribing welfare service? OR approved mental health profession* OR AMHP*))) AND la.exact("ENG") AND pd(20100101-20210608))
S3	AND ((AB,TI(complex* OR chang* OR chronic OR coexist* OR co exist* OR combin* OR concomitant OR comorbid* OR co morbid* OR cooccur* OR co occur* OR develop* OR high support OR life limiting OR long standing OR longstanding OR long term OR multi* OR ongoing OR on going OR persistent OR priorit* OR serious* OR severe OR several OR simultaneous OR special*) AND pd(20100101-20210608))
S4	AND (AB,TI(need? OR care OR circumstance* OR condition? OR existence? OR experience? OR initiative? OR intervention? OR issue* OR live? OR mitigat* OR patient? OR person? OR people OR problem* OR realit* OR situation? OR social factor* OR support OR target*) AND pd(20100101-20210608))))) AND la.exact("ENG")

Health Utility Values

Set	Searched for
S1	(AB,TI (eq 5d* OR eq5d* OR eq 5* OR eq5* OR euroqual* OR euro qual* OR euroqual 5d* OR euro qual 5d* OR euro qol* OR euroqol*OR euro quol* OR euroquol* OR euro quol5d* OR euroquol5d* OR eur qol* OR eurqol* OR eur qol5d* OR eurqol5d* OR eurqul* OR eurqul5d* OR euro* quality of life OR european qol OR sf36 OR sf 36 OR sf thirty six OR sf thirtysix OR time trade off* OR time tradeoff* OR tto OR timetradeoff* OR subjective wellbeing OR subjective well being OR ASCOT OR adult social care outcomes toolkit OR SCRQOL OR social care related quality of life OR capacity to benefit score OR ICECAP* OR Icepop capability measure for adults OR Icepop capability measure for older people OR Icecap supportive care measure OR Icecap close person measure OR ASCOF OR adult social care outcomes framework) AND pd(20100101-20210608))
S2	AND (((AB,TI((social* OR case* OR communit* OR outreach OR personal OR relief OR support) NEAR/3 (advisor? OR agenc* OR assistant? OR care* OR department* OR deliver* OR institution* OR intervention? OR lead* OR manager? OR organi?ation* OR personnel OR planning OR practi* OR profession* OR program* OR provider? OR provision OR sector* OR service? OR setting? OR staff OR supervi* OR system* OR team* OR unit? OR work*)) OR (AB,TI (care coordinator? OR care co coordinator? OR case manager* OR caseworker* OR case worker* OR best interest? assessor?)) OR (AB,TI (social welfare OR social assistance OR local authorit* OR state support OR social prescribing welfare service? OR approved mental health profession* OR AMHP*))) AND la.exact("ENG") AND pd(20100101-20210608))
S3	AND ((AB,TI(complex* OR chang* OR chronic OR coexist* OR co exist* OR combin* OR concomitant OR comorbid* OR co morbid* OR cooccur* OR co occur* OR develop* OR high support OR life limiting OR long standing OR longstanding OR long term OR multi* OR ongoing OR on going OR persistent OR priorit* OR serious* OR severe OR several OR simultaneous OR special*) AND pd(20100101-20210608))
S4	AND (AB,TI(need? OR care OR circumstance* OR condition? OR existence? OR experience? OR initiative? OR intervention? OR issue* OR live? OR mitigat* OR patient? OR person? OR people OR problem* OR realit* OR situation? OR social factor* OR support OR target*) AND pd(20100101-20210608))))) AND la.exact("ENG")

APA PsycInfo 1806 to March Week 5 2021

#	Searches
1	exp social workers/ or exp social services/ or exp social casework/ or case management/ or social security/ or "welfare services (government)"/ or community welfare services/ or government agencies/
2	((social* or case* or outreach or personal or relief or support) adj3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi?ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*)).ti,ab.
3	(care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?).ti,ab.
4	(("approved mental health" adj (professional? or personnel or staff or team* or worker?)) or AMHP).ti,ab.
5	(social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?).ti,ab.
6	or/1-5
7	comorbidity/
8	((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special*) adj4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*)).ti,ab.
9	SHCN.ti,ab.
10	complex case?.ti,ab.
11	(dual diagnos?s or multi* diagnos?s).ti,ab.
12	(impact adj3 daily adj (life or lives or living or activit* or experienc*)).ti,ab.
13	or/7-12
14	exp social issues/
15	"activities of daily living"/ or exp lifestyle/

#	Searches
16	14 and 15
17	employment status/ or employability/ or occupational tenure/ or occupational status/ or job security/ or job search/ or supported employment/ or vocational rehabilitation/ or vocational evaluation/ or work adjustment training/ or sheltered workshops/ or unemployment/ or personnel termination/ or employee layoffs/
18	((chang* or develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or target*) adj3 (employment or unemployment or unemploy*)).ti,ab.
19	(support* adj3 (employment? or work or vocational)).ti,ab.
20	(employment or unemploy* or underemploy* or under employ*).ti.
21	individual placement?.ti,ab.
22	((finding or gaining or obtaining or keeping or sustaining) adj3 (work or job or employment)).ti,ab.
23	(social firms or (sheltered adj (employment or work))).ti,ab.
24	(precar* adj1 (employment or work)).ti,ab.
25	(paid work or paid employment).ti,ab.
26	(voluntary work or volunteering or unpaid work).ti,ab.
27	(meaningful adj (activit* or employment or work)).ti,ab.
28	("return to work" or "back to work" or absenteeism).ti,ab.
29	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj (work* or disabilit*)).ti,ab.
30	((labo?r force or employment or unemployment) adj status).ti,ab.
31	or/17-30
32	family relations/ or intergenerational relations/ or exp marital relations/ or family conflict/ or marital conflict/ or home environment/ or living alone/ or family reunification/ or living arrangements/
33	((family or families or intergenerat* or inter-generat*) adj (relation* or breakdown or conflict?)).ti,ab.
34	((sexual or intimate or partner?) adj (relation* or conflict?)).ti,ab.
35	((develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or promot* or target*) adj2 relationship?).ti,ab.
36	((carer? or partner or relationship?) adj support*).ti,ab.
37	or/32-36
38	housing/ or assisted living/ or group homes/ or shelters/ or homeless/ or homeless mentally ill/ or deinstitutionalization/ or independent living programs/ or living arrangements/ or residential care institutions/ or halfway houses/ or independent living programs/ or living arrangements/ or residential care institutions/ or poverty areas/ or social environments/ or therapeutic social clubs/ or built environment/ or urban planning/
39	housing.ti.
40	((housing or accommodation or neighbo?rhood? or residence*) adj3 (chang* or address* or condition* or develop* or enhanc* or improv* or initiative? or instability or intervention? or mitigat* or program* or stability or target*)).ti,ab.
41	homeless*.ti,ab.
42	(permanent housing or social housing).ti,ab.
43	((assisted or autonomous or independent or secur* or sheltered or support* or sustain*) adj3 (housing or accommodat* or dwelling? or residen* or tenanc* or tenure?)).ti,ab.
44	((halfway or satellite) adj (accommodat* or dwelling? or home? or house?)).ti,ab.
45	(neighbo?rhood? adj (characteristic* or intervention* or program*)).ti,ab.
46	((environment* or housing or neighbo?rhood?) and infrastructure).ti,ab.
47	or/38-46
48	socioeconomic status/ or "income (economic)"/ or budgets/ or economic security/ or financial strain/ or exp employee benefits/ or *disadvantaged/ or *social deprivation/
49	money.ti.
50	((access* or improv* or manag* or supplement*) adj2 (cash or money or financ* or income? or savings)).ti,ab.
51	((financial adj (autonomy or security or insecurity)) or loans or borrowing or budgeting or microcredit or microfinance or social fund*).ti,ab.
52	(extreme poverty or high poverty).ti,ab. or poverty.ti.
53	((address* or escap* or improv* or "out of" or support* or target*) adj2 (depriv* or poor or poverty)).ti,ab.
54	(((food or fuel) adj (insecurity or poverty)) or food bank?).ti,ab.
55	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj2 (debt? or poverty or ((economic or financial) adj hardship?))).ti,ab.
56	((basic or low or minimum) adj3 (wage? or income?)).ti,ab.
57	(family adj (income? or tax credit?)).ti,ab.
58	welfare benefit?.ti,ab.
59	or/48-58
60	exp criminal offenders/ or criminal record/ or prisoners/ or criminal rehabilitation/ or reintegration/
61	((crime? or criminal* or offend* or offence? or recidiv*) adj3 (initiative? or intervention? or program* or mitigat* or address* or diver* or prevent* rehabilitat*)).ti,ab.
62	((inmate? or prisoner? or convict? or felon?) adj3 (rehabilitat* or releas*)).ti,ab.
63	(community adj2 (reentry or re-entry)).ti,ab.
64	or/60-63
65	social isolation/ or loneliness/ or abandonment/ or alienation/ or exp social discrimination/ or stigma/ or health disparities/
66	(community involvement or community network* or loneliness or social* alienat* or social connect* or social inclusion or social* isolat* or social network* or social participation or social stigma*).ti,ab.
67	or/65-66
68	human rights/ or exp civil rights/ or exp freedom/ or government policy making/ or digital divide/ or information literacy/
69	exp minority groups/ or exp "racial and ethnic groups"/ or asylum seeking/ or immigration/ or refugees/ or at risk populations/ or disadvantaged/
70	(((civil* or human or legal or social) adj rights) or (social justice or equal protection or social protection)).ti,ab.

#	Searches
71	((social or community or neighbo?rhood?) adj3 (equit* or inequit* or inequalit*)).ti,ab.
72	(digital adj (inclusion or exclusion or divide or equit* or inequit* or inequalit*)).ti,ab.
73	((disadvantaged or underserved or under served or vulnerab* or at risk or high risk) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
74	((minorit* or emigra* or immigra* or migra* or foreigner* or refugee* or transient*) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
75	or/68-74
76	crime victims/ or elder abuse/ or domestic violence/ or battered females/ or exposure to violence/ or intimate partner violence/ or physical abuse/ or exp sexual abuse/ or shelters/ or interpersonal control/ or coercion/ or slavery/ or human trafficking/ or *freedom/ or exp alcohol abuse/ or exp drug abuse/
77	(crime victim? or revictimi* or ((victim* or crime?) and survivor*)).ti,ab.
78	((domestic or marital or partner? or spous* or surviv*) adj3 (abus* or rape? or sex* assault* or violence)).ti,ab.
79	coercive control.ti,ab.
80	((female? or women?) adj (refuge? or shelter?)).ti,ab.
81	(exploitation or safe guarding or safeguarding).ti,ab.
82	(((substance or drug or alcohol) adj (abuse or misuse?)) or "substance use" or "illegal drug use*" or addict* or alcoholi* or (problem* adj1 drinking)).tw.
83	or/76-82
84	or/16,31,37,47,59,64,67,75,83
85	exp disabilities/ or exp chronic illness/ or cognitive impairment/ or diminished capacity/ or exp health impairments/ or exp mental disorders/ or exp sensory system disorders/ or special needs/ or exp central nervous system disorders/ or exp sense organ disorders/ or terminally ill patients/
86	(disable? or disabilit* or handicap* or retard* or disorder? or impair* or condition? or illness* or capacity or competen* or incompeten* or difficulty or difficulties or deficit? or dysfunct*).ti.
87	or/85-86
88	exp health care services/ or exp community facilities/ or exp elderly care/ or exp mental health programs/ or social psychiatry/ or exp occupational health/ or exp rehabilitation/
89	((communit* or elder* or mental* or long term or custod* or psychosocial* or palliative or terminal or reabl* or rehabilitat*) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
90	((allied health professional? or AHP? or clinical or clinician? or consultant? or family doctor? or general practi* or GP? or medical or medic? or nurse? or occupational therapist? or physician? or ((speech or language) adj2 therapist?) or SLT?) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
91	or/88-90
92	84 and (87 or 91)
93	6 and 13 and 92
94	exp economics/
95	exp "costs and cost analysis"/
96	cost containment/
97	money/
98	resource allocation/
99	or/94-98
100	budget*.ti,ab.
101	cost*.ti.
102	(economic* or pharmaco?economic*).ti.
103	(price* or pricing*).ti,ab.
104	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
105	(financ* or fee or fees).ti,ab.
106	(value adj2 (money or monetary)).ti,ab.
107	or/99-105
108	"quality of life measures"/
109	(quality adjusted or quality adjusted life year*).tw.
110	(qaly* or qal or qald* or qale* or qtime* or qwb* or daly).tw.
111	(illness state* or health state*).tw.
112	(hui or hui2 or hui3).tw.
113	(multiattibute* or multi attribute*).tw.
114	(utilit* adj3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*)).tw.
115	utilities.tw.
116	(eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol*or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol).tw.
117	(euro* adj3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5 domain* or 5domain*)).tw.
118	(sf36 or sf 36 or sf thirty six or sf thirtysix).tw.
119	(time trade off*1 or time tradeoff*1 or tto or timetradeoff*1).tw.
120	exp "quality of life"/ and ((quality of life or qol) adj (score*1 or measure*1)).tw.
121	exp "quality of life"/ and (health adj3 status).tw.
122	(quality of life or qol).tw. and "costs and cost analysis"/ use psyh
123	((qol or hrqol or quality of life).tw. or *quality of life/) and ((qol or hrqol* or quality of life) adj2 (increas* or decreas* or improv* or declin* or reduc* or high* or low* or effect or effects or worse or score or scores or change*1 or impact*1 or impacted or deteriorat*)).ab.

#	Searches
124	"costs and cost analysis"/ use psyh and cost-effectiveness ratio*.tw. and (cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
125	exp "quality of life"/ and (quality of life or qol).ti.
126	exp "quality of life"/ and ((quality of life or qol) adj3 (improv* or chang*)).tw.
127	exp "quality of life"/ and health-related quality of life.tw.
128	((capabilit* or wellbeing or well-being) adj4 (measur* or index* or instrument* or tool*)).tw.
129	(subjective wellbeing or subjective well-being).tw.
130	(ASCOT or "adult social care outcomes toolkit").tw.
131	(SCRQOL or "social care- related quality of life").tw.
132	capacity to benefit score.tw.
133	(ICECAP* or "Icepop capability measure for adults" or "Icepop capability measure for older people" or "Icecap supportive care measure" or "Icecap close person measure").tw.
134	(ASCOF or "adult social care outcomes framework").tw.
135	(Warwick Edinburgh Mental Well-being scale or WEMBS or S-WEMWBS).tw.
136	ONS-4.tw.
137	GHQ-12.tw.
138	(Personal Well-Being Index* or PWI-A).tw.
139	(OPUS* or "older people's utility scale").tw.
140	or/108-139
141	107 or 140
142	93 and 141
143	limit 142 to english language
144	limit 143 to yr="2010 -Current"

Social Care Online: https://www.scie-socialcareonline.org.uk/

Search
AllFields:'social work* or social care* or care coordinator* or care co-ordinator*'
- OR AllFields:'case manager* or caseworker* or case-worker* or case worker* or best interest* assessor*'
- OR AllFields:'approved mental health professional* or AMHP'
- OR AllFields:'social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service*'
AND
HE search:
AND AllFields:'budget* or cost* or economic* or fee or fees or financ* or money or monetary or pharmacoeconomic* or price* or pricing'
OR
HUV search:
eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol*or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eurqul* or eurqul5d* or euro* quality of life or european qol
OR
sf36 or sf 36 or sf thirty six or sf thirtysix
OR
time trade off* or time tradeoff* or tto or timetradeoff*
OR
subjective wellbeing or subjective well-being
OR
ASCOT or adult social care outcomes toolkit
OR
SCRQOL or social care- related quality of life
capacity to benefit score
OR
ICECAP* or Icepop capability measure for adults or Icepop capability measure for older people or Icecap supportive care measure or Icecap close person measure
ASCOF or adult social care outcomes framework
OR
Warwick Edinburgh Mental Well-being scale or WEMBS or S-WEMWBS
OR
ONS-4 or GHQ-12 or Personal Well-Being Index* or PWI-A or OPUS* or older people's utility scale

Social Policy and Practice 202104 [OVID]

#	Searches
1	((social* or case* or outreach or personal or relief or support) adj3 (advisor? or agenc* or assistant? or care* or department* or deliver* or institution* or intervention? or lead* or manager? or organi?ation* or personnel or planning or practi* or profession* or program* or provider? or provision or sector* or service? or setting? or staff or supervi* or system* or team* or unit? or work*)).ti,ab.

#	Searches
2	(care coordinator? or care co-ordinator? or case manager* or caseworker* or case-worker* or case worker* or best interest? assessor?).ti,ab.
3	(("approved mental health" adj (professional? or personnel or staff or team* or worker?)) or AMHP).ti,ab.
4	(social welfare or social assistance or local authorit* or local council* or state support or social prescribing or welfare service?).ti,ab.
5	or/1-4
6	((complex* or chang* or chronic or coexist* or co exist* or combin* or concomitant or comorbid* or co-morbid* or cooccur* or co occur* or develop* or high support or (intellectual* and physical*) or life limiting or long standing or longstanding or long term or (mental* and physical*) or multi* or ongoing or on-going or persistent or priorit* or serious* or severe or several or simultaneous or special*) adj4 (need? or care or circumstance* or condition? or existence? or experience? or initiative? or intervention? or issue* or live? or mitigat* or patient? or person? or people or problem* or realit* or situation? or social factor* or support or target*)).ti,ab.
7	SHCN.ti,ab.
8	complex case?.ti,ab.
9	(dual diagnos?s or multi* diagnos?s).ti,ab.
10	(impact adj3 daily adj (life or lives or living or activit* or experienc*)).ti,ab.
11	or/6-10
12	((chang* or develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or target*) adj3 (employment or unemployment or unemploy*)).ti,ab.
13	(support* adj3 (employment? or work or vocational)).ti,ab.
14	(employment or unemploy* or underemploy* or under employ*).ti.
15	individual placement?.ti,ab.
16	((finding or gaining or obtaining or keeping or sustaining) adj3 (work or job or employment)).ti,ab.
17	(social firms or (sheltered adj (employment or work))).ti,ab.
18	(precar* adj1 (employment or work)).ti,ab.
19	(paid work or paid employment).ti,ab.
20	(voluntary work or volunteering).ti,ab.
21	(meaningful adj (activit* or employment or work)).ti,ab.
22	("return to work" or "back to work" or absenteeism).ti,ab.
23	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj (work* or disabilit*)).ti,ab.
24	((labo?r force or employment or unemployment) adj status).ti,ab.
25	or/12-24
26	((family or families or intergenerat* or inter-generat*) adj (relation* or breakdown or conflict?)).ti,ab.
27	((sexual or intimate or partner?) adj (relation* or conflict?)).ti,ab.
28	((develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or promot* or target*) adj2 relationship?).ti,ab.
29	((carer? or partner or relationship?) adj support*).ti,ab.
30	or/26-29
31	housing.ti.
32	((housing or accommodation or neighb?rhood? or residence*) adj3 (chang* or address* or condition* or develop* or enhanc* or improv* or initiative? or instability or intervention? or mitigat* or program* or stability or target*)).ti,ab.
33	homeless*.ti,ab.
34	(permanent housing or social housing).ti,ab.
35	((assisted or autonomous or independent or secur* or sheltered or support* or sustain*) adj3 (housing or accommodat* or dwelling? or residen* or tenanc* or tenure?)).ti,ab.
36	((halfway or satellite) adj (accommodat* or dwelling? or home? or house?)).ti,ab.
37	(neighbo?rhood? adj (characteristic* or intervention* or program*)).ti,ab.
38	((environment* or housing or neighbo?rhood?) and infrastructure).ti,ab.
39	or/31-38
40	money.ti.
41	((access* or improv* or manag* or supplement*) adj2 (cash or money or financ* or income? or savings)).ti,ab.
42	((financial adj (autonomy or security or insecurity)) or loans or borrowing or budgeting or microcredit or microfinance or social fund*).ti,ab.
43	(extreme poverty or high poverty).ti,ab. or poverty.ti.
44	((address* or escap* or improv* or "out of" or support* or target*) adj2 (depriv* or poor or poverty)).ti,ab.
45	(((food or fuel) adj (insecurity or poverty)) or food bank?).ti,ab.
46	((alleviat* or ease or manag* or prevent* or reduc* or stop*) adj2 (debt? or poverty or ((economic or financial) adj hardship?))).ti,ab.
47	((basic or low or minimum) adj3 (wage? or income?)).ti,ab.
48	(family adj (income? or tax credit?)).ti,ab.
49	welfare benefit?.ti,ab.
50	or/40-49
51	((crime? or criminal* or offend* or offence? or recidiv*) adj3 (initiative? or intervention? or program* or mitigat* or address* or diver* or prevent* rehabilitat*)).ti,ab.
52	((inmate? or prisoner? or convict? or felon?) adj3 (rehabilitat* or releas*)).ti,ab.
53	(community adj2 (reentry or re-entry)).ti,ab.
54	or/51-53
55	(community involvement or community network* or loneliness or social* alienat* or social connect* or social inclusion or social* isolat* or social network* or social participation or social stigma*).ti,ab.
56	(((civil* or human or legal or social) adj rights) or (social justice or equal protection or social protection)).ti,ab.
57	((social or community or neighbo?rhood?) adj3 (equit* or inequit* or inequalit*)).ti,ab.

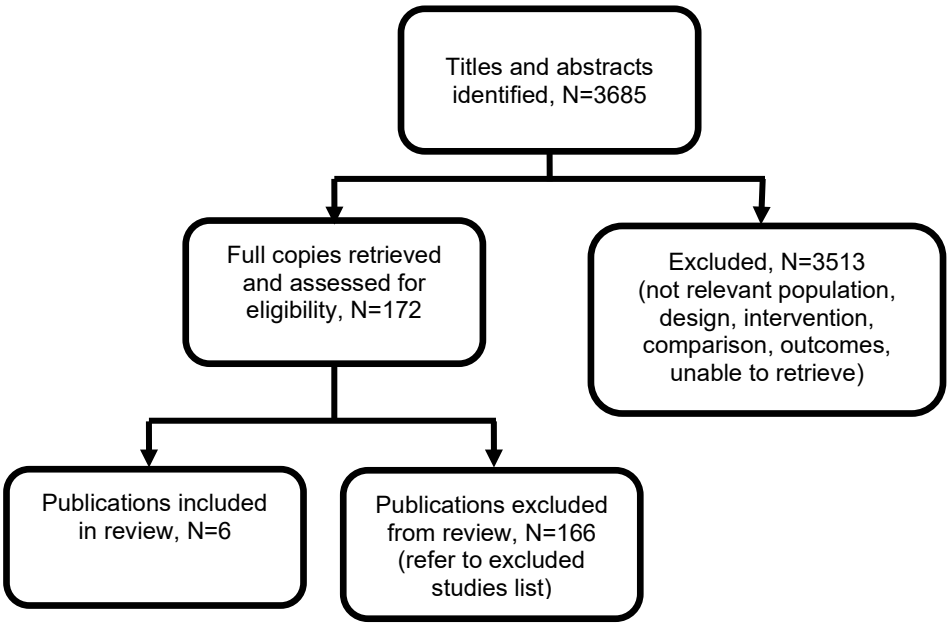
#	Searches
58	(digital adj (inclusion or exclusion or divide or equit* or inequit* or inequalit*)).ti,ab.
59	((disadvantaged or underserved or under served or vulnerab* or at risk or high risk) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
60	((minorit* or emigra* or immigra* or migra* or foreigner* or refugee* or transient*) adj3 (adult? or famil* or person? or people? or population?)).ti,ab.
61	or/56-60
62	(crime victim? or revictimi* or ((victim* or crime?) and survivor*)).ti,ab.
63	((domestic or marital or partner? or spous* or surviv*) adj3 (abus* or rape? or sex* assault* or violence)).ti,ab.
64	coercive control.ti,ab.
65	((female? or women?) adj (refuge? or shelter?)).ti,ab.
66	(exploitation or safe guarding or safeguarding).ti,ab.
67	(((substance or drug or alcohol) adj (abuse or misuse?)) or "substance use" or "illegal drug use*" or addict* or alcoholi* or (problem* adj1 drinking)).ti,ab.
68	or/62-67
69	or/25,30,39,50,54-55,61,68
70	(disable? or disabilit* or handicap* or retard* or disorder? or impair* or condition? or illness* or capacity or competen* or difficulty or difficulties or deficit? or dysfunct*).ti.
71	((communit* or elder* or mental* or long term or custod* or psychosocial* or palliative or terminal or reable* or rehabilitat*) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
72	((allied health professional? or AHP? or clinical or clinician? or consultant? or family doctor? or general practi* or GP? or medical or medic? or nurse? or occupational therapist? or physician? or ((speech or language) adj2 therapist?) or SLT?) adj3 (care or agenc* or deliver* or department? or facilit* or institution* or network* or organi?ation* or provider? or provision? or partner* or sector* or service* or setting*)).ti,ab.
73	71 or 72
74	5 and 11 and 69 and (70 or 73)
75	budget*.ti,ab.
76	cost*.ti.
77	(economic* or pharmaco?economic*).ti.
78	(price* or pricing*).ti,ab.
79	(cost* adj2 (effective* or utilit* or benefit* or minimi* or unit* or estimat* or variable*)).ab.
80	(financ* or fee or fees).ti,ab.
81	(value adj2 (money or monetary)).ti,ab.
82	or/75-81
83	(quality adjusted or quality adjusted life year*).tw.
84	(qaly* or qal or qald* or qale* or qtime* or qwb* or daly).tw.
85	(illness state* or health state*).tw.
86	(hui or hui2 or hui3).tw.
87	(multiattribute* or multi attribute*).tw.
88	(utilit* adj3 (score*1 or valu* or health* or cost* or measur* or disease* or mean or gain or gains or index*)).tw.
89	utilities.tw.
90	(eq-5d* or eq5d* or eq-5* or eq5* or euroqual* or euro qual* or euroqual 5d* or euro qual 5d* or euro qol* or euroqol*or euro quol* or euroquol* or euro quol5d* or euroquol5d* or eur qol* or eurqol* or eur qol5d* or eurqol5d* or eur?qul* or eur?qul5d* or euro* quality of life or european qol).tw.
91	(euro* adj3 (5 d* or 5d* or 5 dimension* or 5dimension* or 5 domain* or 5domain*)).tw.
92	(sf36 or sf 36 or sf thirty six or sf thirtysix).tw.
93	(time trade off*1 or time tradeoff*1 or tto or timetradeoff*1).tw.
94	((quality of life or qol) adj (score*1 or measure*1)).tw.
95	((quality of life or qol) and (health adj3 status)).tw.
96	((qol or hrqol or quality of life) and (qol or hrqol* or quality of life)).tw. adj2 (increas* or decreas* or improv* or declin* or reduc* or high* or low* or effect or effects or worse or score or scores or change*1 or impact*1 or impacted or deteriorat*).ab.
97	(cost-effectiveness ratio* and (perspective* or life expectanc*)).tw.
98	((quality of life or qol) adj3 (improv* or chang*)).tw.
99	health-related quality of life.tw.
100	((capabilit* or wellbeing or well-being) adj4 (measur* or index* or instrument* or tool*)).tw.
101	(subjective wellbeing or subjective well-being).tw.
102	(ASCOT or "adult social care outcomes toolkit").tw.
103	(SCRQOL or "social care- related quality of life").tw.
104	"capacity to benefit score".tw.
105	(ICECAP* or "Icepop capability measure for adults" or "Icepop capability measure for older people" or "Icecap supportive care measure" or "Icecap close person measure").tw.
106	(ASCOF or "adult social care outcomes framework").tw.
107	(Warwick Edinburgh Mental Well-being scale or WEMBS or S-WEMWBS).tw.
108	ONS-4.tw.
109	GHQ-12.tw.
110	(Personal Well-Being Index* or PWI-A).tw.
111	(OPUS* or "older people's utility scale").tw.
112	or/83-111
113	82 or 112
114	74 and 113

#	Searches
115	limit 114 to yr="2010 -Current"

Appendix C Effectiveness and Qualitative evidence study selection

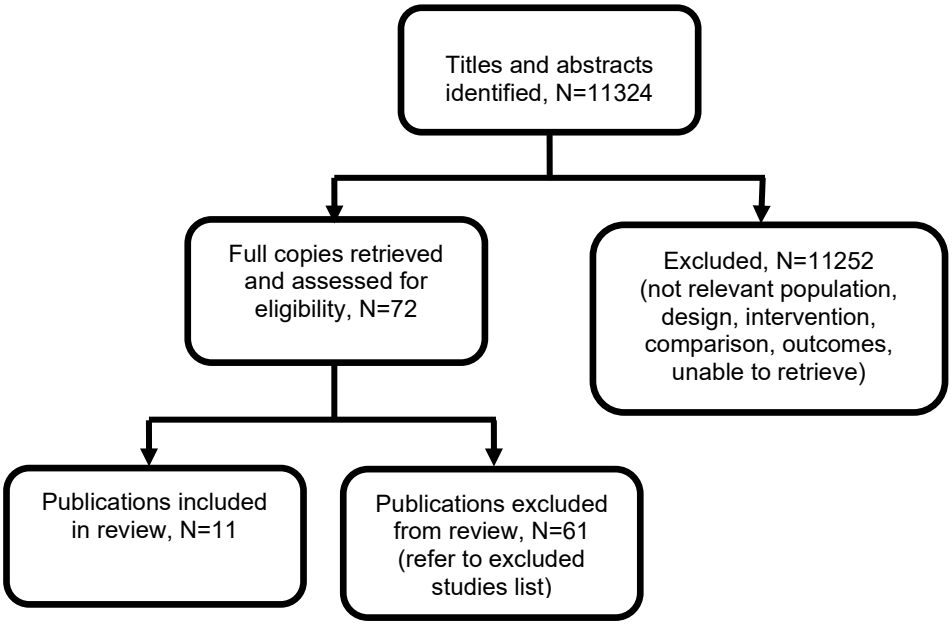
Study selection for review question C: What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Figure 3: Study selection flow chart for effectiveness review question



Study selection for review question C: Based on the views and experiences of everyone involved, what works well and what can be improved about case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Figure 4: Study selection flow chart for qualitative review question



Appendix D Evidence tables

Evidence tables for review question C: What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Table 8: Evidence tables – effectiveness evidence

Study details	Results and risk of bias assessment
Full citation Bonsack, C., Golay, P., Gibellini Manetti, S., Gebel, S., Ferrari, P., Besse, C., Favrod, J., Morandi, S., Linking Primary and Secondary Care after Psychiatric Hospitalization: Comparison between Transitional Case Management Setting and Routine Care for Common Mental Disorders, Frontiers in Psychiatry, 7, 2016 **Ref Id** 1280274 **Country/ies where the study was carried out** Switzerland **Study type** Randomised controlled trial. **Study dates** Not reported. **Inclusion criteria** • Participants hospitalised in the admission ward of the participating psychiatric hospital, returning home after discharge and followed up by a GP or private psychiatrist (primary or secondary outpatient care). • Aged between 18 and 65 years. **Exclusion criteria**	**Results** <u>Ambulatory care contact - mean (±SD)</u>[1] At 3 months following discharge: TCM (n=51): 2.79 (1.42); TAU (n=51): 1.93 (1.29); Cohen's *d*=0.64 (medium effect) Difference between groups at 1 month after discharge: ß=0.098; p=0.372 Difference between groups 1 and 3 months after discharge: ß=0.371; p=0.004 Difference between groups 3 to 6 months after discharge: ß=0.076; p=0603 Difference between groups 6 to 12 months after discharge: ß=0.108; p=0.406 <u>Rate of hospital readmission 12 months following discharge*</u> TCM: n=14 (calculated) (27.5%); TAU: n=22 (calculated) (43.1%); Adjusted hazard ratio: 0.583 (95% CI 0.300 to 1.132); p=0.111 **<u>Risk of bias assessment using Cochrane RoB tool v2.0</u>** **1. Bias arising from the randomisation process (Low/High/Some concerns)** Low risk of bias. **2. Bias arising due to deviations from intended interventions (Low/High/Some concerns)** Some concerns, no information provided on whether participants and carers or people delivering the interventions were aware of intervention allocation; it appears from the participant flow chart that ITT analyses were conducted. **3. Bias due to missing outcome data (Low/High/Some concerns)** Some concerns, (15.7% (TCM) and 19.6% (TAU) lost to follow-up at 12 months. **4. Bias in measurement of the outcome (Low/High/Some concerns)** Some concerns, same measurement methods and thresholds used at comparable timepoints. **5. Bias in selection of the reported result (Low/High/Some concerns)**

Study details	Results and risk of bias assessment
• Participants with organic disorders. • Non-French speaking. • Participants followed up within the university psychiatric services (tertiary outpatient care). **Participant characteristics** Age (years) - mean (±SD) Transitional case management (TCM) (n=51): 40.0 (11.9) Treatment as usual (TAU) (n=51): 41.3 (10.6) Sex (female) - n (%) TCM: 34 (66.7); TAU: 27 (52.9) Ethnicity (Caucasian) - n (%) TCM: 43 (84.3); TAU: 47 (92.2) Clinical status - mean (±SD) Global assessment of functioning: TCM: 45.5 (5.9); TAU: 46.0 (7.0) Symptom checklist global score (SCL-90R): TCM: 1.1 (0.5); TAU: 1.2 (0.7) Duration of illness - n (%) <1 year: TCM: 18 (35.3); TAU: 17 (33.3 Between 1 and 5 years: TCM: 17 (33.3); TAU: 14 (27.5) >5 years: TCM: 16 (31.4); TAU: 20 (39.2) Clinical history - n (%) First psychiatric admission: TCM: 43 (84.3); TAU: 39 (76.5) Main disorder - n (%) Affective disorder: TCM: 27 (52.9); TAU: 36 (70.6) Neurotic, stress-related or somatoform disorder: TCM: 10 (19.6); TAU: 4 (7.8) Personality disorder: TCM: 6 (11.8); TAU: 3 (5.9) Psychotic disorder: TCM: 4 (7.8); TAU: 4 (7.8) Substance use: TCM: 4 (7.8); TAU: 4 (7.8) **Intervention** TCM: treatment as usual plus input from a case manager, nurse, or a social worker to co-ordinate care provision and represent the person's viewpoint. Includes: system co-ordination, engagement in psychiatric	Some concerns, different outcomes mentioned in the statistical analysis section have data reported; reported results for the outcome measurements appear to correspond to all intended analyses. **Overall risk of bias (Low/High/Some concerns)** Some concerns. **Source of funding** Swiss National Science Foundation and ARCOS (Association Réseau de la Communauté Sanitaire de la Région Lausannoise). **Other information** [1]The potential influence of age, sex, level of education, initial level of social functioning, and familial situation was controlled for in an adjusted model. Only significant covariates were included in an additional model.

Study details	Results and risk of bias assessment
care, continuation of substance abuse treatment, medication adherence, family involvement and social support network, life skills training and support, integration of medical care, establishment of community linkage, and practical needs assistance. Includes constructing a joint crisis plan with the case manager. **Comparator** TAU: referral to a GP or private psychiatrist after discharge. **Follow-up** 1, 3, 6 and 12 months.	
Full citation Chung, T. E., Gozdzik, A., Palma Lazgare, L. I., To, M. J., Aubry, T., Frankish, J., Hwang, S. W., Stergiopoulos, V., Housing First for older homeless adults with mental illness: a subgroup analysis of the At Home/Chez Soi randomized controlled trial, International Journal of Geriatric Psychiatry, 33, 85-95, 2018 **Ref Id** 939915 **Country/ies where the study was carried out** Canada (Moncton, Montreal, Toronto, Vancouver, and Winnipeg). **Study type** Randomised controlled trial. **Study dates** October 2009 to July 2011. **Inclusion criteria** • Aged at least 18 years old (19 years in Vancouver); • Absolutely homeless (defined as having no fixed place to stay for more than 7 nights and little likelihood of obtaining housing in the upcoming month) or precariously housed (defined as single room occupancy, rooming house, or hotel/motel with a recent history of	**Results** <u>Generic QoL (EQ-5D) - difference in mean changes between HF and TAU from baseline (95% CI)</u> **12 months** ≥50 years old (n=470): 4.36 (-0.62 to 9.34) 18 to 49 years old (n=1,678): -1.44 (-4.10 to 1.22) Difference in difference of mean changes from baseline between age groups (95% CI)[5]: +5.80 (0.15 to 11.45); p=0.044 **24 months** ≥50 years old (n=470): 0.37 (-4.62 to 5.35) 18 to 49 years old (n=1,678): -1.13 (-3.75 to 1.48) Difference in difference of mean changes from baseline between age groups (95% CI)[5]: +1.50 (-4.13 to 7.13); p=0.602 <u>Condition-specific QoL (QoLI-20 total score) - difference in mean changes between HF and TAU from baseline (95% CI)</u> **12 months** ≥50 years old (n=470): 9.75 (4.98 to 14.52) 18 to 49 years old (n=1,678): 3.39 (0.90 to 5.88) Difference in difference of mean changes from baseline between age groups (95% CI)[5]: +6.36 (0.97 to 11.74); p=0.021 **24 months** ≥50 years old (n=470): 8.35 (3.37 to 13.33) 18 to 49 years old (n=1,678): 1.36 (-1.21 to 3.92) Difference in difference of mean changes from baseline between age groups (95% CI)[5]: +6.99 (1.39 to 12.59); p=0.014

Study details	Results and risk of bias assessment
absolute homelessness); • Had a mental illness with or without a concurrent substance use disorder (as determined by the Mini International Neuropsychiatric Interview 6.0 based on DSM-IV criteria). **Exclusion criteria** • No legal status in Canada; • Already receiving an assertive community treatment (ACT) or intensive case management (ICM). **Participant characteristics** Age (years) - mean (±SD) **≥50 years old** Housing First (HF): 55.4 (4.6); Treatment as usual (TAU): 56.22 (5.1) **18 to 49 years old** HF: 36.8 (8.7); TAU: 36.8 (8.6) Gender - n (%) **≥50 years old** HF: Male: 176 (69.6); Female or other[1]: 77 (30.4) TAU: Male: 156 (71.9); Female or other[1]: 61 (28.1) **18 to 49 years old** HF: Male: 593 (65.5); Female or other[1]: 312 (34.5) TAU: Male: 519 (67.1); Female or other[1]: 254 (32.9) Need level[2] - n (%) **Moderate needs** **≥50 years old** HF: 190 (75.1); TAU: 133 (61.3) **18 to 49 years old** HF: 565 (62.4); TAU: 438 (56.7) **High needs** **≥50 years old** HF: 63 (24.9); TAU: 84 (38.7) **18 to 49 years old** HF: 340 (37.6); TAU: 335 (43.3) Racial, ethnic or cultural identify - n (%) **Aboriginal** **≥50 years old** HF: 34 (13.4); TAU: 22 (10.1) **18 to 49 years old** HF: 229 (25.3); TAU: 180 (23.3)	**Risk of bias assessment using Cochrane RoB tool v2.0** **1. Bias arising from the randomisation process (Low/High/Some concerns)** Some concerns, participants randomised using a computer-based adaptive randomisation procedure; randomisation algorithm performed by a central data collection system and concealed from researchers and participants; demographic and clinical details differed between younger and older homeless adults receiving HF or TAU. **2. Bias arising due to deviations from intended interventions (Low/High/Some concerns)** Some concerns, no information relating to whether participants and personnel blinded; participants with missing outcome data, and the reasons for this, were reported. **3. Bias due to missing outcome data (Low/High/Some concerns)** Low risk of bias, the authors state that the study had some missing data, but numbers were quite low and unlikely to bias the findings. **4. Bias in measurement of the outcome (Low/High/Some concerns)** Some concerns, outcome assessors were aware of the intervention received. **5. Bias in selection of the reported result (Low/High/Some concerns)** Low risk of bias. **Overall risk of bias (Low/High/Some concerns)** Some concerns. **Source of funding** Financial contribution from Health Canada provided to the Mental Health Commission of Canada (MHCC). **Other information** [1]Other includes transsexual, transgendered, and other self-reported terms. [2]As only ACT services were available at Moncton, all participants with moderate needs at Moncton (n=128) were only randomised to receive ACT or TAU. In total, 30 moderate needs participants aged ≥50 years old (HF n=17; TAU n=13) and 98 participants with moderate needs aged 18 to 49 years old (HF n=49; TAU n=49) were randomised to receive ACT or TAU. [3]Ethno-racial includes black, East Asian, Indian Caribbean, Latin American, Middle Eastern, South Asian, Southeast Asian, and mixed ethnicity. [4]With the exception of Moncton, where only ACT was available.

Study details	Results and risk of bias assessment
Ethno-racial[3] **≥50 years old** HF: 45 (17.8); TAU: 48 (22.1) **18 to 49 years old** HF: 238 (26.3); TAU: 201 (26.0) **White** **≥50 years old** HF: 174 (68.8); TAU: 147 (67.7) **18 to 49 years old** HF: 438 (48.4); TAU: 392 (50.7) Housing status - n (%) **Absolutely homeless** **≥50 years old** HF: 205 (81.0); TAU: 181 (83.4) **18 to 49 years old** HF: 738 (81.6); TAU: 627 (81.1) **Precariously housed** **≥50 years old** HF: 48 (19.0); TAU: 36 (16.6) **18 to 49 years old** HF: 166 (18.4); TAU: 146 (18.9) Multnomah Community Ability Scale (MCAS) - mean (±SD) **≥50 years old** HF: 61.4 (8.9); TAU: 59.9 (8.4) **18 to 49 years old** HF: 60.5 (8.0); TAU: 59.8 (8.3) Mini International Neuropsychiatric Interview (MINI) diagnostic categories - n (%) **Major depressive episode** **≥50 years old** HF: 131 (51.8); TAU: 108 (49.8) **18 to 49 years old** HF: 481 (53.2); TAU: 399 (51.6) **Manic or hypomanic episode** **≥50 years old** HF: 22 (8.7); TAU: 17 (7.8) **18 to 49 years old** HF: 116 (12.8); TAU: 117 (15.1) **Post-traumatic stress disorder** **≥50 years old**	[5]The differences in treatment effectiveness between the age groups were assessed using 3-way interaction models (treatment * time * age). All outcome models were adjusted for study site and need level to consider group differences. EQ-5D (range 0 to 100, higher values representing better quality of life). Lehman QoL Interview 20 index produces a total score ranging from 20 to 140, with larger values corresponding to greater quality of life. **NB:** participants received financial compensation after each interview.

Study details	Results and risk of bias assessment
HF: 54 (21.3); TAU: 36 (16.6) **18 to 49 years old** HF: 286 (31.6); TAU: 253 (32.8) **Panic disorder** **≥50 years old** HF: 56 (22.1); TAU: 39 (18.0) **18 to 49 years old** HF: 202 (22.3); TAU: 207 (26.8) **Mood disorders with psychotic features** **≥50 years old** HF: 28 (11.1); TAU: 31 (14.3) **18 to 49 years old** HF: 149 (16.5); TAU: 144 (18.6) **Psychotic disorder** **≥50 years old** HF: 75 (29.6); TAU: 76 (35.0) **18 to 49 years old** HF: 309 (34.1); TAU: 291 (37.6) **Drug use disorder (abuse or dependence)** **≥50 years old** HF: 79 (31.2); TAU: 71 (32.7) **18 to 49 years old** HF: 528 (58.3); TAU: 451 (58.3) **Alcohol use disorder (abuse or dependence)** **≥50 years old** HF: 87 (34.4); TAU: 80 (36.9) **18 to 49 years old** HF: 422 (46.6); TAU: 367 (47.5) Suicidality - n (%) **No/Low** **≥50 years old** HF: 168 (66.4); TAU: 153 (70.5) **18 to 49 years old** HF: 578 (63.9); TAU: 469 (60.7) **Moderate/High** **≥50 years old** HF: 85 (33.6); TAU: 64 (29.5) **18 to 49 years old** HF: 327 (36.1); TAU: 304 (39.3) **Intervention**	

Study details	Results and risk of bias assessment
HF: immediate access to scattered-site housing plus off-site supports: • ICM (for participants with moderate needs): case managers available 12 hours per day and 7 days per week; participant to staff ratio (20:1 or less); meet at least weekly with participants and develop an individualised care plan.[4] • ACT (for participants with high needs): psychiatrists, nurses, case managers, and peer support workers available 24 hours per day and 7 days per week; participant to staff ratio (10:1 or less); develop individualised care plans; cost of housing offset by rent supplements ($CAD 375 to $CAD 600 with participants paying 30% of their income for rent). **Comparator** TAU: existing services available in participants respective communities. **Follow-up** 24 months.	
Full citation Creemers, H., Veldink, J. H., Grupstra, H., Nollet, F., Beelen, A., van den Berg, L. H., Cluster RCT of case management on patients' quality of life and caregiver strain in ALS, Neurology, 82, 23-31, 2014 **Ref Id** 1238339 **Country/ies where the study was carried out** The Netherlands **Study type** Cluster randomised controlled trial **Study dates** March 2009 to July 2011 **Inclusion criteria**	**Results** ALSAQ-40 Emotional Functioning (0 to 100)[2] - mean (±SD)[3] **Baseline** Case management plus usual care (n=70): 21.3 (18.2) Usual care (n=61): 19.3 (17.0) **4 months** Case management plus usual care (n=43): 19.8 (14.6) Usual care (n=39): 19.4 (16.6) **8 months** Case management plus usual care (n=28): 21.5 (13.5) Usual care (n=22): 20.0 (16.1) **12 months** Case management plus usual care (n=30): 22.8 (16.4) Usual care (n=27): 19.1 (14.7) Linear mixed model, β (SE); p value[4] Time: 0.54 (0.58); p=0.35 Time X group: 0.33 (0.79) p=0.68

Study details	Results and risk of bias assessment
• Participants with amyotrophic lateral sclerosis (ALS) and their caregivers. • Receiving care from multi-disciplinary ALS team. **Exclusion criteria** **Participants:** • Cognitive dysfunction (Mini-Mental State Examination score ≤20); Insufficient understanding of the Dutch language; Institutionalised. **Caregivers:** • Insufficient understanding of the Dutch language. **Patient characteristics** Patient age (years) - mean (±SD) Case management + usual care: 63 (11); usual care: 62 (11) Sex (male) - % Case management + usual care: 57; usual care: 64 Caucasian ethnicity - % Case management + usual care: 100; usual care: 97 Primary care giver is partner - % Case management + usual care: 82; usual care: 84 Amyotrophic Lateral Sclerosis Assessment Questionnaire 40 item (ALSAQ-40) sum score - mean (±SD) Case management + usual care: 37 (17); usual care: 37 (18) ALSAQ-40 emotional functioning - mean (±SD) Case management + usual care: 21 (18); usual care: 19 (17) **Intervention** Case management plus usual care: Client-centred approach provided by 2 experienced occupational therapists. Case managers provided	**Risk of bias assessment using Cochrane RoB tool v2.0** **1. Bias arising from the randomisation process (Low/High/Some concerns)** Some concerns, team clusters randomised using computer-generated randomisation; allocation concealment at the cluster level (participants recruited after randomisation of clusters); demographic details of participants and caregivers were comparable with no significant between-group differences, or between participants and non-participants. **2. Bias arising due to deviations from intended interventions (Low/High/Some concerns)** Some concerns, no details provided on blinding of participants but participants aware they were in a trial; case manager not blinded when administering outcome assessment questionnaires at baseline home visits; ITT analyses used and adjustments made for potential clustering in the data. **3. Bias due to missing outcome data (Low/High/Some concerns)** Low risk of bias, Intervention: n= 5 (7%) participants, n=3 caregivers (4.5%) discontinued; control: n= (16.4%) participants, n=10 (16.7%) caregivers discontinued; linear mixed models used and statistical analysis adjusted for clustering of data; missing assessment data were high, but the authors did not consider missing data to differ significantly between intervention group (participants 111/284(39.1%), caregivers 100/264 (37.9%) and control group (participants 92/244 (37.7%), caregivers 98/240 (40.8%). **4. Bias in measurement of the outcome (Low/High/Some concerns)** Low risk of bias, appropriate methods used for measuring outcomes; same measurement methods and thresholds used at comparable timepoints; outcome assessors blinded to intervention at 4, 8 and 12 month follow-up. **5. Bias in selection of the reported result (Low/High/Some concerns)** Low risk of bias, different outcomes mentioned in the statistical analysis section have data reported at the different timepoints stated; reported results for the outcome measurements appear to correspond to all intended analyses. **Overall risk of bias (Low/High/Some concerns)** Some concerns. **Source of funding** ZonMw (The Netherlands Organisation for Health Research and Development). **Other information**

Study details	Results and risk of bias assessment
participants with information to enable them to make decisions on how they would prefer their needs to be met (in relation to somatic, psychosocial, environmental, or care issues): • Information on multi-disciplinary ALS team and other professional caregivers involved. • Written and oral information and advice. • Emotional support. • Referrals to health care providers and agencies. • Mediation where problems arose between participants and health care providers or agencies. • Support during participant contact with agencies and suppliers. • Evaluation in the handling of issues raised by participants. **Comparator** Usual care: Neuropalliative care provided by multi-disciplinary team (including rehabilitation medicine consultant, occupational therapist, physical therapist, speech pathologist, dietician, social worker, psychologist, and consultant physicians). Community and social services (including general practitioners, district nurses, home care services, paramedics, social workers, and voluntary workers) play an important role in care for participants with ALS and their caregivers.[1] **Follow-up** 4, 8 and 12 months.	[1]Community and social services (including general practitioners, district nurses, home care services, paramedics, social workers, and voluntary workers) play an important role in care for participants with ALS and their caregivers. [2]Score range; lower scores indicate a better situation (each scale is transformed into a scale of 0 to 100 with 100 indicating worst health). [3]Authors adjusted for clustering of data and for significant differences in baseline characteristics of participants between intervention and control group.. [4] β=multilevel regression coefficient for the effect of case management compared with usual care and is an estimation of the longitudinal relationship between the parameter and the outcome. Time = change over time (4 months) in outcome for both groups; time X treatment group interaction term – change over time (4 months) in outcome different for both groups. Intracluster correlation coefficient: all intracluster correlation coefficient values were less than zero.
Full citation de Vet, R., Beijersbergen, M. D., Jonker, I. E., Lako, D. A. M., van Hemert, A. M., Herman, D. B., Wolf, J. R. L. M., Critical Time Intervention for Homeless People Making the Transition to Community Living: A Randomized Controlled Trial, American journal of community psychology, 60, 175-186, 2017 **Ref Id** 1201747	**Results** General QoL at 9 months - mean (±SD)[2] CTI (n=90): 5.26 (1.27) Care as usual (n=83): 5.08 (1.32) Adjusted mean difference (95% CI): 0.21 (-0.19 to 0.60) Family support at 9 months - mean (±SD)[2] CTI (n=84): 3.41 (1.27) Care as usual (n=79): 3.00 (1.37) Adjusted mean difference (95% CI): 0.36 (0.02 to 0.71); p<0.05

Study details	Results and risk of bias assessment
Country/ies where the study was carried out The Netherlands **Study type** Multicentre, parallel-group randomised controlled trial. **Study dates** 1 December 2010 to 1 December 2012. **Inclusion criteria** **Shelters** • Provide short-term residential services (that is, 24-hour services for a period generally no longer than 12 months) to at least 50 adults each year. • Expected to continue providing services for the next 5 years.[1] **Participants** • Aged 18 years or over. • Stayed at a participating shelter for <14 months. • Participants who knew when they would be exiting the shelter or receiving priority status for social housing. • Moving to housing without supervision or daily supportive services and for which rent would be paid. **Exclusion criteria** • Participants moving to an area where there were no participating organisations providing services. **Participant characteristics** Age (years) - mean (±SD) Critical Time Intervention (CTI) (n=94): 41.42 (11.27); Care as usual (n=89): 39.72 (11.87) Gender (female) - n (%) CTI: 51 (54); Care as usual: 34 (38); p=0.03 History of literal homelessness - n (%) CTI: 62 (66); Care as usual: 52 (58)	Social support at 9 months - mean (±SD)[2] CTI (n=87): 3.39 (1.15) Care as usual (n=77): 3.33 (1.03) Adjusted mean difference (95% CI): -0.27 (-0.62 to 0.08) **Risk of bias assessment using Cochrane RoB tool v2.0** **1. Bias arising from the randomisation process (Low/High/Some concerns)** Low risk of bias. **2. Bias arising due to deviations from intended interventions (Low/High/Some concerns)** Some concerns, participants, shelter staff and research assistant did not have foreknowledge of intervention assignment but were informed of intervention allocation during the trial. **3. Bias due to missing outcome data (Low/High/Some concerns)** Low risk of bias, <5% participants not included in ITT analyses. **4. Bias in measurement of the outcome (Low/High/Some concerns)** Some concerns, the authors stated that some of the data collectors had occasionally become aware of condition assignment, which may have influenced assessment of outcomes. **5. Bias in selection of the reported result (Low/High/Some concerns)** High risk of bias, 4 outcomes outlined in the study protocol were not reported in the study publication; the authors stated the reason was to reduce the conceptual overlap between several of the outcome measures and to minimise potential bias resulting from a relatively high amount of missing data on some variables. **Overall risk of bias (Low/High/Some concerns)** High risk of bias. **Source of funding** The Netherlands Organisation for Health Research and Development (ZonMw) and the Academic Collaborative Centre for Shelter and Recovery. **Other information** [1]Due to slow recruitment of shelters, additional shelters were recruited that did not meet the original eligibility criteria: 9 provided services to fewer than 50 adults per year; 3 offered long-term services (for periods longer than 12 months); 1 shelter was expected to close within the next 5 years. [2]Intention-to-treat analyses for outcomes adjusted for baseline scores/proportions and organisation. Family and social support measured using the average score on a 5-point scale of 5 items from the RAND Course of Homelessness Study (Burnam & Koegel, 1989) - how

Study details	Results and risk of bias assessment
Family support - mean (±SD) CTI (n=88): 2.94 (1.44); Care as usual (n=88: 2.97 (1.32) Social support - mean (±SD) CTI (n=89): 3.41 (1.09); Care as usual (n=88: 3.10 (1.12); p=0.06 Unmet care needs in 1 or more life areas - n (%) CTI (n=87): 64 (74); Care as usual (n=88): 62 (71) General QoL - mean (±SD) CTI: 4.75 (1.16); Care as usual: 4.78 (1.35) Brief Symptom Inventory (BSI) global severity index - mean (±SD) CTI (n=89): 0.59 (0.53); Care as usual (n=87): 0.59 (0.55) Rosenberg Self-Esteem Scale (RSES) - mean (±SD) CTI (n=90): 31.51 (5.64); Care as usual (n=89): 31.10 (5.57) Excessive alcohol use in past 30 days - n (%) CTI (n=86): 18 (21); Care as usual (n=86): 17 (20) Cannabis use in past 30 days - n (%) CTI (n=87): 12 (14); Care as usual (n=82): 16 (20) **Intervention** CTI: Includes different timings: Phase I (transition to the community between discharge and 3 months post-discharge); Phase II (try-out between 3 and 6 months post-discharge); Phase III (transfer of care between 6 and 9 months post-discharge). The 3 phases involve different responsibilities of CTI worker (for example, building relationships with community, assessing participants needs, frequency of contact); different materials (for example, risk and needs assessment, personal recovery plan, activity log); different intensities in relation to meeting frequency and duration. In each shelter organisation, 2 or 3 case managers (with a degree in social work or related field) from community service teams delivered the intervention. Recommended caseloads for CTI workers was 16 adults. **Comparator**	often relatives or friends and acquaintances would be available to provide practical and emotional support. Quality of life was assessed using a 2 item average score on a 7-point scale, from Lehman's Brief Quality of Life Interview (Lehman, 1983). Participants received financial incentives to complete interviews, increasing over time from €15 at baseline to €30 at 9-month follow-up.

Study details	Results and risk of bias assessment
Care as Usual: provision of services after discharge, but type, approach, intensity, and duration differed depending on the shelter organisation, clients' needs, and funds available, and frequency, intensity and duration were less compared to CTI. Clients with complex needs received case management services after discharge from all except 1 organisation. Average caseloads for case managers ranged between 10 and 30 adults. **Follow-up** 9 months.	
Full citation Lindahl, M. L., Berglund, M., Tönnesen, H., Case management in aftercare of involuntarily committed patients with substance abuse. A randomized trial, Nordic Journal of Psychiatry, 67, 197-203, 2013 **Ref Id** 1203001 **Country/ies where the study was carried out** Sweden **Study type** Multi-centre randomised controlled trial. **Study dates** Not reported. **Inclusion criteria** • Citizen in a participating municipality. • Committed to treatment by an administrative court because of substance abuse. • Allocated to treatment at one of the 3 participating institutions for court-ordered treatment.[1] **Exclusion criteria** Not reported. **Patient characteristics** Age (years) - mean (±SD)	**Results** Use of health and social care at 6 month's follow-up - n (calculated) Case management (n=13): 12 (92%); TAU (n=21): 16 (76%); p=0.23 Use of medical assisted treatment at 6 month's follow-up: p=0.46 Use of institutional/inpatient care at 6 month's follow-up: p=0.27 **Risk of bias assessment using Cochrane RoB tool v2.0** **1. Bias arising from the randomisation process (Low/High/Some concerns)** Some concerns, randomisation using Urn randomisation; randomisation used the following covariates: age groups, gender, housing, substance abuse, and Montgomery-Asberg Depression Rating Scale; research unit administrators allocated participants to groups; demographic characteristics were comparable with no significant between-group differences. **2. Bias arising due to deviations from intended interventions (Low/High/Some concerns)** High risk of bias, no information provided on blinding or appropriateness of statistical analysis; no deviations from the intended intervention reported. **3. Bias due to missing outcome data (Low/High/Some concerns)** Low risk of bias, case management: 0 lost to follow-up; TAU: 2 (8.7%) lost to follow-up. **4. Bias in measurement of the outcome (Low/High/Some concerns)** Some concerns, same measurement methods and thresholds used at comparable timepoints, blinding unclear. **5. Bias in selection of the reported result (Low/High/Some concerns)** High risk of bias, the authors stated that follow-up interviews were performed at 6 and 12 months following discharge, but data were only reported at 6 months.

Study details	Results and risk of bias assessment
Case management (n=13): 34 (12.26); TAU (n=23): 40 (11.31) Gender (female) - n (%) Case management: 3 (23); TAU: 6 (26) Alcohol abuse - n (%) Case management: 5 (39); TAU: 14 (60) Drug abuse - n (%) Case management: 9 (61); TAU: 9 (40) Homeless in past 30 days - n (%) Case management: 4 (31); TAU: 9 (40) Disability/sickness benefits - n (%) Case management: 6 (46); TAU: 11 (48) **Intervention** Case manager: meeting between person with complex needs, staff at the participating institution, social worker and case manager (case managers had a university degree in social work and long-term experience of field-work with people with substance abuse) to agree on a service plan comprising 10 domains (physical and mental health, legal status, relationship-family, relationship-friends, occupation, substance abuse, housing, budget and skills), and to agree on the persons short- and long-term goals. **Comparator** Treatment as usual (TAU): conference at the participating institution with a social worker, staff at the institution and the person with complex needs with the aim of deciding on a service plan.[2] **Follow-up** 6 and 12 months post-discharge.	**Overall risk of bias (Low/High/Some concerns)** High risk of bias. **Source of funding** Supported by the Ministry of Health and Social Affairs' task force - Mobilise against Drugs, the National Board of Institutional Care and The Skane county administrative board. **Other information** [1]Commitment of person with substance abuse (alcohol, illegal drugs and volatile solvents) based on the person having ongoing substance abuse, requiring treatment to stop the abuse and that voluntary intervention was not possible. In addition, one or more sub-criteria had to be applicable (that is, that the person could seriously endanger their physical or mental health, run a risk of compromising their life, or be liable to inflict serious injury to themselves or to someone closely related to them. [2]Legislations specifies that the social welfare office supports and helps people with housing, substance abuse treatment and occupation after completion of institutional care. The caseload can differ from 20 to 40 cases per social worker and the social worker worked office hours.
Full citation Ruchlewska, A., Wierdsma, A. I., Kamperman, A. M., van der Gaag, M., Smulders, R., Roosenschoon, B., Mulder, C. L., Effect of crisis plans on admissions and emergency visits: a randomized controlled trial, PloS one, 9, e91882, 2014 **Ref Id** 1284316	**Results** Psychiatric Hospital admissions at 18 months - n (%) PACP (n=69): 33 (47.8) CCP (n=70): 24 (34.3) Control (n=73): 33 (45.2) Hospital admissions (voluntary) at 18 months - n (%) PACP (n=69): 16 (23.2)

Study details	Results and risk of bias assessment
Country/ies where the study was carried out The Netherlands **Study type** Multi-centre, randomised controlled trial. **Study dates** January 2008 to March 2011. **Inclusion criteria** • Outpatients recruited from 12 Assertive Community Teams and Illness Management & Recovery teams. • Aged 18 to 65 years. • Diagnosis of schizophrenia or other psychotic disorder, and bipolar disorder II. • At least 1 emergency outpatient contact with mental health services, or 1 voluntary or involuntary admission in the past 2 years. **Exclusion criteria** • Somatic illness that caused a psychotic disorder. • Inability to provide informed consent because of mental incapacity. • Insufficient command of the Dutch language. • Already have a crisis plan or another type of advance statement. **Participant characteristics** Gender (male) - n (%) PACP: 50 (72.5); CCP: 46 (65.7); control: 49 (67.1) Age (years) ±SD PACP: 40.3 (10.9); CCP: 40.6 (11.6); control: 39.4 (11.6) Diagnosis (psychotic disorder) – n (%) PACP: 53 (76.8); CCP: 45 (64.3); control: 56 (76.7) Ethnicity (Dutch) - n (%) PACP: 43 (62.3); CCP: 42 (60.0); control: 46 (63.0)	CCP (n=70): 14 (20.0) Control (n=73): 12 (16.4) Emergency admission at 18 months - n (%) PACP (n=69): 12 (17.4) CCP (n=70): 7 (10.0) Control (n=73): 14 (19.2) Admissions (under court order) - n (%) PACP (n=69): 11 (15.9) CCP (n=70): 7 (10.0) Control (n=73): 19 (26.0) Emergency visits - n (%) PACP (n=69): 22 (31.9) CCP (n=70): 22 (31.4) Control (n=73): 25 (34.2) Logistic regression - admission at follow-up (court-ordered admission as reference) PACP: ß 0.582 (SE: 0.416); OR (95% CI) 1.79 (0.79 to 4.04), p=0.16 CCP: ß 0.960 (SE: 0.468); OR (95% CI) 2.61 (1.04 to 6.54), p=0.04 **Risk of bias assessment using Cochrane RoB tool v2.0** **1. Bias arising from the randomisation process (Low/High/Some concerns)** Some concerns, randomisation stratified by treatment team, using envelopes containing 12 lots per team; demographic characteristics were comparable with no significant between-group differences. **2. Bias arising due to deviations from intended interventions (Low/High/Some concerns)** High risk of bias, deviations from intended intervention with imbalance across intervention groups. **3. Bias due to missing outcome data (Low/High/Some concerns)** Low risk of bias. **4. Bias in measurement of the outcome (Low/High/Some concerns)** Some concerns, no information provided on whether outcome assessors were aware of the intervention received by study participants or whether this may have influenced assessment of the outcomes. **5. Bias in selection of the reported result (Low/High/Some concerns)**

Study details	Results and risk of bias assessment
HoNOS - n (range)[1] PACP: 11 (2 to 25); CCP: 11 (3 to 24); control: 10 (1 to 23) **Interventions** Patient Advocate Crisis Plan (PACP): 2 advocates (social workers with over 15 years of work experience in the mental health services; 1 also an expert through experience) collected data from people using services for the care plan, then discussed strategies to prevent crises. People using services, supported by the advocate, agreed crisis plans with clinicians and this was signed off by all involved in the crisis plan (for example, friends and family). Clinician facilitated Crisis Plan (CCP): clinicians (mostly psychiatric nurses) developed the crisis plan as part of the person's regular treatment. Factors associated with crisis were discussed and strategies developed to prevent them. Clinicians and people using services formulated the crisis plan together and this was signed by all involved in the development process. The crisis plan is evaluated annually or more frequently if necessary and included in the person's records and electronic records of all emergency psychiatric services that the person might come into contact with. Control group: no crisis plan. **Follow-up** 18 months.	Some concerns, no information on pre-specified analysis plan. **Overall risk of bias (Low/High/Some concerns)** High risk of bias. **Source of funding** ZonMw and BavoEuropoort. **Other information** The researcher needed to remind clinicians to finish the crisis plan and had to undertake a mean of five actions (that is, e-mails or telephone calls) in the CCP condition. In the PACP condition, no reminders were necessary in order to finish the plan. [1]HoNOS used to check for differences in psychosocial functioning.

ACT: assertive case management; ALS: amyotrophic lateral sclerosis; ALSAQ-40: amyotrophic lateral sclerosis assessment questionnaire; ARCOS: Association Réseau de la Communauté Sanitaire de la Région Lausannoise; BSI: brief symptom inventory; CAD: Canadian dollar; CCP: Clinician facilitated Crisis Plan; CI: confidence interval; CMHT: community mental health team; CTI: critical time intervention; DSM-IV: diagnostic and statistical manual of mental disorders fourth edition; EQ-5D: EuroQol-5 Dimensions; GAF: global assessment of functioning; HF: Housing First; GP: General Practitioner; HoNOS: Health of the Nation Outcome Scales; ICM: intensive case management; ITT: intention-to-treat; MCAS: Multnomah community ability scale; MHCC: Mental Health Commission of Canada; MINI: mini international neuropsychiatric interview; NA: not applicable; NZa: Dutch Healthcare Authority; PACP: Patient Advocate Crisis Plan; PReP: pre-release planning; QoL: quality of life; QoLI-20: Lehman Quality of Life Interview 20 Index; RCT: randomised controlled trial; RoB: risk of bias; RSES: Rosenberg self-esteem scale; SCL-90R: symptom checklist global score; SD: standard deviation; SE: standard error; TAU: treatment as usual; TCM: transitional case management; ZoMw: The Netherlands Organisation for Health Research and Development.

Evidence tables for review question C: Based on the views and experiences of everyone involved, what works well and what can be improved about case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Table 9: Evidence tables – qualitative evidence

Study details	Methods and participants	Results	Limitations
Full citation Abendstern, M., Care coordination for older people in England: Does context shape approach?, Journal of Social Work, 19, 427-449, 2019 **Ref Id** 1220527 **Country/ies where the study was carried out** UK (England) **Study type** General qualitative inquiry (forming part of a larger mixed-methods study). **Study aims** To increase the understanding of the role of the non-statutory sector in the provision of care coordination for older people in England. **Study dates** February to May 2015.	**Recruitment strategy** Purposive sampling from 122 national survey participants, including adult social care, brokerage, hospital discharge support, and specialist dementia advice and support services. All services were contracted to provide care coordination to older people. Service managers approached practitioners for inclusion in the study and provided them with background information prior to interview. **Setting** Community offices, hospitals or memory clinics. **Participant characteristics** <u>Adult social care and brokerage services</u> Provided short- or long-term support to older people with complex needs (1 brokerage services was specifically for people from a Black or Asian Minority Ethnic Community). <u>Hospital discharge services</u> Short-term support provided to older people (in 1 case defined as people over 55 years) with low-level needs to return to independent living following an inpatient admission or to prevent one. <u>Specialist memory services</u> Provided short- and medium-term services to people with dementia with varying levels of needs. **Data collection and analysis**	**Findings (including author's interpretation)** <u>Influence of context on practice</u> *Service location* Service location impacted on the nature of initial contact between potential service users and practitioners, with specialist dementia and hospital discharge support services able to see individuals 'in situ' as they were hospital-based. Adult social care and brokerage services were office-based and appointments were made to see individuals at home or at a local resource centre: • Adult social care and brokerage services usually involved a telephone call to arrange a visit (described as a largely administrative procedure). • Hospital discharge and specialist dementia services initial contact as often face-to-face. *Target group* Assessments to identify service user's circumstances to appropriately tailor and implement a support plan were influenced by the complexity of needs and whether these were specific to a particular condition or set of circumstances. However, the focus of assessments varied dependent on the target group of the different services:	**Limitations (assessed using the CASP checklist for qualitative studies). Answer options for each item are 'yes', 'can't tell' or 'no'.** **1. Was there a clear statement of the aims of the research?** Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes. **4. Was the recruitment strategy appropriate to the aims of the research?** Yes, how the different types of services and practitioners were recruited is explained. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are clear and justified, but no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the author did not discuss their own role in the formulation of the research

Study details	Methods and participants	Results	Limitations
	Data collection Semi-structured interviews (lasting approximately 1 hour) were conducted with 1 practitioner from each service to explore each care coordination element provided by the service, by whom, and length of time. Each interview was audio recorded and transcribed. Data were anonymised. <u>Data analysis</u> Data were interpreted in a systematic way using both deductive and inductive data analysis methods, drawing on framework analysis. Data were coded to identify concepts or themes, which were then analysed for similarities and variations between types of service. The process was performed by 3 authors who discussed, reflected, and re-visited decisions until consensus was reached.	• Brokerage services supporting people with complex needs undertook assessments in terms of a 'checking' nature: "We don't assess as such ... I would read that assessment prior to the visit but I wouldn't use that as my benchmark ... I would start from the beginning with the client and ask what they felt they need". (Respondent 1) p.437. • Adult social care services to support people with complex needs described assessments were described as comprehensive, including activities of daily living (ADLs), mobility, nutrition, family and community networks, risks, and what individuals themselves were able and willing to undertake. • Specialist dementia services, providing support to individuals with low and complex needs, described assessments as 'holistic' touching on a wide range of areas in an individual's life. ADL assessments were more superficial than adult social care assessments, including screening to identify where referral to a social work team was warranted and focusing on whether particular concerns were likely to arise for someone with dementia and their carer. • Hospital discharge service assessments were narrowly focused and targeted people whose needs were low level; aimed at assessing immediate and short-term needs and realistic goals, such as potential difficulties or risks to the practitioner (for example, aggressive pets) in addition to the individual being supported (for example, whether they could use their kettle).	questions, or consider the researchers influence on the respondents. **7. Have ethical issues been taken into consideration?** Yes, ethical approval for the study was received from the University of Manchester Research Ethics Committee. **8. Was the data analysis sufficiently rigorous?** Yes, it is clear how themes were derived, and data were analysed for similarities and variations between service types. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the authors acknowledged that the inclusion of only one source of data (that is, practitioners) provides only one perspective, and the purposive sampling potentially limits the generalisability of the findings. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor limitations. **Source of funding** NIHR SSCR and the Association of Directors of Adult Social Services. **Other information** The core elements of care coordination include: • Referral (determining eligibility through initial assessment). • Assessment (assessing individual regarding functioning,

Study details	Methods and participants	Results	Limitations
		Provider or commissioner role The role of practitioners as a provider or commissioner particularly impacted on implementation and brokerage: • Hospital discharge services had a more extensive role as a direct provider of assistance rather than service commissioner (individuals were allocated a worker who visited weekly to assess progress towards goals and provided assistance with, for example, shopping, making snacks. • Specialist dementia service practitioners were more likely to signpost service users to other sources of advice and assistance. "We will check out whether they are getting benefits ... and I will refer on if things aren't getting claimed for. I will give information on our local services and other services ... I'll give out information on solicitors, how to do it yourself". (respondent 4) p.438. • Adult social care services largely comprised referring to and negotiating with a range of service providers. Brokers were specifically concerned with supporting people who had been allocated a personal budget, and were involved in helping individuals to decide, for example, whether they preferred to employ a PA or use a commissioned services. Broker practitioners highlighted the labour intensity of this work because of the amount of paperwork involved and the complexities of explaining the positives and negatives of employing a PA. *Length of contact*	needs, existing support, aspirations and goals). • From assessment to support planning (discussion of needs, wishes and preferences and type of support available to meet them). • Support planning (developing a package of services or supports incorporating informal networks and formal services). • Implementation/brokerage (arrangement of services through contacting services and sharing service user information or signposting and supporting individuals to arrange services themselves). • Monitoring (continued contact with service user and providers to ensure services are provided in accordance with support plan - can involve service changes). • Reviewing (scheduled assessment of service users' situation and functioning to identify changes and measure progress toward desired goals). • Closure (based on nature of service (pre-determined length) or individual service user's situation (no longer requiring support or requiring more intensive support than available within the service).

Study details	Methods and participants	Results	Limitations
		Length of contact affected how different services conducted monitoring, reviewing, and case closure. Longer term services were more likely than shorter term ones to have a monitoring role, however, monitoring was fundamental to short-term hospital discharge services because of their provider role. Monitoring in these services was conducted in person as part of the weekly service for its 6 week duration. Other service groups mentioned that monitoring was minimal, irregular, and informal, conducted over the telephone or through contact at drop-in or group services: • Reviews of the circumstances of service users and their length of contact with services were linked; reviews differed dependent on case complexity and statutory obligation. In more complex cases they were described as re-assessments and conducted face-to-face (reviewing needs and goals, finding out if further support was needed, and altering support plans as necessary). In less complex cases, for example in specialist dementia services, a brief telephone call might suffice. • Hospital discharge services described their final meeting with the service user as a review - revisiting goals they had hoped to achieve at the beginning and closing the case with a referral to another service, if required. • Adult social care and brokerage services described a workload management system whereby cases that were inactive but might require future input were closed and service users were not informed of their case	

Study details	Methods and participants	Results	Limitations
		closure. Service users were reported to prefer this approach. • "We'll reach a point where we have to just close that on the system … I normally send a letter … don't forget that we're here if you need us … So that they feel that … that door is always open and I haven't used the dreaded phrase, case closed. But it is as far as we're concerned internally". (respondent 6) p.439. <u>Standards of practice</u> • Standards that guided practice across care coordination elements were reported as continuity; person-centred; and strengths-based approaches with a focus on goals, and self-determination. • A network of support was also evident, with some evidence of advocacy on behalf of individual service users. • All services provided continuity of support in the form of a named worker and this was reported as valuable for a service user's sense of comfort and security. "It might take five weeks before you are getting to know somebody so it is better for that person if they have got one person going". (respondent 6) p.439. • 3 services provided continuity from referral onwards. In contrast, hospital discharge services involved 2 members; 1 undertook the initial hospital-based assessment and support plan and the other taking on the case from the first home visit, undertaking further assessments, refining the support plan	

Study details	Methods and participants	Results	Limitations
		as required and providing information, advice, and practical support. • Person-centred and strength-based approaches were emphasised in terms of the way practitioners spoke to people and focusing on strengths as well as needs of the service user. "Talk me through your day. So that isn't focusing on any negatives because during that day, people will say what they can do ... We have a conversation about somebody's day and from that conversation we usually determine what support the individual will require to meet their needs". (respondent 9) p.440. • All services emphasised the importance of supporting people to recover or enhance their independence and self-determination by undertaking things for themselves, for example, by signposting service users to a range of relevant services and agencies to which they could refer themselves. • Advocacy was also regarded as important when individuals were not able to act for themselves. Two services provided advocacy: specialist dementia services and brokers. • A focus on goals was evident within all services but most obvious in relation to hospital discharge services where goals were emphasised in the assessment process.	
Full citation Archard, P. J., Murphy, D., A practice research study concerning homeless	**Recruitment strategy** Convenience sampling strategy. Service users were identified and contacted through the organisation running the supported accommodation in which they resided.	**Findings (including author's interpretation)** <u>Rapport, commitment, flexibility and worker autonomy and practical assistance</u> *Service users perspectives*	**Limitations (assessed using the CASP checklist for qualitative studies). Answer options for each item are 'yes', 'can't tell', or 'no'.**

Study details	Methods and participants	Results	Limitations
service user involvement with a programme of social support work delivered in a specialized psychological trauma service, Journal of psychiatric and mental health nursing, 22, 360-70, 2015 **Ref Id** 1077040 **Country/ies where the study was carried out** UK (England) **Study type** Exploratory, general qualitative inquiry. **Study aims** To examine experiences of the support work programme by people using services in supported housing for people experiencing homelessness, and to explore the worker-service user engagement and influence of context on positive outcomes. **Study dates** Not reported.	**Setting** Specialised traumatic stress service. **Participant characteristics** **Trauma survivors (N=4** Gender (male) - n (%): 4 (100) Age (years) - range: 45 to 58 Ethnicity: White British Housing status: UK homeless shelter/hostel resident **Support workers (N=2)** Female support workers who had successfully completed placements at the time of interview; 1 was in the final year of her social work training and the other had begun to practice in a qualified post as a social worker. **Data collection and analysis** Data collection 8 narrative interviews were conducted (support workers: n=2 interview; service users: n=4 interviews plus n=2 follow-up interviews to elaborate on themes). Interviews were conducted in service premises and participants' residences and lasted between 50 and 80 minutes. Interviews sought participants' experiences of working together and any development they felt was made as a consequence. Interviews were mostly audio recorded, with 2 documented in note form because of too much noise occurring in the vicinity. Because of difficulties with literacy, interview transcripts were not returned to service users. Data analysis	• Perceived benefits about the involvement of support workers from the service users perspective included the particular role taken by the social workers and the way in which the role was implemented. • Service users appreciated the face-to-face time that support workers could provide if they had a relatively modest caseload: "I found it very useful to talk to them ... because they sat and listened and the [shelter] staff don't always have the time, haven't always got the time to sit and listen to us". (service user 4) p.363. • In addition, the effort and energy put into visiting and spending time with service users was seen as essentially altruistic, and a personal commitment to them. • Some service users reported that being listened to without being judged or told to follow a particular course of action was emotionally cathartic and to a certain extent, something of a motivational force in catalysing hopes for personal adjustment and change: "Philosophically they helped me in my head; it was like get it together [service user name], you know". (service user 2) p.364. • Connections between support workers and services users appeared to be most strongly based on rapport built during workers active involvement with practical matters, for example spending	**1. Was there a clear statement of the aims of the research?** Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes. **4. Was the recruitment strategy appropriate to the aims of the research?** Yes, the authors explain how participants were recruited. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are clear and justified, but there was no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the authors did not discuss their own roles in the formulation of the research questions or consider their influence on the participants. **7. Have ethical issues been taken into consideration?** Yes, ethical approval for the study was granted by the University Department Research Governance and Ethics Review Board; participants were made fully aware of the research aims and intentions and were free to withdraw at any time. Informed consent was obtained from all participants and procedures were put in

Study details	Methods and participants	Results	Limitations
	Thematic analysis was used and data coded to identify themes and sub-themes. The coding of transcripts was carried out by 1 author, the development of themes was verified by the second author, and the coherence of the analysis was verified by a third health and social care researcher independent to the study.	time in residences and helping with shopping and cleaning. • A recurrent theme was the appreciation by service users for the role support workers played in relocation, helping with packing, sorting and unpacking, and helping some service users to acclimatise to the transition and become more autonomous and domestically skilled. *Support workers perspectives* • The proximity to service users' everyday realities was seen as a key difference between the practice of support workers and the more formal, consulting room confined activities of resident psychology professionals. This type of flexible working was mainly possible because of the independence support workers experienced and the freedom they had to work outside usual office hours and away from the office, enabling them to really get to know the service users, listen to what they wished to achieve from involvement and spending prolonged periods building relationships with service users. • The lack of administrative and technological constraints resulting from this contrasted with excessively bureaucratic practices in other student placements and previous professional positions held in the health and social care field (described as involving feeling routinely tethered to a desk and computer, saddled with ritualised work tasks and subject to something of a 'fishbowl atmosphere', that is, rigorous	place to safeguard participants' psychological welfare. **8. Was the data analysis sufficiently rigorous?** Yes, the authors clearly explained how themes and sub-themes were derived using thematic analysis. Themes were verified by a second researcher and coherence of the analysis was verified by a third independent researcher. However, contradictory data were not discussed. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the authors acknowledged that the study's modest sample meant that the findings were not necessarily reliably representative of all homeless service users that come into contact with support work programmes or those who practiced on it. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor limitations. **Source of funding** None. **Other information** The support work programme augmented psychotherapeutic interventions in order to more comprehensively attend to the psychological and social needs of service users, to improve capacity to offer early intervention and outreach help, and help over time; and to provide a more joined up approach to educating trainee mental health professional in the field of psychological trauma. The service worked

Study details	Methods and participants	Results	Limitations
		audit-like practices and organisational fixations on performance. <u>Truncated involvement and incongruities in professional status</u> *Service users perspectives* • There were some aspects of involvement that caused the service users some concern: ○ Support workers age compared to service users' identify as middle-aged homeless men was perceived to compromise their ability to adequately relate to their situations and life histories by 2 service users. ○ Apprehension about workers' status as professionals 'in-training' rather than 'qualified' was reported by 1 service user. ○ Aspects of the programme that contributed to a perceived unhelpfulness (or inhibited helpfulness) was the nature of worker involvement; with a certain rapport and closeness achieved between service users and workers, which may then cease abruptly: "You miss them sometimes, they stop [for a short period] and then they move on ... And it's not the same without them". (service user 1) p.364. "I tell people all me problems and I get close to them male or female. I open up about my problems and the	alongside local providers of supported accommodation and front line agencies providing support to long-term homeless and vulnerably domiciled persons. Support work involved providing practical assistance with everyday tasks, benefit and grant applications, seeking of accommodation with service users, home visits and meetings with family and support networks, and liaison with other agencies and making of referrals, where necessary.

Study details	Methods and participants	Results	Limitations
		next thing I know they're gone". (service user 4) p.364. "You tell them about your personal life and then they, I mean I've nothing to hide (. . .) and they know all that; but then they go away and then don't come back, and then someone else comes and they take their place and then they expect you to tell them all over again and then they move on". (service user 4) p.365. • This was corroborated by 1 support worker who spoke of her frustration at the limitations of minimal periods of involvement, with gaining an understanding of a service user's situation and personal history taking time, along with brokering a connection with service users who could be quite sceptical about support worker involvement.	
Full citation Biringer, E., Hartveit, M., Sundfor, B., Ruud, T., Borg, M., Continuity of care as experienced by mental health service users - a qualitative study, BMC health services research, 17, 763, 2017 **Ref Id** 973860 **Country/ies where the study was carried out**	**Recruitment strategy** Service users referred to the community mental health centre (CMHC) were recruited by their therapist at initial contact with the CMHC. **Setting** CMHC providing specialist mental health services (includes outpatient clinics, outreach services, and 2 inpatient units). **Participant characteristics** Health and welfare service users: N=10 Follow-up at 2 years (range: 27 to 30 months): n=8 service users	**Findings (including author's interpretation)** <u>Relationship</u> **Good continuity** Trusting relationship; participants valued ongoing relationships with the same contact person. *Subjective experience:* • Mutual knowledge and respect. • Feelings of trust and safety. • Perception that support is helpful. **Poor continuity**	**Limitations (assessed using the CASP checklist for qualitative studies). Answer options for each item are 'yes', 'can't tell', or 'no'.** **1. Was there a clear statement of the aims of the research?** Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes.

Study details	Methods and participants	Results	Limitations
Norway **Study type** Hermeneutic-phenomenological study. **Study aims** To explore experiences and perceptions of people with mental health for continuity of care within and across services in relation to recovery. **Study dates** 2011 to 2012.	<u>Age (years) - mean (range)</u> 33 (18 to 54) <u>Gender - number</u> Male: n=6 Female: n=4 Service users' mental health issues included: chronic bodily pains and fatigue; depression and/or anxiety; mental health issues with or without periods of substance abuse and/or alcohol abuse; bipolar type II; psychotic episodes; delusions. **Data collection and analysis** Data collection Interviews lasted approximately 1 hour at baseline and follow-up. Interviews were conducted in a setting of the participants' choice and explored the participants' experiences with aspects of continuity of care. Interviews were audio recorded and transcribed verbatim. Data analysis A data-driven stepwise approach, in line with thematic analysis, was adopted. Two researchers discussed and agreed on preliminary themes and further developed. For the 8 participants with follow-up data, data were analysed longitudinally to identify changes in insights and perceptions. Authors emphasised reflexivity, exchanging ideas with service users, throughout the research process.	Frequent breaks in contact with professionals, which could result in service users experiencing setbacks in treatment. *Subjective experience:* • Frustrating having to repeat personal story to different contact(s). "It's always the same. I have to tell my whole life story again and again. Even though they have the records, they still want to hear it. No, it's happened too many times [...]. It's easier just to deal with one person. That's so much better than being thrown around backwards and forwards between different social workers". (participant 6 at follow-up) p.7. • Developing relationships with new contacts provokes anxiety. • Feelings of rejection. • Perceptions that professionals do not care. • Setback in terms of diagnostic evaluation and treatment. *Suggested improvements:* • Do not change contact person. • Inform service users in advance about changes in contact person. • Show service users that professionals care about their situations. • Take peoples' anxiety into consideration. • Do not expect service users to act perfectly. • Provide the person with follow-up over time.	**4. Was the recruitment strategy appropriate to the aims of the research?** Yes, how the service users and were recruited is explained. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are clear and justified, but no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** Yes, the authors acknowledged that the researcher's involvement and prior understanding may impact on the research, and therefore practised reflexivity throughout the research process to exchange ideas with service users. The authors were also aware that emotional distress may be caused by the interviews and were available to assist the service user to contact their therapist if necessary. **7. Have ethical issues been taken into consideration?** Yes, ethical approval was obtained from the Regional Committee for Medical Research Ethics and Norwegian Social Science Data Service. **8. Was the data analysis sufficiently rigorous?** Yes, it is clear how themes were derived using a data-driven stepwise procedure in line with thematic analysis. Themes were discussed between 2 researchers. For the 8 participants with follow-up data, data were analysed longitudinally to identify changes in insights and perceptions over

Study details	Methods and participants	Results	Limitations
		• Include family in information and contact. <u>Timeliness</u> **Good continuity** Receiving help when needed and not having to wait with worsening problems. *Subjective experience:* • Feelings of relief. • Avoidance of negative consequences of long waiting times. **Poor continuity** Being kept waiting and not knowing what is going to happen. *Subjective experience:* • Worries about problems and future contacts with services. • Challenges experienced with managing mental health and related problems, including hardships in daily lives. • Worsening of problems. • Risk of suicide. *Suggested improvements:* • Work quicker. • Make use of the waiting time. <u>Mutuality</u> **Good continuity** Both professionals and service users take initiatives, contact is available to service users	time. To ensure reliability of the findings, authors compared findings and interpretations (between baseline and follow-up) throughout the process. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** No or minor limitations. **Source of funding** Authors received grants from the Norwegian Extra Foundation for Health and Rehabilitation/Norwegian Council for Mental Health, and the Regional Research Network on Mood Disorders (MoodNet).

Study details	Methods and participants	Results	Limitations
		whenever something comes up and they have a say in decision-making. *Subjective experience:* • Feeling that the professional is reliable and cares. • Feeling that you have a say in decisions. **Poor continuity** Service users always being the ones to take the initiative in order to make things happen. *Subjective experience:* • Feelings of frustration and indifference, and the thought that you have to 'fight' the system. "I had a battle with them too [...] ... Things take time and are difficult. It's really confusing [...] when on person says one thing and another something else, then you get a letter with a third thing, and you just sit there...". (participant 2 at follow-up) p.10. • Feeling ignored because professionals do not make contact. *Suggested improvements:* • Attend collaborative meetings. • Do not expect service users to act perfectly. • Do not be square (that is, do not follow rules systematically if the rules create impractical or paradoxical situations for the service user).	

Study details	Methods and participants	Results	Limitations
		• Be open to contact, also between scheduled appointments or across services. <u>Choice</u> **Good continuity** Having the opportunity to choose from a variety of options regarding where to be treated and what kind of support is available. Having the opportunity to influence decisions and possibly increase personal continuity by making individual choices suited to personal situation and context. *Subjective experience:* • Feeling that the situation is created according to personal needs in terms of treatment and practical aspects. "They are totally superb because they concentrate on you as a person in relation to 'What do you want? What do you wish to happen? What can we help you with?' [...] Everybody was at the meeting and just [said] 'OK, now we're here for you.' And you feel completely overwhelmed. Four people sitting around me and just talking about you [me] and [saying] 'Yes, what can we fix for you?' and so on. So, it has been very good. I have only positive things to say about both 'NAV' and the doctor and the cooperation there ...". (participant 10 at follow-up) p.10 to 11. **Poor continuity** Having no choice in terms of decisions about where, when and how to get help, and no possibility of influencing decisions about contacts, treatments and support. Following rules made by the system, for example, when being transferred between services.	

Study details	Methods and participants	Results	Limitations
		Subjective experience: • Feeling ignored. • Feelings of indifference or opposition towards professionals, treatment and the system. • Starting to ignore the system and its rules. *Suggested improvements:* • Do not be square (that is, do not follow rules systematically if the rules create impractical or paradoxical situations for the service user). • Be open to contact, also between scheduled appointments or across services. <u>Knowledge</u> **Good continuity** Knowing about evaluations and future plans, and receiving information about scheduled meetings and support interventions in good time. Service users knowing who is communicating information about them, and how and why. *Subjective experience:* • Understanding what is happening and what is going to happen in future. • Feeling more secure. • Experiencing predictability in practical terms. **Poor continuity** Lack of information about what is happening, and why and how. Not knowing how or whether the	

Study details	Methods and participants	Results	Limitations
		involved parties communicate about the service user or their situation. *Subjective experience:* • Feelings of confusion, distress and insecurity. One participant seeking support from the Labour and Welfare Administration because of a distressing financial situation due to her mental health problems experienced misunderstandings and confusion in her communications: "There's poor communication from their side and from my side at times, but that's because I get fed up when I ring to find out what's happening and I get three different letters within a week with three different appointments. They don't speak to each other, I get totally ...". (participant 2 at follow-up) p.11. • Feelings of tiredness and indifference. *Suggested improvements:* • Talk to each other. • Attend collaborative meetings. • Inform service users in advance about changes in contact persons. • Work quicker. • Provide information about (planned) evaluations, treatments and support. • Convey the same messages. • Make use of the waiting time. • Include family in information and contact. • Provide general information about mental health problems, available services and treatments.	

Study details	Methods and participants	Results	Limitations
Full citation Carver, H., Douglas, M. J., Tomlinson, J. E. M., The outreach worker role in an anticipatory care programme: a valuable resource for linking and supporting, Public Health, 126 Suppl 1, S47-S52, 2012 **Ref Id** 1221478 **Country/ies where the study was carried out** UK (Scotland) **Study type** General qualitative inquiry. **Study aims** To improve the understanding of the views of staff and people using services in terms of the Keep Well outreach worker role. **Study dates** July to October 2010.	**Recruitment strategy** Purposive sampling to identify a variety of Keep Well staff members and to recruit service users who had received support from an outreach worker (OW). Staff were contacted by email and service users were recruited through their OWs. **Setting** Lothian Keep Well project. **Participant characteristics** Keep Well Staff (N=12): project nurse (n=1); nurse case manager (n=1; practice nurse (n=2); OWs (n=4); GPs (n=4). Service users (N=4). **Data collection and analysis** Data collection Most interviews were conducted by telephone; lasting for approximately 24 minutes with Keep Well Staff and 7 minutes with service users. One service user was interviewed face-to-face because they spoke very little English and an interpreter was used. <u>Data analysis</u> Interviews were audio recorded and transcribed in full by 2 researchers using a thematic analysis approach. Topics were identified and coded and then grouped into themes. The process was repeated until no new themes emerged.	**Findings (including author's interpretation)** <u>Differences in understanding the role</u> • Service users viewed the OWs as providing individualised support based on their individual needs for a variety of issues, from physical activity to alcoholism. This support was viewed as beneficial in encouraging service users to improve their health and lives, and was perceived as support service users: "might not have got elsewhere". (OW) p.S49. This suggested that OWs were dealing with previously unmet needs. • OWs were viewed as linking practices, service users and local services, thereby clarifying confusion about the availability of local services and allowing service users to utilise these services: "I see the outreach worker as kinda being the conduit for that they have the information maybe like a wee bit of a catalyst and bringing the person together with what is already available that can meet their needs and I suppose if there's something that's not available for somebody's needs then it would be the outreach worker that would be kinda highlighting there's a bit of a gap in services". (project nurse) p. S50. <u>Benefits of the role</u>	**Limitations (assessed using the CASP checklist for qualitative studies). Answer options for each item are 'yes', 'can't tell', or 'no'.** **1. Was there a clear statement of the aims of the research?** Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes. **4. Was the recruitment strategy appropriate to the aims of the research?** Yes, how the service users and Keep Well staff were recruited is explained. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are clear and justified, and the authors mention data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the authors did not discuss their own roles in the formulation of the research questions or consider their influence on the participants. **7. Have ethical issues been taken into consideration?** Yes, ethical approval for the study was sought from the NHS Lothian Research Ethics Committee, who advised that ethical and R&D approval was not

Study details	Methods and participants	Results	Limitations
		• OWs were viewed as beneficial to practices and service users in terms of the time they had available to spend with service users to discuss issues most relevant to them. • OWs were also viewed as beneficial in terms of the skills they possessed which allowed them to be successful in their role (for example, good partnership working, helping practices to view service user issues in a less medical manner and being knowledgeable) and qualities of OWs in terms of being approachable, flexible, non-judgemental, respectful and helpful. <u>Problems and barriers</u> A number of issues were viewed negatively, including: • High staff turnover which resulted in practices not knowing the OWs, and concerns about putting pressure on busy OWs, therefore practices were less likely to refer service users. • An initial lack of referrals was viewed as frustrating by OWs: "demotivating and despiriting and boring". (OW) p.S49. • Issues relating to the project were highlighted in terms of information technology, paperwork and a lack of recognition of the importance of OWs: "A lot of time is spent keeping records up to date ... and writing to GPs to let them know what I've done when really if	required as the study was deemed to be evaluation rather than research. **8. Was the data analysis sufficiently rigorous?** Can't tell, themes were derived using thematic analysis, but only limited details were provided. Contradictory data were discussed in terms of those who declined to participate may have had different views or experiences compared to those who participated who may have had more positive experiences of receiving support from and outreach worker and therefore more willing to participate in the study. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the authors suggest strengths and limitations of the study and implications for policy and practice. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate limitations. **Source of funding** None. **Other information** The Keep Well programme was introduced across 5 Scottish regions with high levels of deprivation to provide holistic health checks to reduce health inequalities. The role of an 'outreach worker' was created to provide assistance to individuals who found it difficult to obtain support or stay engaged with services.

Study details	Methods and participants	Results	Limitations
		we had a one you k now a sort of more you know joined up IT system then I wouldn't need to be sending out all the stuff and duplicating stuff". (OW) p.S50.	
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/ies where the study was carried out** Australia **Study type** General qualitative inquiry. **Study aims** To examine how clinical and non-clinical case managers work together in care planning and explore the perceived influence of support. **Study dates** Not reported.	**Recruitment strategy** Service users were randomly selected, with equal representation from the 3 NGOs in HASI Stage 1. Permission was sought from service users to review their care plan and consult with relevant others (NGO case managers, family members and clinical case managers). **Setting** 3 NGOs. **Participant characteristics** Sex (males) - n/N (% calculated) 13/20 (65) Age (years) 37 Primary diagnosis - n/N (% calculated) Schizophrenia: 12/14 (85.7) **Data collection and analysis** Data collection Service user interviews were guided by semi-structured, open-ended interview schedules. Interviews reflected care planning in terms of practices to facilitate psychosocial rehabilitation, service user involvement, and service integration. Participants also reflected on their experiences with HASI, which ranged up to 24 months. Data analysis Interview data were triangulated with a review of the 20 care plans. Triangulation involved constant comparison analysis (coding data and	**Findings (including author's interpretation)** Service user needs, preferences and clinical considerations • Care plans were service user driven, enabling them to articulate their needs, goals and strategies to achieve these. However, the level of service user participation varied with a minority of service users knowing about their plan and the active role they played in its development. A few service users stated that they resisted disagreeable goals identified by other people, including case managers. Service users stated that at times they guided the plan while at other times it was steered by case managers: "I say what I think, they say what they think, and then we come to a mutual understanding - I don't feel like I'm just there". (service user) p.485. • The service user approach was viewed as enabling service users to engage in dialogue about sustainable recovery and to identify their goals and strategies towards achieving these goals. A non-clinical case manager recalled: "We know where we're going ... It makes the big picture more obvious	**Limitations (assessed using the CASP checklist for qualitative studies). Answer options for each item are 'yes', 'can't tell', or 'no'.** **1. Was there a clear statement of the aims of the research?** Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes. **4. Was the recruitment strategy appropriate to the aims of the research?** Yes, how the service users and case managers were recruited is explained. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are clear and justified, but no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the authors did not discuss their own roles in the formulation of the research questions or consider their influence on the participants. **7. Have ethical issues been taken into consideration?**

Study details	Methods and participants	Results	Limitations
	discussing with research team, identifying and comparing themes across sites and participants) and member checking (discussing themes with stakeholders).	and reduces an *ad hoc* approach", p.485. • Identifying incremental, achievable goals with short time frames was reported to be an important part of service user driven care planning, contributing to recovery, even when mental health was unstable. According to service user and non-clinical case managers, it facilitated communication, guidance and motivation: o A small group of service users were not aware of having a care plan and spoke instead of a weekly activity schedule, which suggested that daily activities were not service user driven: "[The case manager] types up some notes and sheets of chores to do, a calendar of what's on when ... She also drew up a budget and a shopping list ... If I feel like chips or chocolate, they say, 'No, it's no good for you'". (service user) p.485. • Service user participation in planning was also reported to be influenced by the working relationship between the clinical and non-clinical case managers. Service users in 2 of 3 sites felt encouraged to participate in care planning with both case managers: "[The two case managers] work better together. The more people, the better the brainstorming and the better the result". (service user) p.486.	Yes, ethical approval for the study was sought from the University of New South Wales and New South Wales Health. **8. Was the data analysis sufficiently rigorous?** Yes, it is clear how themes and sub-themes were derived using triangulation involving constant comparison analysis and member checking. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the authors acknowledged the small sample size limits generalisability of the findings and that although service users were randomly selected, they did not represent all service users in HASI. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor limitations. **Source of funding** The research was based on the Social Policy Research Centre's study of the Mental Health Housing and Accommodation Support Initiative, which was commissioned by New South Wales Health. **Other information** Case management refers to HASI care planning (that is, non-clinical case management practices facilitated by NGOs). All service users had a care plan to facilitate recovery, specifying goals and sources of support. HASI is a community care programme for people in New South Wales, Australia,

Study details	Methods and participants	Results	Limitations
		• However, other service users felt disengaged from the planning when they thought the 2 case managers were too close: "[They] said things that I didn't understand. But I'm not qualified to understand what they were talking about". (service user) p.486. <u>Inclusive, active partner participation</u> • The involvement of clinical case managers in care planning was reported to improve the quality of support through complementarity, consistency and collaboration. Non-clinical case managers provided psychosocial rehabilitation, for example supporting service users during daily activities to bolster recovery. Clinical case managers' expertise helped partners to understand the contributors to mental illness, medication and associated side-effects, and this was respected by both service users and non-clinical case managers: "[The clinical case manager] reinforces goals like diet, [and] as an authority, it's important to have him there", p.486. • However, employing clinical authority was reported to risk disregarding other options: "[A consumer] has a flat affect and is depressed a lot. He said he'd like to see a psychologist, but the [clinical] case manager wasn't supportive ... It	with a poor housing history and chronic mental illness, encompassing conditions with lasting, persistent or recurring symptoms. Non-clinical case managers are generally qualified or experienced in allied health specialities, such as social work or community care.

Study details	Methods and participants	Results	Limitations
		was really disappointing". (non-clinical case manager) p.486. • Co-operation was reported to increase consistency in strategies to achieve goals, and collaboration improved the quality of the planning, harnessed professional networks and augmented options: "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) p. 486. • However, in one site, clinical case managers had weak organisational partnerships with their non-clinical colleagues, did not participate in review meetings and had limited contact. Non-clinical case managers reported that irregular interaction with the clinical case managers hindered the continuity and quality of care such as, ensuring sufficient services and avoiding duplication. <u>Planning as a process</u> • Care planning reviews typically started with reassessing needs using standardised measures, followed by meetings between the service user, non-clinical case manager and relevant others. Frequency of review meetings ranged from 3 to 6 months. Most service users were happy with the frequency, but others preferred it to be more or less often to "speed things	

Study details	Methods and participants	Results	Limitations
		up" (service user) or to have "time to get my shit together". (service user) p.487. • Monitoring of plans also varied, with non-clinical case managers attending weekly or monthly team meetings to discuss service user progress, contribute to goal implementation, review the relevancy of the plan, and modify it accordingly. • Team discussions and contact with service users provided non-clinical case managers with opportunities for reflective practice about care planning and to link service user goals, strategies and rationales, and to discuss these with the service user and clinical case manager. However, reflective practice varied across sites, with service users not always understanding the purpose, process or benefits of care planning. This was particularly the case when clinical case managers regarded care planning as paperwork, rather than as a part of a reflective process of recovery.	
Full citation de Lange J., Factors facilitating dementia case management: results of online focus groups, Dementia: The International Journal of Social Research and Practice, 17, 110-125, 2018 **Ref Id** 1221953	**Recruitment strategy** Convenience sampling including 13 networks of a total of approximately 70 regional dementia care networks in The Netherlands. Project coordinators of 13 dementia care networks answered an open call for participation from the Dutch Alzheimer Association. Purposive sampling to identify and recruit professionals involved in case management within the regional networks. **Setting** Regional dementia care networks (N=13). **Participant characteristics**	**Findings (including author's interpretation)** <u>Good cooperation between partners</u> • Professionals reported that cooperation between partners in their regional network was a prerequisite for offering good dementia case management; promoting integration of care and meeting the needs of people with dementia and their informal caregivers and facilitating commitment to and support for case management among partners.	**Limitations (assessed using the CASP checklist for qualitative studies). Answer options for each item are 'yes', 'can't tell', or 'no'.** **1. Was there a clear statement of the aims of the research?** Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes.

Study details	Methods and participants	Results	Limitations
Country/ies where the study was carried out The Netherlands **Study type** Grounded theory. **Study aims** To identify facilitating factors for case management in dementia care from the perspectives of professionals involved in dementia care. **Study dates** October 2010 to October 2011.	Participants: N=99 (case manager: n=42; GP: n=9; GP nurse: n=1; neurologist/geriatrician: n=14; nurse: n=16; nursing assistant: n=1; project leader: n=9; psychologist: n=2; manager: n=3; lobbyist: n=1; welfare policymaker: n=1). **Data collection and analysis** Data collection One focus group was conducted for each participating regional dementia care network using a web-based application. A topic guide with discussion questions and statements were developed and participants could log in, read others' comments and respond at any point within a 2-week period. Typed responses were automatically transferred to the dataset with transcriptions. <u>Data analysis</u> Transcripts of the focus groups were analysed using an inductive method based on grounded theory and thematic analysis. Open coding, memo writing and constant comparison methods were used and performed independently by 2 researchers initially. Disagreements were discussed until consensus was reached. Categories of facilitating factors were identified and compared with regard to similarities and differences. Mind maps were used and discussed until consensus was reached between the 2 researchers and results were discussed with the research group.	• Case managers were also viewed as facilitators of cooperation, playing an active role in linking stakeholders and promoting case management, in particular to GPs. Good cooperation was reported to include: • *Agreements with the network partners clarifying mutual expectations*: Professionals indicted that making, detailing and honouring agreements with the network partners (documented in a care programme document) was important. • Allocation of tasks among cooperating partners and the job content of case managers were viewed as particularly necessary. • Routes of referral and inter-professional consultations about referrals were also seen to be necessary, and absence of competition between organisations was perceived to be helpful. • *Easy referrals to case management and direct contact*s: Professionals recommended regular contact between case managers and GPs who often make referrals to case management. They mentioned the option to set up a central regional point for applications for case management to ensure the route of referral was clear and case management easy to find for GPs and other professionals. • However, centralisation could hinder direct contact between case managers and other professionals - direct contact was viewed as very important for a smooth and swift referral of service users and for attuning to changing needs of service users. • *Transparency and reciprocity in communication*: Professionals reported	**4. Was the recruitment strategy appropriate to the aims of the research?** Yes, how the service users and case managers were recruited is explained. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are clear and justified, but no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the authors did not discuss their own roles in the formulation of the research questions or consider their influence on the participants. **7. Have ethical issues been taken into consideration?** Yes, ethical approval for the study was not required under the national Dutch legislation, because all participants were competent individuals and the study did not involve interventions or treatments. Participants received written information about the study and data were kept anonymous. **8. Was the data analysis sufficiently rigorous?** Yes, it is clear how themes and sub-themes were derived using constant comparison analysis (based on thematic analysis and grounded theory) and discussions with the research team. **9. Is there a clear statement of findings?** Yes.

Study details	Methods and participants	Results	Limitations
		open and transparent communication and exchange of information between the case manager and other professionals a main factor for good cooperation. • They also highlighted that multi-disciplinary consultation, care plan consultations, discussion, and informal consultations as facilitators of transparency in communication. • Some professionals expressed a preference for the use of pre-existing structures, for example, allowing case managers to use the GP's electronic medical records. • *Broad cooperation within the network on different levels*: Intensive cooperation between primary health care professionals (particularly GPs and case managers) and between primary and secondary health care professionals was reported to be required in the dementia care networks: "We need clear collaboration agreements between care providers in the dementia care network, between general practitioner and case manager, but also between specialist in geriatric medicine or psychologist and case manager. Unfortunately, there is a lot of competition between care providers". (case manager) p.116. • There was also mention of the importance of good cooperation with various care organisations in the network and municipal policy-makers, and that the involvement of informal care organisations and welfare and care administration offices improved the	**10. How valuable is the research?** Valuable. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor limitations. **Source of funding** National Care for the Elderly Programme of The Netherlands Organisation for Health Research and Development (ZonMw-NPO). **Other information** One of the regional networks had experience with organising case management since 1995, 7 networks had started with case management between 2003 and 2008, while 5 networks had started offering case management since 2009 or 2010. 7 networks delivered case management only when there had been a formal diagnosis of dementia, while case management may have started in the pre-diagnosis stage in the remaining 6 networks. In all participating networks, the case managers (nurses or social workers specialised in dementia care) act as a central, trusted contact person, guiding service users and families through the process of care. Face-to-face contacts (mainly at home) are often combined with email or telephone contacts. Frequency of contacts is guided by the needs of the individuals with dementia and their informal carers.

Study details	Methods and participants	Results	Limitations
		chance of successful implementation of case management. <u>Organisational embedding with an independent position of case managers</u> • Professionals considered organisational embedding of the case manager as very important for the implementation of case management. • The independence of case managers was mentioned in terms of case management matching the needs of the person with dementia, and the interests of the person with dementia, and not the interest of the organisation to which case managers belong, should influence the case manager. • Important facilitators of the independence of case managers were reported to be supervision and coaching, transparent working arrangements between the network partners and the absence of competition. Three ways of organisational embedding were identified: • *Multiple providers of case management*: According to the professionals, an important benefit of multiple providers is the variety in expertise and background of the different organisations, which increases options for the service user. This enables case managers to learn from each other, which can improve the quality of their work: "Since case management is broad, you have to be familiar with lots of things like home care, living arrangements and welfare. Thus, it is very desirable	

Study details	Methods and participants	Results	Limitations
		for different organisations to work together. Together, you'll know more!" (case manager) p.117. • However, some participants highlighted that there may be disadvantages of multiple health care providers because the independence of the case manager can be compromised and competition can result in organisations pressuring their case managers to refer service users to their own care organisation. • A further disadvantage of multiple health care providers highlighted by the participants is that there is no central point to contact case managers. • In addition, each organisation has its own way of doing things and this can create diversity in the execution of case management, resulting in confusion about responsibilities and job content of case managers. Continuity of case management can therefore be jeopardised if organisations determine whether they offer or cease to offer case management for reasons such as lack of funding. • *An independent organisation of case managers*: Professionals suggested case managers achieved greatest independence when case management is employed by an independent organisation that has no interest in referring clients to a particular organisation. However, professionals considered a lack of multi-disciplinarity as a potential disadvantage: one case manager expected "... case management to become a separate fragment, while connections [to other	

Study details	Methods and participants	Results	Limitations
		professionals] become very short", p. 117. • *One broad care institute providing case management*: Some professionals preferred case management to be provided by 1 organisation in the network, with perceived benefits including uniform care process and clear referrals. <u>Structural funding</u> • Structural financing was seen as a prerequisite to successfully implementing case management. However, networks used various funding resources and professionals reported some obstacles of the various ways of financing. Professionals therefore considered it important to have funding that is clear in advance and makes case management publicly accessible: "It would be nice that you did not have to think about funding every time you are delivering care. As a professional you should offer the right care at the right time in the right place, independently of the right funding". (case manager) p.118. • Furthermore, structured financing should offer continuity, providing sustainable case management and preserving the relationship between the case manager and service user that has already been established. <u>Competent case managers</u>	

Study details	Methods and participants	Results	Limitations
		• Professionals considered a basic level of knowledge and skills of case managers important: o Communication skills enabling case managers to deal with different people with dementia, informal carers and professionals. o A proactive style of work. o The ability to reflect on their behaviour and knowledge of their own limits. o Analytical capabilities to analyse complex care situations. o Excellent expertise in dementia and informal care. • In addition, it was suggested that case managers should have coaching, assisting and advisory skills, and should be able to work in a multi-disciplinary team. The importance of maintaining levels of expertise and skills by coaching, peer review, training and attending symposia was acknowledged as this enhanced case management. <u>Familiarity with case management in the region</u> • Participants emphasised the importance of GPs and other professionals being familiar with the availability of case management because this was viewed as necessary for promoting referrals and cooperation: "Clients are referred by GPs most of the time. We work together closely with a number of them. Others refer less often. They do not seem to be fully	

Study details	Methods and participants	Results	Limitations
		aware of the opportunities and benefits of case management". (case manager) p. 119.	
Full citation Donnelly, S., Begley, E., O'Brien, M., How are people with dementia involved in care-planning and decision-making? An Irish social work perspective, Dementia: The International Journal of Social Research and Practice, 18, 2985-3003, 2019 **Ref Id** 1222094 **Country/ies where the study was carried out** Ireland **Study type** Phenomenologocial study (as part of a mixed-methods study). **Study aims** To assess older people's involvement in decision-making relating to care planning, focusing on people with a cognitive impairment and dementia. **Study dates** Not reported.	**Recruitment strategy** Participants were recruited from 9 Community Health Organisation areas in Ireland. **Setting** PCCC; Adult Safeguarding; Medical, Psychiatry of Later Life; and Adult Mental Health services. **Participant characteristics** Social workers: N=21 **Data collection and analysis** <u>Data collection</u> In-depth telephone interviews lasted between 40 and 90 minutes. All data were anonymised and related to how older people with dementia are involved in decision-making relating to their care. <u>Data analysis</u> An interpretive inductionist framework was used and analysis also followed an iterative data reduction process (that is, extracting data and grouping in terms of similarities and trends). Convergent themes were identified.	**Findings (including author's interpretation)** <u>No standardised approach to involvement</u> • Social workers identified formal meetings, such as care planning meetings, as a key element of the decision-making process between the person with dementia, their families and HSCPs. • However, there was no standardised practice for this and there were wide variations in how, and if, people were involved. Participants unanimously identified the significance of capacity as influencing the involvement of decision-making and the importance of promoting a person-centred approach: "If a person didn't have capacity, I would try and involve them, or I would advocate on their behalf. There are time implications in involving them, but it is so important to do this. Different professionals have different practices, but overall, there are positive experiences and we would try and follow a person-centred model". (mental health social worker) p.2991. • Social workers recognised that extra time was required to actively involve the person with dementia in decision-making, and different approaches were undertaken by different professionals to determine whether they were involved	**Limitations (assessed using the CASP checklist for qualitative studies). Answer options for each item are 'yes', 'can't tell', or 'no'.** **1. Was there a clear statement of the aims of the research?** Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes. **4. Was the recruitment strategy appropriate to the aims of the research?** Can't tell, insufficient detail provided on recruitment strategy. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are clear and justified, but no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the authors did not discuss their own roles in the formulation of the research questions or consider their influence on the participants. **7. Have ethical issues been taken into consideration?**

Study details	Methods and participants	Results	Limitations
		or not, regardless of their ability or desire to participate: "For the person with dementia an assumption is made based on the MMSE [Mini Mental State Assessment) score whether they can be involved or not ... in principle they should be involved but in practice they are not". (medical social worker) p.2992. • Some social workers referred to the possible tokenistic involvement of people with dementia and that decision-making can take place in a covert manner: "For people with dementia it does tend to be tokenistic ... decisions can't be made against them, but plans are often made behind their backs and they're not really actively involved. They are either 'in' or 'out'". (medical social worker) p.2992. <u>Reasons given for non-involvement</u> • Social workers identified the complexities of dementia as a barrier to participation because, for example, of the longer time it took to ascertain the person's wishes. The current care system was not seen to be supporting autonomy in many cases: "... the elephant in the room is around capacity ... the current approach is too simplistic and the current system is not fit for purpose ... there is no concept of functional capacity at the moment and everything is very medically led. When	Yes, ethical approval for the study was submitted to the Human Research Ethics Committee (Humanities) in the University College Dublin and awarded ethical exemption as research participants were not deemed to be a 'vulnerable' population. **8. Was the data analysis sufficiently rigorous?** Yes, it is clear how themes and sub-themes were derived using an interpretive inductionist framework and following an iterative data reduction process. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the authors discussed limitations of the study, including the generalisability of the findings to contexts other than Ireland, and findings reflecting the perspective of social workers only. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Serious limitations. **Source of funding** No financial support received.

Study details	Methods and participants	Results	Limitations
		they don't have capacity they're not really involved and if they are, it tends to be tokenistic". (community social worker) p.2993. <u>Impact of family members</u> • The interdependency between people with dementia and their family/caregivers was highlighted. The reliance of HSCPs' on family carers to facilitate discharge arrangements and provide care were often the reason why the older person was completely excluded from decision-making. The dominant influence of doctors and consultants was also reported as well as organisational ageism, for example, in the hospital setting: "The social worker talks with the older person about plans, etc. before any discussion with family members. However, doctors don't always follow suit. Rather, they often go directly to the family and by-pass the person. Ageism is rife in the hospital". (medical social worker) p.2993. • However, other social workers reported more positive experiences and received support from the doctors involved. • Social workers recognised the difficulties often experienced in balancing the older person's involvement and needs and preferences with that of their family members. • Where necessary, social workers reported that they referred to existing health care policy and legislation to ensure the person with dementia's	

Study details	Methods and participants	Results	Limitations
		wishes and preferences were adhered to where possible: "Often there can be disagreements between the patient and a family member ... If there is family anxiety relating to an older person remaining at home, I would try and explain things from a human rights perspective and also use the legislation to highlight that an older person can't be detained or sent to a nursing home against their will". (mental health social worker) p.2994. <u>Social workers as advocates</u> • Advocacy was highlighted as being critical for people living with dementia in order to support their views and wishes being identified and upheld. • However, social workers highlighted challenges of acting as an advocate: "In relation to people with dementia, it's much harder to advocate for them as their families are usually more vocal. We would still try to elicit their views and present them to the rest of the team". (community social worker) p.2995. <u>Structures which supported active involvement</u> • Social workers identified time required in family meetings/care planning meetings to fully discuss discharge planning options was a critical factor in supporting the active involvement of	

Study details	Methods and participants	Results	Limitations
		people with dementia in care planning and decision-making processes: "More time for older person to consider options, - often family meetings are rushed to facilitate timely discharge if medically fit". (medical social worker) p.2995. • Social workers identified the importance of flexibility and creativity, reporting that care planning meetings would be held in the home of the person with dementia in order to optimise their participation and involvement. • However, there were practical challenges to involving people living with dementia, including if they became agitated or did not appear to want to be part of discussions. <u>Suggested changes to improve participation</u> • *Adoption of a systems approach*: the importance of adopting a broad systems approach was recognised: "... a good knowledge of family dynamics". (community social worker) p.2996, and a strong therapeutic relationship with the person with dementia was viewed as critical. • Embedding a multi-disciplinary approach which included the person with dementia and their family caregivers was also suggested to be helpful to, for example, formalise care	

Study details	Methods and participants	Results	Limitations
		planning and decision-making. If the person with dementia did not wish to attend the care planning meeting, all care options and decisions considered or reached should be fully discussed with them after the meeting. • The environment was also highlighted as being important, with the hospital setting perhaps not being the most conducive for people with dementia to make decisions. • The number of people in attendance at the care planning meeting as well as the need for pre-meeting preparation were also highlighted as important to enhance a relaxed environment. • *Education and training*: Social workers reported that a lack of knowledge by HSCPs, in conjunction with the absence of clear policies and procedures, directly contributed to people with dementia being excluded. They highlighted the need for increased education and training of HSCPs: "Train all members of MDT regarding the right for older people to be involved in decision-making - perhaps develop a specific policy/procedure that must be adhered to within the hospital. Be clear with families that patients have the right to be involved in all aspects of the decision-making process". (medical social worker) p.2996. • *Cultural change at macro level*: Social workers suggested that adopting a rights-based approach when working with people with dementia required a cultural change and a shift in attitudes at the organisational and societal level was important.	

Study details	Methods and participants	Results	Limitations
		• Social workers also highlighted the importance of legal implementation of advance care directives: "... Need a system where an individual's prior wishes is given legal standing when they are no longer able to make decision, i.e. putting advanced care directives on a legal footing". (community social worker) p.2997.	
Full citation Goodridge, D., Bandara, T., Marciniuk, D., Hutchinson, S., Crossman, L., Kachur, B., Higgins, D., Bennett, A., Promoting chronic disease management in persons with complex social needs: A qualitative descriptive study, Chronic Respiratory Disease, 16, 2019 **Ref Id** 1222731 **Country/ies where the study was carried out** Canada **Study type** General qualitative inquiry. **Study aims** To identify challenges relating to availability, accessibility, and acceptability faced by socially complex people with COPD who were	**Recruitment strategy** Participants who were referred to the CDMP, but declined to participate, were recruited by the LiveWell Nurse Clinicians using a standard recruitment script. LiveWell staff members were recruited, but no further details were provided. **Setting** Saskatoon Health Region. **Participant characteristics** Service users: n=37 (received services from the Case Manager over the 6-month period from April to September 2015) Initerviewed Participants: N=4 patientts (9 agreed to be interviewed, but 5 were lost to follow-up); N=2 Managers; N=1 social work Case Manager <u>Age (years) - median (range)</u> 53 (28 to 78) <u>Gender (male) - n (%)</u> 19 (51.4) <u>Primary medical diagnoses - n (%)</u> COPD: 15 (40.5) COPD and diabetes: 5 (13.5)	**Findings (including author's interpretation)** <u>Contextual and personal influences on CDMP participation</u> • *Poverty*: Poverty (associated with inadequate housing and limited access to supports) was reported to have a profound influence on an individual's capacity to participate in the CDMP. • One of the main causes of missed appointments with health care providers was the lack of financial resources interfering with service users ability to connect with health care providers, particularly where telephones were not available or transportation to appointments could not be afforded or arranged. • *(Dis)ability*: Low levels of general and health literacy were identified as major barriers for a number of service users in attempting to manage their chronic illnesses despite the presence of health care: "I didn't know how to talk to social workers. Like I thought they were all above me and everything and they	**Limitations (assessed using the CASP checklist for qualitative studies). Answer options for each item are 'yes', 'can't tell', or 'no'.** **1. Was there a clear statement of the aims of the research?** Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes. **4. Was the recruitment strategy appropriate to the aims of the research?** Can't tell, how service users were recruited is explained, but details on the recruitment of LiveWell CDMP staff were not provided. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are clear and justified, but no mention of data saturation.

Study details	Methods and participants	Results	Limitations
eligible for a traditional CDMP, but declined participation. **Study dates** April to September 2015.	Diabetes: 16 (43.2) <u>Chronic psychiatric illness - n (%)</u> 10 (27.0) Managers: n=2 Social work case manager: n=1 Focus group with nurse clinicians: n=5 **Data collection and analysis** <u>Data collection:</u> Service user interviews were conducted in their homes or another location of their choice. Interviews were digitally recorded. <u>Data analysis:</u> Interviews were professionally transcribed and coded by a research assistant and doctorally prepared nurse. Theory-driven thematic analysis was used, whereby initial coding involved a parallel, formative process of coding and synthesis using *a priori* theoretical knowledge. Data that did not correspond to theoretical categories were discussed by the team to determine if there was sufficient evidence of patterns across participants to constitute data-driven themes.	controlled my life. I was scared of them". (service user) p.5. • *Personal attitudes and beliefs*: Service users experienced feelings of shame about health conditions or their living circumstances which further isolated them and made it more challenging for providers to care for them. One service user did not fully disclose all of their health conditions to the case manager: "I didn't tell [case manager] at first that I had Hep C and HIV. My daughter did because I was ashamed of it". (service user) p.6. • A lack of trust in other people was highlighted as an important barrier to establishing interpersonal connections needed for people with complex social needs to engage in the CDMP: "You don't feel so pessimistic, or down, or dare I say, sometimes suicidal; sometimes I think about that. You know because what's to look forward to nothing, you know just … grief". (service user). • Hopelessness was also recognised as a key barrier to engaging socially complex persons in the CDMP. However, some service users did demonstrate resourcefulness when they had the ability to improve their health and social isolation. <u>Health system influences on participation in CDMP</u>	**6. Has the relationship between researcher and participants been adequately considered?** No, the authors did not discuss their own roles in the formulation of the research questions or consider their influence on the participants. **7. Have ethical issues been taken into consideration?** Yes, ethical approval for the study was granted by the University of Saskatchewan Behavioural Research Ethics Committee; signed informed consent forms were obtained from all participants. **8. Was the data analysis sufficiently rigorous?** Yes, it is clear how themes and sub-themes were derived using a theory-driven thematic analysis technique. Although the process of coding and synthesis of the data used *a priori* theoretical knowledge. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate limitations. **Source of funding** Canadian Foundation for Healthcare Improvement.

Study details	Methods and participants	Results	Limitations
		• *Availability (the extent to which the health system meets the needs of service users, in conjunction with the level of openness to the participation of underserved groups in the planning and evaluation of those services)*: Service users and health care providers agreed that the existing CDMP did not address the most critical self-identified needs of socially complex people and was therefore of relatively low interest to them. • *Accessibility*: Travelling to providers was repeatedly highlighted as a barrier for people living with social complexity to participate in the CDMP, and a particular challenge for people living with COPD: "These are people who can't leave their house because they are so short of breath even the bus stop is too far. And how can we expect somebody to make an appointment who can't catch a bus ... they're booking off almost an entire day to get through to get to that appointment and back". (case manager) p.6. • A major barrier identified as affecting the ability of service users to care for themselves was inaccessible communication by health care providers and not receiving critical information about their care. This was recognised by a case manager: "Just the way that some of the professionals talk to patients - it's very quick. It's very concise. And they use	**Other information** The LiveWell CDMP consists of individual follow-up, evidence-informed optimisation of management, exercise re-conditioning and pulmonary rehabilitation, support and education and is delivered by specialty-certified nurse clinicians and educators in collaboration with physician directors and other inter-professional members of the health care team. A new role (social work Case Manager position) was introduced into the CDMP to allow for the collection of critical data about socially complex non-participants in CDMP and to attempt to engage this group. N=37 individuals received services from the case manager, n=9 agreed to be interviewed, but n=5 were lost to follow-up (moved or unable to locate).

Study details	Methods and participants	Results	Limitations
		really big words. And that intimidates patients ... that creates a big disconnect between the client and the service. (case manager) p.6. • *Acceptability*: Trust was often an issue and influenced by experiences at the health care system level, including previous negative experiences and perceptions that could affect a service users' willingness to engage in the CDMP: "Before, I used to use [street drugs] and Emergency knew me from that, but they also knew that I quit, and they still treated me like I was a user". (service user), p.7. • The power differential between service providers and service users reinforced and increased the powerlessness felt by service users, with service users reporting dehumanising experiences with health care providers that created long-standing mistrust. • CDMP providers were reported to sometimes adopt a judgemental and dominant approach which presented barriers to engaging people with complex needs. • Even when service users did engage in CDMP programmes, there was reported to be relatively limited understanding on the part of some providers to factors limiting participation: "We have people who are living in poverty and trying to get their next meal, "How am I gonna eat?" And yet we write them off because they don't	

Study details	Methods and participants	Results	Limitations
		show up for an appointment". (case manager) p.7.	
Full citation O'Donnell, D., The case management approach to protecting older people from abuse and mistreatment: lessons from the Irish experience, British Journal of Social Work, 45, 1451-1468, 2015 **Ref Id** 1227265 **Country/ies where the study was carried out** Ireland **Study type** General qualitative inquiry (using a hermeneutic approach). **Study aims** To explore the experiences of social care workers who are responsible for managing case of elder abuse in Ireland, to inform practice. **Study dates** Not reported.	**Recruitment strategy** Purposive sampling was used to recruit senior case workers.[1] **Setting** Each of the 4 HSE administrative regions. **Participant characteristics** Senior case managers (N=16) with over 10 years of social work experience. **Data collection and analysis** <u>Data collection</u> Interviews were conducted using a topic guide, at a convenient time and place to the participant (usually their place of work). With the exception of 1 interview, the remainder were audio recorded. <u>Data analysis</u> Inductive thematic analysis was used, involving open coding from which themes were identified. Collaborative team discussion facilitated further coding and linking of data, which was then translated into an agreed structure incorporating themes and sub-themes.	**Findings (including author's interpretation)** <u>Elder abuse case management</u> • Participants highlighted the importance of gaining appropriate information in the early stages of case management and intervention in order to deliver effective service user centred intervention. "You identify the risks to the older person, you identify the wishes of the older person and based on the risks and the wishes of the older person you formulate a management or a protection plan". (senior case worker) p.1456. • Participants also highlighted the importance of supporting the service user to lead the direction of the intervention and to empower them to take control of their situation. • An important feature of a protection plan was the management of the care situation of the older person which can often include a wide range of services and reduce the older person' isolation, but also for monitoring to take place through communications between care providers and case workers. "... that is a way of knowing whether [an intervention] is working or not. Is this woman coping? Is she refusing services? ... So the care plan is the safety net ... The monitoring is in there	**Limitations (assessed using the CASP checklist for qualitative studies). Answer options for each item are 'yes', 'can't tell', or 'no'.** **1. Was there a clear statement of the aims of the research?** Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes. **4. Was the recruitment strategy appropriate to the aims of the research?** Yes, how social workers were recruited is explained) **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are clear and justified, but no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the authors did not discuss their own roles in the formulation of the research questions or consider their influence on the participants. **7. Have ethical issues been taken into consideration?** Yes, ethical approval was received from the research team's institutional Human

Study details	Methods and participants	Results	Limitations
		plus the feedback". (senior case worker) p.1457. • Participants highlighted that their case management practice was centred around the service user, and where service user's capacity was impaired, the case workers established the best interests of the older person and acted as their advocate. "So my intervention is around talking with the older person, talking to them or explaining options to them, offering them support and following up on what they need me to do". (senior case worker) p.1457. • Participants highlighted the importance of existing relationships between service users and their family members and wider community to minimise the risk of isolation, even where there were concerns regarding the treatment of the older adult. "We would be conscious not to damage some of those relationships because ... if the person becomes ill or dependent and that is the person they are going to go back to for support. So we have to tread carefully". (senior case worker) p.1457. • Key aspects for successful case management included: the increased safety of the service user, the establishment and continual review of a protection plan, a service user centred approach, and also effective inter-agency working (including all relevant	Research Ethics Committee; participants were informed of their rights and protections and signed a consent form. **8. Was the data analysis sufficiently rigorous?** Yes, it is clear how themes and sub-themes were derived using inductive analytical processes and collaborative team discussion. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the authors acknowledge limitations in transferability of the findings to other settings and contexts. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor limitations. **Source of funding** Health Service Executive (as part of a programme of research conducted at the National Centre for the Protection of Older People at University College Dublin). **Other information** [1]Senior case workers in Ireland are specialist elder abuse social workers and case managers.

Study details	Methods and participants	Results	Limitations
		service providers, family members and the older person). • Participants acknowledged the challenge to achieving a positive outcome to an elder abuse case presented by the right to self-determination, but this right still needed to be respected. <u>Practice strategies for overcoming challenges</u> • Participants mentioned valuing service users autonomy and tailoring their case management according to the wishes of the service user who were considered to have capacity. • However, participants also highlighted that tensions could arise with other agencies when trying to balance the wishes of the older person with what other people thought was best for them. "You might be under a fair bit of pressure from your colleagues, like maybe a public health nurse, a home help or a GP ... that famous phrase, 'something must be done' ... And you go along and talk to him but he might still say, 'no I don't want anything' ... you have to respect that as well, if he is able to make that decision". (senior case worker) p.1458. • Participants spoke about difficulties working within a medical environment particularly in relation to their authority to access services for service users. A balance between social work and medical providers was needed to represent better practice for the service	

Study details	Methods and participants	Results	Limitations
		user in terms of implementation of their care plan or intervention. "There is a lack of a clinical pathway for people who are in these sort of social circumstances, social vulnerabilities. Maybe not having had the opportunity to have a medical [diagnostic code for a mental disorder] on their situation and the gatekeepers to services are medicalised (*sic*), it is a dominant medical discourse. And I think in these situations it often needs a balance between the social and the medical". (senior case worker) p.1458. • Participants emphasised awareness raising and effective inter-agency communication as key strategies for overcoming the challenges that arise within and between agencies. "The more I do awareness-raising and training, the more people understand. And I am talking to them and saying ... they have the right to choice, the right to self-determination. And sometimes the choices that they choose are not ones that you or me (*sic*) may feel are the right choice or that, but you have to respect that they have made that choice". (senior case worker) p.1459. • A predominant theme related to challenges faced by participants in managing a demanding caseload with their feelings of working in isolation and overwhelming time demands, and budget and travel restrictions. • Participants reported prioritising according to risk and planned	

Study details	Methods and participants	Results	Limitations
		'geographical visits' to overcome the challenges of working alone and with limited resources: "Sometimes it's kind of a practical matter as well, let's say if you are going to visit a certain area and you have two or three cases there, you kind of tend to maybe deal with them first because you know you can actually go and visit the person". (senior case worker) p.1459. • However, the practicalities of 'geographical visits' also presented challenges in terms of visiting clients in very isolated areas, thereby disadvantaging these service users. <u>Augmenting protective practice</u> • Participants spoke about what they considered to be best social work practice for adult protection. This included placing the service user's wishes at the centre of case management, building up rapport and trust with the service user, and counselling them in decision making. • However, participants highlighted that this remained complex and challenging in practice, emphasising the lack of supportive legislation as contributing to the challenge. • Many participants argued that relevant legislation would reduce some of the challenges associated with the protection of older adults and would support the case workers in terms of balancing concerns for risk with the rights of an individual.	

Study details	Methods and participants	Results	Limitations
		• Participants identified a further challenge in terms of the lack of legislative authority for the role of the senior case worker in terms of their authority to have service users assessed for capacity, and their right to recommend protective services. "Senior case workers for the protection of older people have lots of responsibility but very little authority or legislative framework to back that up. So they are in a double whammy. The expectation is high and the resources or the authority is very, very low". (senior case worker) p.1461. • Many participants also highlighted limited direct access to care services which were a vital aspect of their protection plans and expressed frustration at the lack of authority for their role which presented a barrier to accessing necessary services and to successful inter-agency working. "Well to me the biggest challenge is that we have a policy which suggests that we have more powers than we actually have ... when it comes to actually resource management you don't necessarily get all that much more influence in terms of getting those resources". (senior case worker) p.1461.	
Full citation Redfern, H., Social work and complex care systems: the case of people hospitalised with a	**Recruitment strategy** Purposive sampling to recruit social workers experienced in working with adults living with disabilities. **Setting**	**Findings (including author's interpretation)** <u>Characteristics of Adults with Disabilities Pathway (ADP) that contribute to extended length of stay</u>	**Limitations (assessed using the CASP checklist for qualitative studies). Answer options for each item are 'yes', 'can't tell', or 'no'.**

Study details	Methods and participants	Results	Limitations
disability, Australian Social Work, 69, 27-38, 2016 **Ref Id** 1223072 **Country/ies where the study was carried out** Australia **Study type** General qualitative inquiry. **Study aims** To explore how transitions from acute hospital care to the next-level-of-care could be more effective and efficient in people living with disabilities under the age of 65 years. **Study dates** Not reported.	Queensland tertiary acute care hospital. **Participant characteristics** Social workers: N=5. **Data collection and analysis** <u>Data collection</u> Participants were interviewed for approximately 45 minutes using a semi-structured interview schedule. Interviews were audio recorded and fully transcribed. <u>Data analysis</u> Thematic analysis was undertaken to identify patterns related to case details, common factors contributing to discharge delays and extended length of stay, and social workers' approaches to addressing these issues.	• Social workers identified important factors that impacted on length of stay (for example significant intellectual capacity issues and behavioural management issues such as risk to self or others) through the process of care decisions and care planning. • Examination of these decision-making processes and the experiences around assessment for, and access to, community care were reported to be important. <u>Access to ongoing rehabilitation services</u> • Social workers highlighted the transition from acute care to the next-level-of care in specialised rehabilitation or palliative care as a key factor in extended hospital stay. • Conflicts between service providers were highlighted as contributing to delays with assessment and planning for community care: "It was an ongoing kind of debate between hospital staff and DS [disability services] as to whether the person needed rehab.... But without a clear discharge plan - which couldn't be established until they had gained the most potential they could ... so that DS could look at identifying accommodation and a funding package - none of it could be done". (hospital social worker) p.32. <u>Assessment and planning for community care</u>	**1. Was there a clear statement of the aims of the research?** Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes. **4. Was the recruitment strategy appropriate to the aims of the research?** Yes, how hospital social workers were recruited is explained. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are clear, but no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the authors did not discuss their own roles in the formulation of the research questions or consider their influence on the participants. **7. Have ethical issues been taken into consideration?** Yes, ethical approval was gained from the Hospital Human Research Ethics Committee. **8. Was the data analysis sufficiently rigorous?** Can't tell, themes were derived using thematic analysis, but only limited details were provided.

Study details	Methods and participants	Results	Limitations
		• Delays in decision-making can occur when planning for the next-level-of-care involves assessments by other agencies (for example, rehabilitation facilities, disability services). Social workers reported 3 main issues: o Waiting times for assessment and allocation of suitable funding. o Limited resources allocated. o Lack of options available for the next-level-of care. "I think that sort of wait is unacceptable. And yet you see it regularly ... waiting for Disability Services to come up with the needs assessment, then ... often they'll accept them as a client, but there'll be no funding, so they're still waiting". (social worker commenting on a service user who waited over 3 months for a DS assessment, then 4 months for an Aged Care Assessment Team assessment) p.33. "Funding is a bit thing, number one probably, but it is also housing which is a big issues as well. So when you're dealing with Queensland Health and the Department of Communities, but within that Housing and Disability Services, there's a communication between the three ... one can't happen without the other, because you can't have suitable housing unless Disability feel that they're going to be able to support this person, otherwise they're not going to get this housing and vice versa ... communication between the	**9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the authors acknowledge the limitations of the study in terms of involving only 1 hospital, and the need for further research. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate limitations. **Source of funding** Not reported.

Study details	Methods and participants	Results	Limitations
		departments is the key". (social worker) p.33. • Social workers highlighted factors that can contribute to delays in discharge and discharge plans, including fluctuations in service users functioning whilst waiting for assessments, waiting for modifications to their homes to be completed, and the level of support service users have available through family care. • Longer hospital stays can result in service users becoming more 'institutionalised', making it harder to discharge them into the community. "A very big barrier to progress toward discharge for this patient group is the lack of opportunity for community access. When you have somebody who's stuck in hospital for one year, or even two years, to not provide them as early as possible with the ability to get out of the hospital, off the ward, out of the hospital complex, into the community to experience normal life, to me, is a travesty of their human rights". (social worker) p.33 to 34. <u>Availability of discharge options</u> • Social workers reported frustrations relating to lack of appropriate alternative discharge options, for example, limited availability of group homes and supported accommodation. • They reported that systems used to facilitate decision making for more suitable resource allocation for their	

Study details	Methods and participants	Results	Limitations
		service user group could be overly technocratic. • One social worker reported that the limited resources that were available were often not utilised effectively because assessments constrained flexible decision making. "One client who's still in the hospital, between DCCS [Disability Services] and myself we got some funding so he can attend a day centre ... The NGO [non-government organisation] that runs the centre also has group homes ... and told us ... they had a vacancy waiting to be filled for four months ... The NGO felt our client would be perfect for it. So we tried to ... link our patient into this vacancy ... but were told 'It's just not possible, it's the register of needs ... that will decide who goes into this vacancy' ... There was another vacancy that we found ... and again he couldn't move in because the register of needs wasn't going to allocate him funding, because ... he [would not] be the best fit ... This is very frustrating. There are two places that this man could have moved into and we've lost those opportunities". (social worker regarding discharge destination for a young man with a disability) p.34. • Issues with younger service users included the reduced funding and choice compared to older people who have access to Home and Community Care Services and other aged care supports. • For some young service users with high care needs, access to aged care facilities is not an option.	

Study details	Methods and participants	Results	Limitations
		Strategies that could assist in reducing length of stay Social workers identified various strategies for reducing length of stay: • Early intervention and referral, discussion with families to identify their care expectations and how these might be feasibly and realistically addressed, and referral to DS as early as possible at the time of the service user's admission. • Advocacy at the service user and systems levels was seen as a key role of social work, but to be effective, there was a need to be aware of all options for community care and strong advocacy on the service user's behalf. • However, hospital social workers recognised that advocacy was not always easy because they are required to meet certain organisational demands in relation to flow of people and length of stay. Social workers suggested engagement of external advocacy services as a valuable alternative and involving the service user and their families in collaborative decision-making processes early on, as much as possible, as critical. • Better care coordination and communication across the different service providers was also seen as important for improving practice.	
Full citation Uittenbroek, R. J., van der Mei, S. F., Slotman, K., Reijneveld, S. A., Wynia, K., Experiences of case managers in providing	**Recruitment strategy** All case managers were invited to participate in the study. **Setting**	**Findings (including author's interpretation)** The changing relationship with older adults	**Limitations (assessed using the CASP checklist for qualitative studies). Answer options for each item are 'yes', 'can't tell', or 'no'.** **1. Was there a clear statement of the aims of the research?**

Study details	Methods and participants	Results	Limitations
person-centered and integrated care based on the Chronic Care Model: a qualitative study on embrace, PLoS ONE, 13, e0207109, 2018 **Ref Id** 1224219 **Country/ies where the study was carried out** The Netherlands **Study type** Grounded theory (as part of Embrace RCT). **Study aims** To assess how district nurses and social workers experience their roles as case managers within Embrace, a person-centred and integrated-care service for community-living older adults. **Study dates** Not reported (conducted 15 to 18 months after the Embrace programme began in 2012).	Within the setting of the Embrace RCT, interviews were held in the case manager's office or another place of their choosing. **Participant characteristics** Case managers: N=11 (district nurses: n=6; social workers: n=5). **Social workers** Age (years) - mean (range) 57 (49 to 61) Gender (female) - n (%) 5 (100) **Data collection and analysis** Data collection Face-to-face, in-depth interviews, lasting approximately 107 minutes (between 88 and 122 minutes) were conducted by one researcher. A topic-based interview guide was used, which included open-ended questions relating to key elements of the CCM and case management in general. Interviews were audio recorded and transcribed verbatim. Transcriptions were reviewed for completeness and accuracy by the same researcher who conducted the interviews. Data analysis Data were analysed using a grounded theory approach. Data remained anonymous. Coding of data was performed independently by 2 researchers, and then findings were compared and discussed. Major themes and sub-themes were then identified and discussed between 4 researchers until consensus was reached.	• *Shift to a person-centred approach*: Case managers reported that their roles had changed from being a traditionally task-oriented one to one that was person-centred focused. This enabled case managers to develop long-term relationships with the older adult to enable in-depth and broad views of the older adult's needs and preferences, and to provide individualised and person-centred care and support: "I try to clarify what their concerns are, what is really bothering them, or find out what's on their minds [...]. Furthermore, you really take a look around, how their house is furnished [...]. I often walk with them around the house [...] and, if someone is 85 and can barely walk and has a huge garden, you'll ask, 'Gosh, how do you manage the garden?' Yes, it is all inclusive [...]". (social worker) p.5. • *Building a relationship of trust*: Case managers invested in the relationship with the older adult by taking sufficient time, being attentive, and by keeping their promises. Critical to this was creating a sociable atmosphere to enhance feelings of connectedness and of building a partnership: "[...] it is important because it's also a part of building a relationship of trust. Clients apparently like the social aspect, having a nice time. Well, I do think that this is an important component, but it's certainly not my	Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes. **4. Was the recruitment strategy appropriate to the aims of the research?** Yes, all case managers from the Embrace RCT participated in the qualitative study. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are clear and justified; the authors acknowledged that the small sample size may have limited data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the authors did not discuss their own roles in the formulation of the research questions or consider their influence on the participants. **7. Have ethical issues been taken into consideration?** Yes, ethical approval for the study was assessed by the Medical Ethical Committee of the University Medical Centre Groningen (as part of Embrace), who concluded that their approval was not required. Informed consent from the case

Study details	Methods and participants	Results	Limitations
	Quotes from interviews were returned to participants to be checked for accuracy.	main reason for coming". (social worker) p.6. Establishing the case manager role *Case management* • Case managers highlighted the central elements of case management to provide person-centred and integrated care: • *Proactive and preventive care*: Case managers stressed the need for in-depth knowledge of an older adult's situation in order to detect problems early and provide proactive and preventive care: "[...] even if there aren't any immediately obvious hazardous situations that could be expected. Keeping in contact could have a preventive effect". (social worker) p.6. • *Monitoring*: Monitoring and reviewing older adults' care situations through regular home visits and follow-up telephone calls, were reported as essential. The intensity of monitoring could be adjusted based on needs of the older adults. • *Self-management support*: Case managers reported that one of their aims was to increase older adults' feeling of responsibility for their situation to provide them with insight into their own abilities, foster their sense of power, motivate them to take steps on their own, and ultimately to take control of their own lives.	managers was obtained prior to interviews. **8. Was the data analysis sufficiently rigorous?** Yes, it is clear how themes and sub-themes were derived using a grounded theory approach. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the authors acknowledged the strengths and limitations of the study and the need for further research. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor limitations. **Source of funding** Not reported (the Embrace RCT was funded by the ZonMw). **Other information** Eligible participants were classified according to self-reported complexity of care needs (INTERMED for the Elderly Self-Assessment (INTERMED-E-SA; range 0 to 60, with a higher score indicating more case complexity) and level of frailty (GFI score 0 to 15 with higher scores indicating greater frailty). Frail risk profile (INTERMED-E-SA <16; GFI ≥5); complex care needs risk profile (INTERMED-E-SA ≥16, regardless of GFI score). Only frail older adults will be

Study details	Methods and participants	Results	Limitations
		• *Care coordination*: Case managers highlighted that they were not responsible for care provision, rather they aimed to achieve continuity of care and enhance the independent living of older adults. • *Collaboration*: Case managers perceived themselves as representatives of older adults. Collaboration between elderly care team members was perceived to be satisfactory, with sharing of medical information and discussions around physical functioning leading to a broader perspective on older adults' situations. • Case managers were reported to experience appreciation on the part of the GP, who in turn, had confidence in them. Case managers experienced better access to the GP when it came to discussing the needs of the older adults. *Care and support plan* • There was agreement among case managers suggesting that, although time-consuming, computer-based individual care and support plans were suitable for gaining a complete overview of the older adult's situation. • However, some case managers reported the use of a computer as a barrier to communicating with older adults. • The comprehensive assessment of older adults' situations provided case managers with in-depth insight and helped to establish a basis for the continuation of care. • However, case managers reported that older adults could not always judge the	discussed here as they are case managed by a social worker. Embrace (a person-centred and integrated care and support service with the aim of prolonging the ability of older adults to continue living in their own homes): compromising an elderly care physician, a community nurse (case manager for older adults with risk profile 'complex care needs'), and a social worker (case manager for older adults with the 'frail' risk profile).

Study details	Methods and participants	Results	Limitations
		severity of the problems or how to solve those problems. This was also reflected in terms of annual reviews of the care plan, whereby older adults evaluated their past year's achievements and set new goals. <u>The case manager's toolkit</u> Case managers reported that case management within a person-centred integrated case service requires knowledge and experience, as well as competencies. • *Knowledge and experience*: Case managers agreed that higher vocational education, a basic medical knowledge regarding ageing and the consequences of ageing were needed in order to provide case management. • They also agreed that work experience in the care and support of older adults, and knowledge of local health care organisations and community services, were essential. • *Competencies of case managers*: Communication and collaboration skills (including listening and asking the right questions, understanding implicit messages, and providing feedback) were considered essential. • Skills in motivating and stimulating older adults to improve their self-management abilities and independence were also seen as important. • Observation skills were also reported as essential to enable the detection of existing problems with older adults and to anticipate future ones (including housing situation, physical appearance, personal hygiene, and the mobility of older adults).	

Study details	Methods and participants	Results	Limitations
		• Furthermore, one case manager suggested that it was essential to be flexible and creative in terms of planning activities with older adults to fit with their daily schedules. • *Preconditions for case managers*: Case managers identified certain conditions that enabled them to fulfil their roles, including autonomy, a quiet workplace, training, and support. However, most case managers reported a lack of support from managers from their own organisations. • Case managers also highlighted the usefulness of exchanging experiences with colleagues because of the experimental nature of their role and the uncertainty about how to fulfil it. • *Differences in professional background*: Differences in the roles of social workers and district nurse case managers were highlighted in terms of some social workers being considered to have insufficient medical knowledge and therefore unable to detect older adults' physical problems, and thereby hindering the provision of preventive care. • However, the differences in expertise was also suggested to have potential advantages in the delivery of care. <u>Benefits of case management</u> • Most case managers reported that their role was truly satisfying and had transformed their career. • Case managers believed that older adults viewed them as confidants and they felt that older adults appreciated the personal attention they received,	

Study details	Methods and participants	Results	Limitations
		which provided them with a sense of strength and support. • Case managers reported that acting as 'brokers' made them feel like they were able to make a difference by organising care and support in collaboration with other organisations or professionals.	

ADL: activities of daily living; ADP: adults with disabilities pathway; CASP: critical appraisal skills programme; CCM: chronic care model; CDMP: chronic disease management programme; COPD: chronic obstructive pulmonary disease; DS: disability services; GFI: Groningen Frailty Indicator; GP: general practitioner; HASI: Housing and Accommodation Support Initiative; HIV: human immunodeficiency virus; HSCP: health and social care professionals; HSE: Health Service Executive; INTERMED-E-SA: INTERMED elderly self-assessment; MDT: multi-disciplinary team; MMSE: mini mental state assessment; N: number; NGO: non-government organisations; NIHR: National Institute for Health Research; OW: outreach worker; PA: personal assistant; PCCC: Primary Community and Continuing Care; RCT: randomised controlled trial; R&D: research and development; SSCR: School for Social Care Research; ZonMw: The Netherlands Organisation for Health Research and Development.

Appendix E Forest plots

Forest plots for review question C: What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

No meta-analysis was conducted for this review question and so there are no forest plots.

Appendix F GRADE and GRADE-CERQual tables

GRADE tables for review question C: What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Table 10: Evidence profile for comparison between Housing First and treatment as usual

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	HF	TAU	Relative (95% CI)	Absolute		
Generic QoL (EQ-5D) - difference in mean changes from baseline between age groups (follow-up 12 months; range of scores: 0 to 100; Better indicated by higher values)												
1 (Chung 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	470	1678	-	Adjusted MD 5.8 higher (0.15 to 11.45 higher)[2]	MODERATE	CRITICAL
Generic QoL (EQ-5D) - difference in mean changes from baseline between age groups (follow-up 24 months; range of scores: 0 to 100; Better indicated by higher values)												
1 (Chung 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	470	1678	-	Adjusted MD 1.5 higher (4.13 lower to 7.13 higher)[2]	MODERATE	CRITICAL
Condition-specific QoL (QoLI-20 total score) - difference of mean changes from baseline between age groups (follow-up 12 months; range of scores: 20 to 140; Better indicated by higher values)												
1 (Chung 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	470	1678	-	Adjusted MD 6.36 higher (0.97 to 11.74 higher)[2]	MODERATE	CRITICAL
Condition-specific QoL (QoLI-20 total score) - difference of mean changes from baseline between age groups (follow-up 24 months; range of scores: 20 to 140; Better indicated by higher values)												
1 (Chung 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	470	1678	-	Adjusted MD 6.99 higher (1.39 to 12.59 higher)[2]	MODERATE	CRITICAL

CI: confidence interval; EQ-5D: EuroQoL 5 Dimensions; HF: Housing First; MD: mean difference; QoL: quality of life; QoLI-20: Lehman quality of life interview 20 index; TAU: treatment as usual.

[1] Serious risk of bias in the evidence contributing to the outcomes as per RoB2 (demographic and clinical details differed between younger and older homeless adults receiving HF or TAU; no information relating to blinding of participants and personnel; outcome assessors aware of intervention allocation).
[2] The differences in treatment effectiveness between the age groups were assessed using 3-way interaction models (treatment * time * age). All outcome models were adjusted for study site and need level to consider group differences.

Table 11: Evidence profile for comparison between critical time intervention and care as usual

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CTI	CAU	Relative (95% CI)	Absolute		
General QoL (Lehman's Brief Quality of Life Interview) (follow-up 9 months; Better indicated by lower values)												
1 (de Vet 2017)	randomised trials (multicentre, parallel-group)	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	90	83	-	Adjusted MD 0.21 higher (0.19 lower to 0.60 higher)[3]	LOW	CRITICAL
Access to family and social support - adjusted mean difference - Family support (follow-up 9 months; Better indicated by higher values)												
1 (de Vet 2017)	randomised trials (multicentre, parallel group)	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	84	79	-	Adjusted MD 0.36 higher (0.02 to 0.71 higher)[3]	VERY LOW	CRITICAL
Access to family and social support - adjusted mean difference - Social support (follow-up 9 months; Better indicated by higher values)												
1 (de Vet 2017)	randomised trials (multicentre, parallel group)	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	87	77	-	Adjusted MD 0.27 lower (0.62 lower to 0.08 higher)[3]	LOW	CRITICAL

CAU: care as usual; CI: confidence interval; CTI: critical time intervention; MD: mean difference; QoL: quality of life.

[1] Very serious risk of bias in the evidence contributing to the outcomes as per RoB2 (4 outcomes outlined in the study protocol were not reported in the study publication; the authors stated the reason was to reduce the conceptual overlap between several of the outcome measures and to minimise potential bias resulting from a relatively high amount of missing data on some variables).
[2] 95% CI crosses 1 MID (0.5x control group SD, for outcome family support at 9 months = 0.685).

[3] Intention-to-treat analyses for outcomes adjusted for baseline scores/proportions and organisations.

Table 12: Evidence profile for comparison between case management and usual care

Quality assessment		Effect	Quality	Importance

							No of participants					
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**CM**	**UC**	**Relative (95% CI)**	**Absolute**		
ALSAQ-40 emotional Functioning (follow-up 4 months; range of scores: 0 to 100; Better indicated by lower values)												
1 (Creemers 2014)	randomised trials (cluster RCT)[1]	serious[2]	no serious inconsistency	no serious indirectness	no serious imprecision	none	43	39	-	MD 0.4 higher (6.4 lower to 7.2 higher)[3]	MODERATE	CRITICAL
ALSAQ-40 emotional Functioning (follow-up 8 months; range of scores: 0 to 100; Better indicated by lower values)												
1 (Creemers 2014)	randomised trials (cluster RCT)[1]	serious[2]	no serious inconsistency	no serious indirectness	serious[4]	none	28	22	-	MD 1.5 higher (6.88 lower to 9.88 higher)[3]	LOW	CRITICAL
ALSAQ-40 emotional Functioning (follow-up 12 months; range of scores: 0 to 100; Better indicated by lower values)												
1 (Creemers 2014)	randomised trials (cluster RCT)[1]	serious[2]	no serious inconsistency	no serious indirectness	serious[5]	none	30	27	-	MD 3.7 higher (4.37 lower to 11.77 higher)[3]	LOW	CRITICAL

ALSAQ-40: amyotrophic lateral sclerosis assessment questionnaire 40; CI: confidence interval; CM: case management; MD: mean difference; RCT: randomised controlled trial; UC: usual care.

[1] Cluster RCT (mean difference calculated with design effect sample size adjustment because of cluster RCT study design).
[2] Serious risk of bias in the evidence contributing to the outcomes as per RoB2 (some concerns relating to allocation concealment and blinding).
[3] Adjusted for clustering of data and for significant differences in baseline characteristics of participants between intervention and control group.
[4] 95% CI crosses 1 MID (0.5x control group SD, for outcome ALSAQ-40 QoL at 8 months = 8.05).
[5] 95% CI crosses 1 MID (0.5 x control group SD, for outcome ALSAQ-40 QoL at 12 months = 7.35).

Table 13: Evidence profile for comparison between transitional case management and treatment as usual

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**TCM**	**TAU**	**Relative (95% CI)**	**Absolute**		
Ambulatory care contact (follow-up 1 month)												

1 (Bonsack 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	51	51	-	p=0.372[3]	VERY LOW	CRITICAL
Ambulatory care contact (follow-up 3 months; Better indicated by higher values)												
1 (Bonsack 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	51	51	-	MD 0.86 higher (0.33 to 1.39 higher)	LOW	CRITICAL
Rate of hospital readmission (follow-up 12 months)												
1 (Bonsack 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	51	51	-	Adjusted HR 0.583 lower (0.300 lower to 1.132 higher); p=0.111 Cohen's *d* = 0.64 (medium effect)	LOW	IMPORTANT

CI: confidence interval; HR: Hazard Ratio; MD: mean difference; TAU: treatment as usual; TCM: transitional case management.

[1] Serious risk of bias in the evidence contributing to the outcomes as per RoB2.
[2] Very serious imprecision; sample size below 200 (this outcome is only reported as a p-value for which there are no GRADE MIDs, the imprecision ratings were undertaken by using the optimum information size so that if the total n≥400, then the quality was not downgraded, if n=200-399, then the quality was downgraded by 1 level and if the total n<200, then the quality was downgraded by 2 levels).
[3] For outcomes using data from p-values it was not possible to calculate absolute effect, therefore summary statistics or narrative results are reported.
[4] 95% CI crosses 1 MID (0.5x control group SD for outcome access to appropriate support = 0.645).
[5] 95% CI crosses 1 MID (0.8 and 1.25 thresholds for HRs are measures made by the NGA and are not 'GRADE default MIDs').

Table 14: Evidence profile for comparison between case management and treatment as usual

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CM	TAU	Relative (95% CI)	Absolute		
Use of health and social care (follow-up 6 months)												
1 (Lindahl 2013)	randomised trials (multicentre)	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	13	21	-	RR 0.32 higher (0.04 lower to 2.47 higher)	VERY LOW	CRITICAL
Use of medical assisted treatment (follow-up 6 months)												
1 (Lindahl 2013)	randomised trials (multicentre)	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	13	21	-	p=0.46[4]	VERY LOW	IMPORTANT
Use of institutional/inpatient care (follow-up 6 months)												
1 (Lindahl 2013)	randomised trials (multicentre)	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	13	21	-	p=0.27[4]	VERY LOW	IMPORTANT

CI: confidence interval; CM: case management; RR: risk ratio; TAU: treatment as usual.

[1] Very serious risk of bias in the evidence contributing to the outcomes as per RoB2 (no information provided on blinding or appropriateness of statistical analysis; the authors stated that follow-up interviews were performed at 6 and 12 months following discharge, but data were only reported at 6 months).
[2] 95% CI crosses 2 MIDs.
[3] Very serious imprecision; sample size below 200 (this outcome is only reported as a p-value for which there are no GRADE MIDs, the imprecision ratings were undertaken by using the optimum information size so that if the total n≥400, then the quality was not downgraded, if n=200-399, then the quality was downgraded by 1 level and if the total n<200, then the quality was downgraded by 2 levels).
[4] For outcomes using data from p-values it was not possible to calculate absolute effect, therefore summary statistics or narrative results are reported.

Table 15: Evidence profile for comparison between Patient Advocate Crisis plan and no crisis plan

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	PACP	No crisis plan	Relative (95% CI)	Absolute		
Rate of psychiatric hospital admission (follow-up 18 months)												
1 (Ruchlewska 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	33/69 (47.8%)	33/73 (45.2%)	RR 1.06 (0.74 to 1.51)	27 more per 1000 (from 118 fewer to 231 more)	VERY LOW	IMPORTANT
Rate of emergency admission (follow-up 18 months)												
1 (Ruchlewska 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12/69 (17.4%)	14/73 (19.2%)	RR 0.91 (0.45 to 1.82)	17 fewer per 1000 (from 105 fewer to 157 more)	VERY LOW	IMPORTANT
Rate of emergency visits (follow-up 18 months)												
1 (Ruchlewska 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	22/69 (31.9%)	25/73 (34.2%)	RR 0.93 (0.58 to 1.49)	24 fewer per 1000 (from 144 fewer to 168 more)	VERY LOW	IMPORTANT
Voluntary admissions (follow-up 18 months)												
1 (Ruchlewska 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	16/69 (23.2%)	12/73 (16.4%)	RR 1.41 (0.72 to 2.76)	67 more per 1000 (from 46 fewer to 289 more)	VERY LOW	IMPORTANT
Court ordered admissions (follow-up 18 months)												
1 (Ruchlewska 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	11/69 (15.9%)	19/73 (26%)	RR 0.61 (0.31 to 1.19)	102 fewer per 1000 (from 180 fewer to 49 more)	VERY LOW	IMPORTANT

CI: confidence interval; PACP: Patient Advocate Crisis Plan; RR: risk ratio.

[1] Very serious risk of bias in the evidence contributing to the outcomes as per RoB2 (no information provided on blinding; deviations from intended intervention with imbalance across intervention groups).
[2] 95% CI crosses 2 MIDs.
[3] 95% CI crosses 1 MID.

Table 16: Evidence profile for comparison between Patient Advocate Crisis plan and Clinician facilitated Crisis Plan

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	PACP	CCP	Relative (95% CI)	Absolute		
Rate of psychiatric hospital admission (follow-up 18 months)												
1 (Ruchlewska 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	33/69 (47.8%)	24/70 (34.3%)	RR 1.39 (0.93 to 2.10)	134 more per 1000 (from 24 fewer to 377 more)	VERY LOW	IMPORTANT
Rate of emergency admission (follow-up 18 months)												
1 (Ruchlewska 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	12/69 (17.4%)	7/70 (10%)	RR 1.74 (0.73 to 4.15)	74 more per 1000 (from 27 fewer to 315 more)	VERY LOW	IMPORTANT
Rate of emergency visits (follow-up 18 months)												
1 (Ruchlewska 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	22/69 (31.9%)	22/70 (31.4%)	RR 1.01 (0.62 to 1.65)	3 more per 1000 (from 119 fewer to 204 more)	VERY LOW	IMPORTANT
Voluntary admissions (follow-up 18 months)												
1 (Ruchlewska 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	16/69 (23.2%)	14/70 (20%)	RR 1.16 (0.61 to 2.19)	32 more per 1000 (from 78 fewer to 238 more)	VERY LOW	IMPORTANT
Court ordered admissions (follow-up 18 months)												
1 (Ruchlewska 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	11/69 (15.9%)	7/70 (10%)	RR 1.59 (0.66 to 3.87)	59 more per 1000 (from 34 fewer to 287 more)	VERY LOW	IMPORTANT

CCP: Clinician facilitated Crisis Plan; CI: confidence interval; PACP: Patient Advocate Crisis Plan; RR: risk ratio.

[1] Very serious risk of bias in the evidence contributing to the outcomes as per RoB2 (no information provided on blinding; deviations from intended intervention with imbalance across intervention groups).
[2] 95% CI crosses 1 MID.
[3] 95% CI crosses 2 MIDs.

GRADE-CERQual tables for review question C: Based on the views and experiences of everyone involved, what works well and what can be improved about case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Overarching theme C1 – What works well

Table 17: Evidence profile (GRADE-CERQual) for theme C1.1: Positive aspects of case management and care planning and what works well

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Sub-theme C1.1.1: Relationships						
4 studies • Archard 2015 Exploratory, general qualitative inquiry. N=4 people experiencing homelessness receiving specialised psychological trauma services. • Biringer 2017 Hermeneutic-phenomenological study. N=10 health and welfare service users (n=8 at 2 year follow-up). • O'Donnell 2015 General qualitative inquiry (using a hermeneutic approach). N=10 senior case managers working with older adults to protect them from abuse. • Uittenbroek 2018 Grounded theory (as part of Embrace RCT). N=11 case managers providing person-centred and integrated care based on the CCM.	Data from 4 studies highlighted some of the benefits experienced by people using services through the involvement of case managers. These included time spent together discussing issues most relevant to people, building relationships to enhance trust and feelings of safety, and counselling service users in decision-making. For example, ""[...] it is important because it's also a part of building a relationship of trust. Clients apparently like the social aspect, having a nice time. Well, I do think that this is an important component, but it's certainly not my main reason for coming" (social worker). [Uittenbroek 2018, p.6].	Minor concerns[1]	No or minor concerns	Moderate concerns[2]	Minor concerns[3]	LOW
Sub-theme C1.1.2: Respect and dignity						

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
2 studies • Archard 2015 Exploratory, general qualitative inquiry. N=4 people experiencing homelessness receiving specialised psychological trauma services. • O'Donnell 2015 General qualitative inquiry (using a hermeneutic approach). N=10 senior case managers working with older adults to protect them from abuse.	Data from 2 studies indicated the positive role and qualities of case managers in terms of being non-judgemental and respecting the wishes of service users. For example, "I found it very useful to talk to them ... because they sat and listened and the [shelter] staff don't always have the time, haven't always got the time to sit and listen to us" (person using services). [Archard 2015, p.363].	Minor concerns[4]	No or minor concerns	Moderate concerns[5]	Minor concerns[6]	LOW
Sub-theme C1.1.3: Collaboration						
3 studies • Dadich 2013 General qualitative inquiry. N=20 service users with chronic mental illness. • de Lange 2018 Grounded theory. N=99 professionals involved in case management within the regional dementia networks. • O'Donnell 2015 General qualitative inquiry (using a hermeneutic approach). N=10 senior case managers working with older adults to protect them from abuse.	Data from 3 studies highlighted the impact that working relationships could have on case management, particularly in terms of inter-agency working (including all relevant service providers, family members and the service user). For example, "[The two case managers] work better together. The more people, the better the brainstorming and the better the result" (person using services). [Dadich 2013, p.486]. Professionals considered organisational embedding of the case manager as very important for the implementation of case management, with successful embedding involving: Multiple providers of case management; an independent organisation of case managers; one broad care institute providing case management. For example, "Since case management is broad, you have to be familiar with lots of things like home care, living arrangements and welfare. Thus, it is very desirable for different organisations to	Minor concerns[7]	No or minor concerns	Minor concerns[8]	Minor concerns[9]	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of findings**	**Adequacy of data**	**Relevance of evidence**	**Overall confidence**
	work together. Together, you'll know more!" (Case manager). [de Lange 2018, p.117].					
Sub-theme C1.1.4: Knowledge						
1 study • Biringer 2017 Hermeneutic-phenomenological study. N=10 health and welfare service users (n=8 at 2 year follow-up).	Data from 1 study suggested that people using services benefited from understanding their situations (in terms of knowing what is happening and what is going to happen in the future) and receiving information regarding meetings and support interventions in good time. [No quotes provided].	No or minor concerns[10]	No or minor concerns	Serious concerns[11]	Minor concerns[12]	LOW

CCM: Chronic Care Model RCT: randomised controlled trial.
[1] No or minor concerns (Biringer 2017) and minor concerns (Archard 2015, O'Donnell 2015, Uittenbroek 2018) about methodological limitations as per CASP qualitative checklist.
[2] Studies together did not offer rich data.
[3] Some evidence is from a substantially different context to the review question (Archard 2015, Biringer 2017, Uittenbroek 2018 - not exclusively social work approach to case management and care planning).
[4] Minor concerns (Archard 2015, O'Donnell 2015) about methodological limitations as per CASP qualitative checklist.
[5] Studies together did not offer rich data.
[6] Some evidence is from a substantially different context to the review question (Archard 2015 - not clear whether specifically case management and care planning approach).
[7] Minor concerns (Dadich 2013, de Lange 201, O'Donnell 2015) about methodological limitations as per CASP qualitative checklist.
[8] Studies together offered moderately rich data.
[9] Some evidence is from a substantially different context to the review question (Dadich 2013, de Lange 2018 - not clear whether exclusively social work approach to case management and care planning).
[10] No or minor concerns about methodological limitations as per CASP qualitative checklist.
[11] Study did not offer rich data.
[12] Some evidence is from a substantially different context to the review question (Biringer 2017 - not exclusively social work approach to case management and care planning).

Table 18: Evidence profile (GRADE-CERQual) for theme C1.2: The extent to which case management and care planning consider professional and informal supporters and environment

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Sub-theme C1.2.1: Family support						
2 studies • Donnelly 2019 Phenomenological study (as part of a mixed-methods study). N=21 social workers involved with care planning and decision-making, working with adults with dementia. • O'Donnell 2015 General qualitative inquiry (using a hermeneutic approach). N=10 senior case managers working with older adults to protect them from abuse.	Data from 2 studies highlighted the importance of existing relationships between people and their family members and carers to help with, for example, care planning and decision-making, and for social workers to gain "... a good knowledge of family dynamics" (community social worker) [Donnelly 2019, p.2996]. Data from the 2 studies also highlighted the importance of the wider community to also help minimise the risk of service user isolation, even where there were concerns regarding the treatment of the person. For example, "We would be conscious not to damage some of those relationships because ... if the person becomes ill or dependent and that is the person they are going to go back to for support. So we have to tread carefully" (senior case worker). [O'Donnell 2015, p.1457].	Moderate concerns[1]	No or minor concerns	Moderate concerns[2]	No or minor concerns	LOW
Sub-theme C1.2.2: Advocacy						
4 studies • Abendstern 2019 General qualitative inquiry (forming part of a larger mixed-methods study). Practitioners working with older adults in adult social care, brokerage, hospital discharge support, and specialist dementia advice and support services. • Donnelly 2019	Data from 4 studies highlighted a key role of case managers in terms of acting as advocates for service users to ensure that the person's best interests are considered, particularly where capacity was impaired. For example, "So my intervention is around talking with the older person, talking to them or explaining options to them, offering them support and following up on what they need me to do" (senior case worker). [O'Donnell 2015, p.1457]. However, the provision of advocacy varies across different services. To be effective, it was suggested that case managers needed to be aware of all options for community care. Social workers recognised that advocacy was not always easy because they are	Moderate concerns[3]	No or minor concerns	Minor concerns[4]	No or minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Phenomenological study (as part of a mixed-methods study). N=21 social workers involved with care planning and decision-making, working with adults with dementia. • O'Donnell 2015 General qualitative inquiry (using a hermeneutic approach).. N=10 senior case managers working with older adults to protect them from abuse. • Redfern 2016 General qualitative inquiry. N=5 social workers working with people living with disabilities.	required to meet certain organisational demands. For example, 'In relation to people with dementia, it's much harder to advocate for them as their families are usually more vocal. We would still try to elicit their views and present them to the rest of the team" (community social worker). [Donnelly 2019, p.2995]. Social workers suggested engagement of external advocacy services as a valuable alternative and involving the person and their families in collaborative decision-making processes early on, as much as possible, as critical.					

[1] *Minor concerns (O'Donnell 2015) and moderate concerns (Donnelly 2019) about methodological limitations as per CASP qualitative checklist.*
[2] *Studies together did not offer rich data.*
[3] *Minor concerns (Abendstern 2019, O'Donnell 2015) and moderate concerns (Donnelly 2019, Redfern 2016) about methodological limitations as per CASP qualitative checklist.*
[4] *Studies together offered moderately rich data.*

Table 19: Evidence profile (GRADE-CERQual) for theme C1.3: Perception about the impact of case management and care planning in meeting needs

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Sub-theme C1.3.1: Assessments						
4 studies ● Abendstern 2019 General qualitative inquiry (forming part of a larger mixed-methods study). Practitioners working with older adults in adult social care, brokerage, hospital discharge support, and specialist dementia advice and support services. ● O'Donnell 2015 General qualitative inquiry (using a hermeneutic approach).. N=10 senior case managers working with older adults to protect them from abuse. ● Redfern 2016 General qualitative inquiry. N=5 social workers working with people living with disabilities. ● Uittenbroek 2018 Grounded theory (as part of Embrace RCT). N=11 case managers providing person-centred and integrated care based on the CCM.	Data from 4 studies highlighted the importance of undertaking comprehensive assessments to gain an in-depth insight into person's circumstances and complexity of needs, in order to tailor a support plan to their needs and set of circumstances, particularly if there are significant intellectual capacity issues. For example, "You identify the risks to the older person, you identify the wishes of the older person and based on the risks and the wishes of the older person you formulate a management or a protection plan" (senior case worker). [O'Donnell 2015, p.1456]. "I try to clarify what their concerns are, what is really bothering them, or find out what's on their minds [...]. Furthermore, you really take a look around, how their house is furnished [...]. I often walk with them around the house [...] and, if someone is 85 and can barely walk and has a huge garden, you'll ask, 'Gosh, how do you manage the garden?' Yes, it is all inclusive [...] (social worker). [Uittenbroek 2018, p.5]. However, the focus of assessments varied dependent on the target group of different service providers. Brokerage services supporting people with complex needs undertook assessments in terms of a 'checking' nature, for example "We don't assess as such ... I would read that assessment prior to the visit but I wouldn't use that as my benchmark ... I would start from the beginning with the client and ask what they felt they need" (Respondent 1; brokerage services). [Abendstern 2019, p.437]. Adult social care services supporting people with complex needs were reported to undertake more comprehensive assessments. Specialist dementia	Moderate concerns[1]	No or minor concerns	Minor concerns[2]	Minor concerns[3]	LOW

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
	services providing support to people with low level and complex needs were described as conducting 'holistic' assessments, touching on a wide range of areas in an individual's life.					
Sub-theme C1.3.2: Choice and flexibility						
3 studies ● Abendstern 2019 General qualitative inquiry (forming part of a larger mixed-methods study). Practitioners working with older adults in adult social care, brokerage, hospital discharge support, and specialist dementia advice and support services. ● Biringer 2017 Hermeneutic-phenomenological study. N=10 health and welfare service users (n=8 at 2 year follow-up). ● Uittenbroek 2018 Grounded theory (as part of Embrace RCT). N=11 case managers providing person-centred and integrated care based on the CCM.	Data from 3 studies emphasised the importance of person-centred and strength-based approaches, focusing on strengths and needs of service users to enhance their independence and self-determination to undertake things for themselves. For example, "They are totally superb because they concentrate on you as a person in relation to 'What do you want? What do you wish to happen? What can we help you with?' [...] Everybody was at the meeting and just [said] 'OK, now we're here for you.' And you feel completely overwhelmed. Four people sitting around me and just talking about you [me] and [saying] 'Yes, what can we fix for you?' and so on. So, it has been very good. I have only positive things to say about both 'NAV' and the doctor and the cooperation there ..." (Participant 10 at follow-up). [Biringer 2017, p.10 to 11]. Providing people with a variety of options seemed to improve the impact of case management and care planning. This was achieved through the provision of information and advice and helping people to implement their own support plan by signposting then to a range of relevant services and agencies to which they could refer themselves. For example, "Talk me through your day. So that isn't focusing on any negatives because during that day, people will say what they can do ... We have a conversation about somebody's day and from that conversation we usually determine what support the individual will require to meet their needs" (respondent 9). [Abendstern 2019, p.440].	Minor concerns[4]	No or minor concerns	Minor concerns[5]	Minor concerns[6]	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Sub-theme C1.3.3: Continuity of care						
3 studies • Abendstern 2019 General qualitative inquiry (forming part of a larger mixed-methods study). Practitioners working with older adults in adult social care, brokerage, hospital discharge support, and specialist dementia advice and support services. • O'Donnell 2015 General qualitative inquiry (using a hermeneutic approach).. N=10 senior case managers working with older adults to protect them from abuse. • Uittenbroek 2018 Grounded theory (as part of Embrace RCT). N=11 case managers providing person-centred and integrated care based on the CCM.	Data from 3 studies suggested that continuity of care made an important contribution to perceptions about whether needs are met. For example, having a named care worker was valuable for a person's sense of comfort and security. For example, "It might take five weeks before you are getting to know somebody so it is better for that person if they have got one person going" (respondent 6). [Abendstern 2019, p.439]. However, this varied across different services with some services providing continuity of care from referral onwards, but other services, such as hospital settings providing continuity of care from the first home visit. Continuity in terms of monitoring and reviewing peoples' care plans and situations through regular communications were also reported as essential. For example, "... that is a way of knowing whether [an intervention] is working or not. Is this woman coping? Is she refusing services? ... So the care plan is the safety net ... The monitoring is in there plus the feedback" (senior case worker). [O'Donnell 2015, p.1457]. Practitioners recognised the importance for people to perceive there was continuity and ongoing monitoring for their changing needs. Adult social care and brokerage services described a workload management system whereby cases that were inactive but might require future input were closed and people were not informed of their case closure. Service users were reported to prefer this approach. For example, "We'll reach a point where we have to just close that on the system … I normally send a letter … don't forget that we're here if you need us … So that they feel that … that door is always open and I haven't used the dreaded phrase, case closed. But it is as far as we're concerned internally" (Respondent 6; adult	Minor concerns[1]	No or minor concerns	Minor concerns[2]	Minor concerns[3]	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
	social care and brokerage services). [Abendstern 2019, p.439].					
Sub-theme C1.3.4: Identifying needs						
3 studies • Biringer 2017 Hermeneutic-phenomenological study. N=10 health and welfare service users (n=8 at 2 year follow-up). • Carver 2012 General qualitative inquiry. N=12 Lothian Keep Well staff and N=4 service users receiving support from an outreach worker. • Dadich 2013 General qualitative inquiry. N= 20 service users with chronic mental illness.	Data from 3 studies highlighted benefits experienced by people when they felt that professionals were reliable and available whenever something came up. People also experienced benefits from being involved in decision-making about their care plan and able to articulate their needs, goals and strategies to achieve these. For example, "I say what I think, they say what they think, and then we come to a mutual understanding - I don't feel like I'm just there" (service user). "We know where we're going ... It makes the big picture more obvious and reduces an ad hoc approach" (non-clinical case manager). [Dadich 2013, p.485]. The support provided by case managers was viewed by people as beneficial in encouraging them to improve their health and lives. It was suggested that case managers were providing people with support they "might not have got elsewhere" (OW) [Carver 2012, p.S49], that is, case managers were dealing with previously unmet needs.	Moderate concerns[7]	No or minor concerns	Minor concerns[8]	Minor concerns[9]	LOW

CCM: Chronic Care Model; OW: outreach worker; RCT: randomised controlled trial.
[1] Minor concerns (Abendstern 2019, O'Donnell 2015, Uittenbroek 2018) and moderate concerns (Redfern 2016) about methodological limitations as per CASP qualitative checklist.
[2] Studies together offered moderately rich data.
[3] Some evidence is from a substantially different context to the review question (Abenstern 2019 - some services provided support to individuals with low level needs; Uittenbroek 2018 - not exclusively social work approach to case management and care planning).
[4] Minor concerns (Abendstern 2019, Biringer 2017, Uittenbroek 2018) about methodological limitations as per CASP qualitative checklist.
[5] Studies together offered moderately rich data.
[6] All evidence is from a substantially different context to the review question (Abenstern 2019 - some services provide support to individuals with low level needs; Biringer 2017, Uittenbroek 2018 - not exclusively social work approach to case management and care planning).
[7] Minor concerns (Biringer 2017 and Dadich 2013) and moderate concerns (Carver 2012) about methodological limitations as per CASP qualitative checklist.
[8] Studies together offered moderately rich data.
[9] All evidence is from a substantially different context to the review question (Biringer 2017, Carver 2012, Dadich 2013 - unclear whether specifically social work approaches to case management or care planning).

Table 2021: Evidence profile (GRADE-CERQual) for theme C1.4: Practitioner satisfaction with case management and care planning

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Sub-theme C1.4.1: Collaboration						
3 studies • Dadich 2013 General qualitative inquiry. N= 20 service users with chronic mental illness. • de Lange 2018 Grounded theory. N=99 professionals involved in case management within the regional dementia networks. • Uittenbroek 2018 Grounded theory (as part of Embrace RCT). N=11 case managers providing person-centred and integrated care based on the CCM.	Data from 3 studies emphasised the importance of cooperation and collaboration between service providers to enhance case management, promote integration of care, and meet the needs of people. For example, "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). [Dadich 2013, p.486]. "We need clear collaboration agreements between care providers in the dementia care network, between general practitioner and case manager, but also between specialist in geriatric medicine or psychologist and case manager. Unfortunately, there is a lot of competition between care providers (Case manager). [de Lange 2018, p.116]. Collaboration was often perceived to be satisfactory, with sharing of medical information and discussions around physical functioning leading to a broader perspective on a person's situations. Case managers experienced better access to the GP when it came to discussing the needs of the person. For example, "Clients are referred by GPs most of the time. We work together closely with a number of them. Others refer less often. They do not seem to be fully aware of the opportunities and benefits of case management" (Case manager). [de Lange 2018, p.119].	Minor concerns[1]	No or minor concerns	Minor concerns[2]	Minor concerns[3]	MODERATE
Sub-theme C1.4.2: The key role of case managers						
3 studies • Carver 2012	Data from 3 studies highlighted the role of social work case managers in terms of linking services and allowing people to utilise these services. For example, "I see the outreach worker as kinda	Moderate concerns[4]	No or minor concerns	Minor concerns[5]	Minor concerns[6]	LOW

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
General qualitative inquiry. N=12 Lothian Keep Well staff and N=4 service users receiving support from an outreach worker. • de Lange 2018 Grounded theory. N=99 professionals involved in case management within the regional dementia networks. • Uittenbroek 2018 Grounded theory (as part of Embrace RCT). N=11 case managers providing person-centred and integrated care based on the CCM.	being the conduit for that they have the information maybe like a wee bit of a catalyst and bringing the person together with what is already available that can meet their needs and I suppose if there's something that's not available for somebody's needs then it would be the outreach worker that would be kinda highlighting there's a bit of a gap in services" (Project nurse). [Carver 2012, p.S50]. Data from the 3 studies also highlighted the essential skills and competencies required for successful case management, including, for example, communication skills, higher vocational education and basic medical knowledge, being approachable, flexible, non-judgemental, respectful and helpful. Most case managers reported that their role was truly satisfying and had transformed their career. Case managers reported that acting as 'brokers' made them feel like they were able to make a difference by organising care and support in collaboration with other organisations or professionals.					
Sub-theme C1.4.3: Working arrangements						
2 studies • Archard 2015 Exploratory, general qualitative inquiry. N=4 people experiencing homelessness receiving specialised psychological trauma services. • Uittenbroek 2018 Grounded theory (as part of Embrace RCT). N=11 case managers providing person-	Data from 2 studies identified certain conditions that enabled case managers to fulfil their roles, including autonomy, a quiet workplace, training, and support (although most case managers reported a lack of support from managers from their own organisations). A flexible approach to working because of the independence of case managers was also reported to be beneficial in terms of the freedom they had to work outside usual office hours and away from the office. The lack of administrative and technological constraints resulting from this contrasted with excessively bureaucratic practices reported to exist in the	Minor concerns[7]	No or minor concerns	Serious concerns[8]	Minor concerns[9]	LOW

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
centred and integrated care based on the CCM.	wider health and social care field. [No relevant quotes provided].					

CCM: Chronic Care Model; OW: outreach worker; RCT: randomised controlled trial.
[1] Minor concerns (Dadich 2013, de Lange 2018, Uittenbroek 2018) about methodological limitations as per CASP qualitative checklist.
[2] Studies together offered moderately rich data.
[3] All evidence is from a substantially different context to the review question (Dadich 2013, de Lange 2018, Uittenbroek 2018 - not clear whether exclusively social work approach to case management and care planning).
[4] Minor concerns (de Lange 2018, Uittenbroek 2018) and moderate concerns (Carver 2012) about methodological limitations as per CASP qualitative checklist.
[5] Studies together offered moderately rich data.
[6] All evidence is from a substantially different context to the review question (Carver 2012, de Lange 2018, Uittenbroek 2018 - unclear whether specifically social work approaches to case management or care planning) to the review question.
[7] Minor concerns (Archard 2015, Uittenbroek 2018) about methodological limitations as per CASP qualitative checklist.
[8] Studies together did not offer rich data.
[9] All evidence is from a substantially different context to the review question (Archard 2015, Uittenbroek 2018 - not clear whether specifically case management or not exclusively social work approach to case management and care planning)

Overarching theme C2 – What could be improved

Table 22 Evidence profile (GRADE-CERQual) for theme C2.1: Issues related to accessing case management and care planning including ongoing review

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Sub-theme C2.1.1: Barriers to involvement						
2 studies • Dadich 2013 General qualitative inquiry. N= 20 service users with chronic mental illness. • Goodridge 2019 General qualitative inquiry. N=37 adults with chronic diseases and complex social needs; N=8 Livewell staff (including n=1 social work case manager).	Data from 2 studies indicated that a lack of trust in other people could act as a barrier to adults with complex social needs engaging with case management and care. People could often feel disengaged from planning when they believed 2 case managers were working very closely and effectively excluding them. For example, "[They] said things that I didn't understand. But I'm not qualified to understand what they were talking about" (person using services). [Dadich 2013, p.486]. Low levels of general and health literacy could also act as a barrier for some people in terms of managing their health conditions, highlighting the need for accessible communications between case managers and adults using services. For example, "I didn't know how to talk to social workers. Like I thought they were all above me and everything and they controlled my life. I was scared of them" (person using services). [Goodridge 2019, p.5].	Moderate concerns[1]	No or minor concerns	Moderate concerns[2]	Minor concerns[3]	LOW
Sub-theme C2.1.2: The influence of subject feelings and experiences						
2 studies • Dadich 2013 General qualitative inquiry. N= 20 service users with chronic mental illness. • Goodridge 2019 General qualitative inquiry. N=37 adults with	Data from 2 studies suggested that a person's circumstances could influence access to and participation with services. Barriers included poverty (associated with inadequate housing and limited access to support), which in turn could result in people feeling shame about health conditions or their living circumstances, which further isolated them and made it more challenging for providers to support them.	Moderate concerns[1]	No or minor concerns	Minor concerns[4]	Minor concerns[3]	LOW

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
chronic diseases and complex social needs; N=8 Livewell staff (including n=1 social work case manager).	Feelings of hopelessness about their health and circumstances were also recognised as a key barrier to engaging individuals with socially complex needs with interventions. For example, "You don't feel so pessimistic, or down, or dare I say, sometimes suicidal; sometimes I think about that. You know because what's to look forward to nothing, you know just … grief" (person using services). [Goodridge 2019, p.6].					

[1] *Minor concerns (Dadich 2013) and moderate concerns (Goodridge 2019) about methodological limitations as per CASP qualitative checklist.*
[2] *Studies together did not offer rich data.*
[3] *All evidence is from a substantially different context (Dadich 2013, Goodridge 2019 - not clear whether exclusively social work approach to case management and care planning) to the review question.*
[4] *Studies together offered moderately rich data.*

Table 23: Evidence profile (GRADE-CERQual) for theme C2.2: The extent to which case management and care planning consider professional and informal supporters and environment

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Sub-theme C2.2.1: The role of family and wider support						
2 studies ● Donnelly 2019 Phenomenological study (as part of a mixed-methods study). N=21 social workers involved with care planning and decision-making, working with adults with dementia. ● Redfern 2016 General qualitative inquiry. N=5 social workers working with people living with disabilities.	Data from 2 studies highlighted factors that could contribute to delays in discharge arrangements and care plans. For example, fluctuations in person's functioning whilst waiting for assessments, waiting for modifications to their homes to be completed, and the level of support people have available through family or community care. For example, "a very big barrier to progress toward discharge for this patient group is the lack of opportunity for community access. When you have somebody who's stuck in hospital for one year, or even two years, to not provide them as early as possible with the ability to get out of the hospital, off the ward, out of the hospital complex, into the community to experience normal life, to me, is a travesty of their human rights" (social worker). [Redfern 2016, p.33 to 34]. Furthermore, the reliance by some health care professionals on family carers to facilitate discharge arrangements and provide care was highlighted. "The social worker talks with the older person about plans, etc. before any discussion with family members. However, doctors don't always follow suit. Rather, they often go directly to the family and by-pass the patient. Ageism is rife in the hospital" (medical social worker). [Donnelly 2019, p.2993]. Social workers recognised the difficulties often experienced in balancing the person's involvement and needs and preferences with that of their family members. Where necessary, social workers reported that they referred to existing health care policy and legislation to ensure the person's wishes and preferences were adhered to where possible. For example, '"Often there can be	Moderate concerns[1]	No or minor concerns	Minor concerns[2]	No or minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
	disagreements between the patient and a family member ... If there is family anxiety relating to an older person remaining at home, I would try and explain things from a human rights perspective and also use the legislation to highlight that an older person can't be detained or sent to a nursing home against their will" (mental health social worker). [Donnelly 2019, p.2993].					
Sub-theme C2.2.2: The importance of the right environment						
2 studies • Abendstern 2019 General qualitative inquiry (forming part of a larger mixed-methods study). Practitioners working with older adults in adult social care, brokerage, hospital discharge support, and specialist dementia advice and support services. • Donnelly 2019 Phenomenological study (as part of a mixed-methods study). N=21 social workers involved with care planning and decision-making, working with adults with dementia.	Data from 2 studies highlighted the importance of environment and service location in case management. Data suggested that service location could impact on ease of contact between professionals and people. For example, specialist dementia and hospital discharge support services were reported to be able to see individuals 'in situ' as they were hospital-based. Adult social care and brokerage services were office-based and appointments were made to see individuals at home or at a local resource centre. However, the data suggested that the hospital setting may not be conducive to decision making for people living with dementia. The number of people in attendance at the care planning meeting as well as the need for pre-meeting preparation were also highlighted as important to enhance a relaxed environment. [No quotes provided].	Moderate concerns[3]	No or minor concerns	Moderate concerns[4]	No or minor concerns	LOW

[1] *Moderate concerns (Donnelly 2019, Redfern 2016) about methodological limitations as per CASP qualitative checklist.*
[2] *Studies together offered some rich data.*
[3] *Minor concerns (Abendstern 2019) and moderate concerns (Donnelly 2019) about methodological limitations as per CASP qualitative checklist.*
[4] *Studies together did not offer rich data.*

Table 24: Evidence profile (GRADE-CERQual) for theme C2.3: Negative aspects of case management and care planning and what improvements could be made

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Sub-theme C2.3.1: Knowledge and communication						
2 studies • Biringer 2017 Hermeneutic-phenomenological study. N=10 health and welfare service users (n=8 at 2 year follow-up). • Goodridge 2019 General qualitative inquiry. N=37 adults with chronic diseases and complex social needs; N=8 Livewell staff (including n=1 social work case manager).	Data from 2 studies highlighted barriers to enabling people to care for themselves, including a lack of information provided to people about their care and inaccessible communications between service providers and with people. For example, "There's poor communication from their side and from my side at times, but that's because I get fed up when I ring to find out what's happening and I get three different letters within a week with three different appointments. They don't speak to each other, I get totally .... (Participant 2 at follow-up). [Biringer 2017, p.11]. "Just the way that some of the professionals talk to patients - it's very quick. It's very concise. And they use really big words. And that intimidates patients ... that creates a big disconnect between the client and the service" (case manager). [Goodridge 2019, p.6].	Moderate concerns[1]	No or minor concerns	Minor concerns[2]	Minor concerns[3]	LOW
Sub-theme C2.3.2: Relationships						
3 studies • Archard 2015 Exploratory, general qualitative inquiry. N=4 people experiencing homelessness receiving specialised psychological trauma services. • Biringer 2017 Hermeneutic-phenomenological study. N=10 health and welfare service users	Data from 3 studies highlighted certain negative aspects associated with case management, including previous negative experiences by people, which could affect levels of trust and willingness to engage with treatment programmes. For example, "Before, I used to use [street drugs] and Emergency knew me from that, but they also knew that I quit, and they still treated me like I was a user" (person using services). [Goodridge 2019, p.7]. In addition, perceptions about support worker involvement could result in negative feelings and potential for setbacks in treatment, such as when frequent breaks in contact with professionals occurred, or a certain rapport and closeness that	Moderate concerns[4]	No or minor concerns	Minor concerns[5]	Minor concerns[6]	LOW

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
(n=8 at 2 year follow-up). ● Goodridge 2019 General qualitative inquiry. N=37 adults with chronic diseases and complex social needs; N=8 Livewell staff (including n=1 social work case manager).	have been achieved between people and workers, then ceases abruptly. For example, "You tell them about your personal life and then they, I mean I've nothing to hide (. . .) and they know all that; but then they go away and then don't come back, and then someone else comes and they take their place and then they expect you to tell them all over again and then they move on" (person using services). [Archard 2015, p.365]. "It's always the same. I have to tell my whole life story again and again. Even though they have the records, they still want to hear it. No, it's happened too many times [...]. It's easier just to deal with one person. That's so much better than being thrown around backwards and forwards between different social workers." (Participant 6 at follow-up). [Biringer 2017, p.7]. The person using services' perspectives were corroborated by 1 support worker who spoke of her frustration at the limitations of minimal periods of involvement, with gaining an understanding of a service user's situation and personal history taking time, along with brokering a connection with people who could be quite sceptical about support worker involvement.					
Sub-theme C2.3.3: Respect and dignity						
1 study ● Goodridge 2019 General qualitative inquiry. N=37 adults with chronic diseases and complex social needs; N=8 Livewell staff (including n=1 social work case manager).	Data from 1 study indicated that power differentials between service providers and people reinforced and increased the powerlessness felt by people, with people reporting dehumanising experiences with health care providers that created long-standing mistrust. Furthermore, service providers were reported to sometimes adopt a judgemental and dominant approach which presented barriers to engaging people with complex needs. For example, "We have people who are living in poverty and trying to	Moderate concerns[7]	No or minor concerns	Moderate concerns[8]	Minor concerns[9]	LOW

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
	get their next meal, "How am I gonna eat?" And yet we write them off because they don't show up for an appointment" (case manager). [Goodridge 2019, p.7].					

[1] *No or minor concerns (Biringer 2017) and moderate concerns (Goodridge 2019) about methodological limitations as per CASP qualitative checklist.*
[2] *Studies together offered moderately rich data.*
[3] *All evidence is from a substantially different context to the review question (Biringer 2017, Goodridge 2019 - not exclusively social work approach to case management and care planning).*
[4] *No or minor concerns (Biringer 2017), minor concerns (Archard 2015) and moderate concerns (Goodridge 2019) about methodological limitations as per CASP qualitative checklist.*
[5] *Studies together offered moderately rich data.*
[6] *All evidence is from a substantially different context to the review question (Archard 2015 - not clear whether specifically case management; Biringer 2017, Goodridge 2019 - not exclusively social work approach to case management and care planning).*
[7] *Moderate concerns about methodological limitations as per CASP qualitative checklist.*
[8] *Study offered moderately rich data.*
[9] *All evidence is from a substantially different context to the review question (Goodridge 2019 - does not exclusively explore social work involvement in the chronic disease management programme).*

Table 25: Evidence profile (GRADE-CERQual) for theme C2.4: Perception about the impact of case management and care planning in meeting needs

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Sub-theme C2.4.1: Choice and flexibility						
2 studies • Biringer 2017 Hermeneutic-phenomenological study. N=10 health and welfare service users (n=8 at 2 year follow-up). • Donnelly 2019 Phenomenological study (as part of a mixed-methods study). N=21 social workers involved with care planning and decision-making, working with adults with dementia.	Data from 2 studies highlighted the importance of flexibility and creativity in terms of a person's involvement in care planning, including where meetings should be held. People using services suggested that negative feelings could arise when they felt they had no choice in terms of decisions about support. Suggested improvements to services included being open to contact, including between scheduled appointments or across services. [No relevant quotes provided].	Moderate concerns[1]	No or minor concerns	Moderate concerns[2]	Minor concerns[3]	LOW
Sub-theme C2.4.2: Changing needs						
3 studies • Biringer 2017 Hermeneutic-phenomenological study. N=10 health and welfare service users (n=8 at 2 year follow-up). • Dadich 2013 General qualitative inquiry. N= 20 service users with chronic mental illness. • Goodridge 2019 General qualitative inquiry. N=37 adults with chronic diseases and complex social needs; N=8 Livewell	Data from 3 studies highlighted negative views in relation to certain aspects of case management and care planning, including variation in the care planning process (for example, frequency of meetings and monitoring plans). Although most service users were happy with the frequency of review meetings, others preferred it to be more or less often to "speed things up" (service user). [Dadich 2013, p.487]. People did not always understand the purpose, process or benefits of care planning, this was particularly true when clinical case managers regarded care planning as paperwork, rather than as a part of a reflective process of recovery. Service users sometimes felt that the support provided did not always address their most critical self-identified needs and were therefore of relatively low	Moderate concerns[4]	No or minor concerns	Minor concerns[5]	Minor concerns[6]	LOW

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
staff (including n=1 social work case manager).	interest to them, which could influence their level of participation. People also expressed negative feelings, such as worsening of problems and risk of suicide, being kept waiting for support, and feelings of being ignored when professionals did not make contact. For example, "I had a battle with them too [...] ... Things take time and are difficult. It's really confusing [...] when on person says one thing and another something else, then you get a letter with a third thing, and you just sit there..." (Participant 2 at follow-up). [Biringer 2017].					
Sub-theme C2.4.3: Capacity, decision-making and involvement						
2 studies • Donnelly 2019 Phenomenological study (as part of a mixed-methods study). N=21 social workers involved with care planning and decision-making, working with adults with dementia. • O'Donnell 2015 General qualitative inquiry (using a hermeneutic approach). N=10 senior case managers working with older adults to protect them from abuse.	Data from 2 studies identified challenges associated with decision-making in terms of the level of involvement of people such as those living with dementia or supported by protective services. Case managers identified the significance of capacity as influencing involvement in decision-making, with some social workers suggesting the possible tokenistic involvement of people with dementia and that decision-making can take place in a covert manner. For example, "... the elephant in the room is around capacity ... the current approach is too simplistic and the current system is not fit for purpose ... there is no concept of functional capacity at the moment and everything is very medically led. When they don't have capacity they're not really involved and if they are, it tends to be tokenistic" (community social worker). [Donnelly 2019, p.2993]. "For people with dementia it does tend to be tokenistic ... decisions can't be made against them, but plans are often made behind their backs and they're not really actively involved.	Moderate concerns[9]	No or minor concerns	Minor concerns[10]	No or minor concerns	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
	They are either 'in' or 'out'" (medical social worker). [Donnelly 2019, p.2992]. Case managers emphasised the importance of promoting person-centred and rights-based approaches, placing the person's wishes at the centre of case management. However, they also highlighted that tensions could arise with other agencies when trying to balance the wishes of the older person with what other people thought was best for them, particularly when capacity is impaired, and the lack of legislative authority for the role of case managers when working with other agencies, in terms of assessing service users for capacity, and their right to recommend services. For example, "Senior case workers for the protection of older people have lots of responsibility but very little authority or legislative framework to back that up. So they are in a double whammy. The expectation is high and the resources or the authority is very, very low" (senior case worker). [O'Donnell 2015, p.1461]. "... Need a system where an individual's prior wishes is given legal standing when they are no longer able to make decision, i.e. putting advanced care directives on a legal footing" (community social worker). [Donnelly 2019, p.2997].					

[1] *Minor concerns (Biringer 2017) and moderate concerns (Donnelly 2019) about methodological limitations as per CASP qualitative checklist.*
[2] *Studies together did not offer rich data.*
[3] *Some evidence is from a substantially different context to the review question (Biringer 2017 - not exclusively social work approach to case management and care planning).*
[4] *Minor concerns (Biringer 2017 and Dadich 2013) and moderate concerns (Goodridge 2019) about methodological limitations as per CASP qualitative checklist.*
[5] *Studies together offered moderately rich data.*
[6] *All evidence is from a substantially different context to the review question (Biringer 2017, Dadich 2013, Goodridge 2019 - not exclusively social work approach to case management and care planning).*
[7] *Moderate concerns about methodological limitations as per CASP qualitative checklist.*
[8] *Study offered moderately rich data.*
[9] *Moderate concerns (Donnelly2019, O'Donnell 2015) about methodological limitations as per CASP qualitative checklist.*
[10] *Studies together offered some rich data.*

Table 26: Evidence profile (GRADE-CERQual) for theme C2.5: Practitioner satisfaction with case management and care planning

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Sub-theme C2.5.1: Difficulties arising from collaboration						
4 studies • Dadich 2013 General qualitative inquiry. N=20 service users with chronic mental illness. • de Lange 2018 Grounded theory. N=99 professionals involved in case management within the regional dementia networks. • O'Donnell 2015 General qualitative inquiry (using a hermeneutic approach). N=10 senior case managers working with older adults to protect them from abuse. • Redfern 2016 General qualitative inquiry. N=5 social workers working with people living with disabilities.	Data from 4 studies highlighted the impact that working relationships and contact between different professionals could have on the continuity and quality of care provided to people, particularly in terms of service user participation in care planning. Lack of or limited direct contact between professionals was viewed as hindering a smooth and swift referral of service users and for attuning to the changing needs of service users. Participants spoke about difficulties working within a medical environment particularly in relation to their authority to access services for people. They emphasised the importance of raising awareness and effective inter-agency communication to overcome the challenges that arise within and between agencies. For example, "There is a lack of a clinical pathway for people who are in these sort of social circumstances, social vulnerabilities. Maybe not having had the opportunity to have a medical [diagnostic code for a mental disorder] on their situation and the gatekeepers to services are medicalised (sic), it is a dominant medical discourse. And I think in these situations it often needs a balance between the social and the medical" (senior case worker). [O'Donnell 2015, p.1458]. Conflicts between service providers were also highlighted as contributing to delays with assessment and planning for community care. For example, "It was an ongoing kind of debate between hospital staff and DS [disability services] as to whether the person needed rehab.... But without a clear discharge plan - which couldn't be established until they had gained the most potential they could ... so that DS could look at identifying accommodation and a funding package	Moderate concerns[1]	No or minor concerns	No or minor concerns[2]	Minor concerns[3]	MODERATE

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
	- none of it could be done" (hospital social worker). [Redfern 2016, p.32]. "I think that sort of wait is unacceptable. And yet you see it regularly ... waiting for Disability Services to come up with the needs assessment, then ... often they'll accept them as a client, but there'll be no funding, so they're still waiting" (social worker commenting on a person using services who waited over 3 months for a DS assessment, then 4 months for an Aged Care Assessment Team assessment). [Redfern 2016, p.33]. Some participants highlighted that there may be disadvantages of multiple health care providers because the independence of the case manager can be compromised. In addition, each organisation has its own way of doing things and this can create diversity in the execution of case management, resulting in confusion about responsibilities and job content of case managers. For example, one case manager expected "... case management to become a separate fragment, while connections [to other professionals] become very short". [de Lange 2018, p.117].					
Sub-theme C2.5.2: Professional competencies						
2 studies ● Donnelly 2019 Phenomenological study (as part of a mixed-methods study). N=21 social workers involved with care planning and decision-making, working with adults with dementia. ● Uittenbroek 2018	Data from 2 studies suggested that a lack of knowledge (for example, medical knowledge) by professionals, in addition to the absence of clear policies and procedures, could hinder the provision of good quality care and the inclusion of adults with complex needs. Participants emphasised the need for increased education and training of professionals and also suggested the potential advantages of different expertise in the delivery of care. For example, "Train all members of MDT regarding the right for older people to be involved in decision-making - perhaps develop a specific	Moderate concerns[4]	No or minor concerns	Moderate concerns[5]	Minor concerns[6]	LOW

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of findings	Adequacy of data	Relevance of evidence	Overall confidence
Grounded theory (as part of Embrace RCT). N=11 case managers providing person-centred and integrated care based on the CCM.	policy/procedure that must be adhered to within the hospital. Be clear with families that patients have the right to be involved in all aspects of the decision-making process" (medical social worker). [Donnelly 2019, p.2996].					
Sub-theme C2.5.3: Resource restrictions						
4 studies • Carver 2012 General qualitative inquiry. N=12 Lothian Keep Well staff and N=4 service users receiving support from an outreach worker. • de Lange 2018 Grounded theory. N=99 professionals involved in case management within the regional dementia networks. • O'Donnell 2015 General qualitative inquiry (using a hermeneutic approach). N=10 senior case managers working with older adults to protect them from abuse. • Redfern 2016 General qualitative inquiry. N=5 social workers working with people living with disabilities.	Data from 4 studies highlighted a number of barriers to implementing successful case management because of limited resources, which were often not utilised effectively. Issues highlighted by social workers included managing demanding caseloads and paperwork, for example, "A lot of time is spent keeping records up to date ... and writing to GPs to let them know what I've done when really if we had a one you know a sort of more you know joined up IT system then I wouldn't need to be sending out all the stuff and duplicating stuff" (OW). [Carver 2012, p.S50]. Other challenges included working in isolation, high staff turnover, and different funding resources and travel restrictions. For example, "It would be nice that you did not have to think about funding every time you are delivering care. As a professional you should offer the right care at the right time in the right place, independently of the right funding" (Case manager). [de Lange 2018, p.118]. "Sometimes it's kind of a practical matter as well, let's say if you are going to visit a certain area and you have two or three cases there, you kind of tend to maybe deal with them first because you know you can actually go and visit the person" (senior case worker). [O'Donnell 2015, p.1459].	Moderate concerns[7]	No or minor concerns	No or minor concerns[8]	Minor concerns[9]	MODERATE

CCM: Chronic Care Model; OW: outreach worker; RCT: randomised controlled trial.
[1] Minor concerns (Dadich 2013, de Lange 2018, O'Donnell 2015) and moderate concerns (Redfern 2016) about methodological limitations as per CASP qualitative checklist.

[2] Studies together offered moderately rich data.
[3] Some evidence is from a substantially different context to the review question (Dadich 2013, de Lange 2018 - not clear whether exclusively social work approach to case management and care planning).
[4] Minor concerns (Uittenbroek 2018) and moderate concerns (Donnelly 2019) about methodological limitations as per CASP qualitative checklist.
[5] Studies together did not offer rich data.
[6] Some evidence is from a substantially different context to the review question (Uittenbroek 2018 - not exclusively social work approach to case management and care planning).
[7] Minor concerns (de Lange 2018 and O'Donnell 2015) and moderate concerns (Carver 2012 and Redfern 2016) about methodological limitations as per CASP qualitative checklist.
[8] Studies together offered some rich data.
[9] Some evidence is from a substantially different context to the review question (Carver 2012 - unclear whether specifically a social work approach to case management or care planning; de Lange 2018 - not exclusively social work approach to case management and care planning).

Appendix G Economic evidence study selection

Study selection for C: What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

A single economic search was undertaken for all topics included in the scope of this guideline. See Supplement 2 for further information.

Appendix H Economic evidence tables

Economic evidence tables for review question C: What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

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

Appendix I Economic model

Economic model for review question C: What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

No economic analysis was conducted for this review question.

Appendix J Excluded studies

Excluded studies for review questions C: What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Excluded effectiveness studies

Table 27: Excluded studies and reasons for their exclusion – effectiveness review

Study	Reason for exclusion
Older people with social care needs and multiple long-term conditions, 2015	Ineligible study design - National Institute for Health and Care Excellence (NICE) guideline references checked but none meet the PICO criteria
Abdul Azeez, E. P., Integrated Practice of Social Work Methods: Prospects of Social Work Intervention Through Community Palliative Care, Social Work Chronicle, 2, 1-13, 2013	Ineligible country - study conducted in India
Actrn,, Evaluation of Gold Coast Integrated Care for patients with chronic disease through a non-randomised controlled clinical trial, http://www.who.int/trialsearch/Trial2.aspx?TrialID=ACTRN12616000821493, 2016	Ineligible study design - clinical trial, no full text publication available
Addicott, R., Supporting care home residents at the end of life, International Journal of Palliative NursingInt J Palliat Nurs, 17, 183-7, 2011	Ineligible study design - qualitative study
Age UK, Care in crisis: causes and solutions, 20p., 2011	Ineligible study design - non-systematic review (narrative review)
Aiden, H., Multimorbidity: understanding the challenge, 48, 2018	Ineligible study design - non-systematic review
Alexopoulos, G. S., Raue, P. J., McCulloch, C., Kanellopoulos, D., Seirup, J. K., Sirey, J. A., Banerjee, S., Kiosses, D. N., Areán, P. A., Clinical Case Management versus Case Management with Problem-Solving Therapy in Low-Income, Disabled Elders with Major Depression: a Randomized Clinical Trial, American journal of geriatric psychiatry, 24, 50-59, 2016	Ineligible country – study conducted in the US
All-Party Parliamentary Group On Dementia, Dementia rarely travels alone: living with dementia and other conditions, 11, 2016	Ineligible study - Parliamentary report
Amjad, H., Towle, V., Fried, T., Association of Experience with Illness and End-of-life Care with Advance Care Planning in Older Adults, Journal of the American Geriatrics Society, 62, 1304-1309, 2014	Ineligible country - study conducted in the US
Ampe, S., Sevenants, A., Smets, T., Declercq, A., Van Audenhove, C., Advance care planning for nursing home residents with dementia: influence of 'we DECide' on policy and practice, Patient education and counseling, 100, 139-146, 2017	Ineligible intervention - not a social work approach to supporting changing needs
Arbaje, A. I., Kansagara, D. L., Salanitro, A. H., Englander, H. L., Kripalani, S., Jencks, S. F.,	Ineligible study design - non-systematic review (narrative review)

Study	Reason for exclusion
Lindquist, L. A., Regardless of age: Incorporating principles from geriatric medicine to improve care transitions for patients with complex needs, Journal of General Internal Medicine, 29, 932-9, 2014	
Arnett, K., Sudore, R. L., Nowels, D., Feng, C. X., Levy, C. R., Lum, H. D., Advance Care Planning: Understanding Clinical Routines and Experiences of Interprofessional Team Members in Diverse Health Care Settings, American Journal of Hospice & Palliative MedicineAm J Hosp Palliat Care, 34, 946-953, 2017	Ineligible country - study in conducted in the US
Aubin, M., Giguère, A., Martin, M., Verreault, R., Fitch, M. I., Kazanjian, A., Carmichael, P. H., Interventions to improve continuity of care in the follow-up of patients with cancer, Cochrane Database of Systematic Reviews, 2012	Ineligible intervention - not a social work approach to supporting changing needs
Aubry, T., Nelson, G., Tsemberis, S., Housing first for people with severe mental illness who are homeless: A review of the research and findings from the at Home-Chez soi demonstration project, Canadian Journal of Psychiatry, 60, 467-474, 2015	Ineligible study design - non-systematic review
Bachmann-Mettler, I., Steurer-Stey, C., Senn, O., Wang, M., Bardheci, K., Rosemann, T., Case management in oncology rehabilitation (CAMON): the effect of case management on the quality of life in patients with cancer after one year of ambulant rehabilitation. a study protocol for a randomized controlled clinical trial in oncology rehabilitation, Trials, 12, 103, 2011	Ineligible study design - protocol
Baird, L. G., Fraser, K., Home Care Case Managers' Integrated Care of Older Adults with Multiple Chronic Conditions: A Scoping Review, Professional case management, 23, 165-189, 2018	Ineligible study design – non-systematic review (scoping review)
Balaban, R., Batalden, M., Ross-Degnan, D., Le Cook, B., Using a Social Worker Transition Coach to Improve Hospital-to-Home Transitions for High-Risk Nonelderly Patients, Journal for healthcare quality : official publication of the National Association for Healthcare Quality., 22, 2019	Ineligible country - study conducted in the US
Barnao, M., The Good Lives Model tool kit for mentally disordered offenders, Journal of Forensic Practice, 15, 157-170, 2013	Ineligible study – non-systematic review (narrative review)
Baxter, K., Changing choices: disabled and chronically ill people's experiences of reconsidering choices, Chronic Illness, 9, 116-32, 2013	Ineligible design – qualitative study
Beresford, Bryony, et, al, Reablement services for people at risk of needing social care: The MoRe mixed-methods evaluation, Health Services and Delivery Research, 7, 2019	Ineligible intervention – not a social work approach to supporting changing needs
Berglund, H., Hasson, H., Kjellgren, K., Wilhelmson, K., Effects of a continuum of care intervention on frail older persons' life	Ineligible outcomes - life satisfaction

Study	Reason for exclusion
satisfaction: a randomized controlled study, Journal of clinical nursing, 24, 1079-1090, 2015	
Bigby, C., Anderson, S., Cameron, N., Identifying conceptualizations and theories of change embedded in interventions to facilitate community participation for people with intellectual disability: A scoping review, Journal of applied research in intellectual disabilities : JARID, 31, 165-180, 2018	Ineligible intervention - not a social work approach to management or care planning
Bitter, N. A., Roeg, D. P., van Nieuwenhuizen, C., van Weeghel, J., Effectiveness of the Comprehensive Approach to Rehabilitation (CARe) methodology: design of a cluster randomized controlled trial, BMC psychiatry, 15, 165, 2015	Ineligible study design – protocol
Black, H. L., Priolo, C., Akinyemi, D., Gonzalez, R., Jackson, D. S., Garcia, L., George, M., Apter, A. J., Clearing clinical barriers: enhancing social support using a patient navigator for asthma care, Journal of Asthma, 47, 913-9, 2010	Ineligible study design - Qualitative study
Bliss, J., While, A. E., Meeting the needs of vulnerable patients: The need for team working across general practice and community nursing services, London Journal of Primary Care, 6, 149-153, 2014	Ineligible study design - non-systematic review (narrative review)
Bodenmann, P., Velonaki, V. S., Griffin, J. L., Baggio, S., Iglesias, K., Moschetti, K., Ruggeri, O., Burnand, B., Wasserfallen, J. B., Vu, F., et al., Case Management may Reduce Emergency Department Frequent use in a Universal Health Coverage System: a Randomized Controlled Trial, Journal of General Internal Medicine, 32, 508-515, 2017	Ineligible population - Not specifically social work approach (focus on clinical/medical health care, but includes social work elements)
Boeckxstaens, P., De Graaf, P., Primary care and care for older persons: position paper of the European Forum for Primary Care, Quality in Primary CareQual Prim Care, 19, 369-389, 2011	Ineligible study design - article as part of a series of Position Papers of the European Forum for Primary Care
Boland, J., Owen, J., Ainscough, R., Mahdi, H., Developing a service for patients with very severe chronic obstructive pulmonary disease (COPD) within resources, BMJ supportive & palliative care, 4, 196-201, 2014	Ineligible intervention - Not a social work supporting changing needs intervention
Bovell-Ammon, A., Mansilla, C., Poblacion, A., Rateau, L., Heeren, T., Cook, J. T., Zhang, T., de Cuba, S. E., Sandel, M. T., Housing Intervention For Medically Complex Families Associated With Improved Family Health: Pilot Randomized Trial, Health affairs (Project Hope), 39, 613-621, 2020	Ineligible country – study conducted in the US
Bozorgmehr, K., Szecsenyi, J., Ose, D., Besier, W., Mayer, M., Krisam, J., Jacke, C. O., Salize, H. J., Brandner, R., Schmitt, S., et al.,, Practice network-based care management for patients with type 2 diabetes and multiple comorbidities (GEDIMAplus): study protocol for a randomized controlled trial, Trials, 15, 243, 2014	Ineligible study design - protocol

Study	Reason for exclusion
Bramley, G., Mangan, C., Conroy, M., Using telemonitoring to support personal care planning for adults with learning disabilities, Journal of telemedicine and telecare, 25, 602-610, 2019	Ineligible intervention - not a social work approach to supporting changing needs
Brenton, C., et al, Stepping forward: commissioning principles for collaborative care and support planning, 38, 2015	Ineligible study design - guidance document
Brewer, W. J., Lambert, T. J., Witt, K., Dileo, J., Duff, C., Crlenjak, C., McGorry, P. D., Murphy, B. P., Intensive case management for high-risk patients with first-episode psychosis: Service model and outcomes, The Lancet Psychiatry, 2, 29-37, 2015	Ineligible population - outcomes not reported separately for participants aged 18 years or older
British Medical Association, Growing older in the UK: a series of expert-authored briefing papers on ageing and health, 72, 2016	Ineligible study design – non-systematic review (collection of narrative briefing papers)
Callaghan, L., Brookes, N., Palmer, S., Older people receiving family-based support in the community: a survey of quality of life among users of 'Shared Lives' in England, Health & social care in the community, 25, 1655-1666, 2017	Ineligible intervention - not a social work approach to case management or care planning.
Care Quality Commission, Health care in care homes: a special review of the provision of health care to those in care homes, 8p., 2012	Ineligible study design - inspections of care homes (to look at how well the health care needs of people living in care homes were met)
Cartwright, C., Hughes, M., Lienert, T., End-of-life care for gay, lesbian, bisexual and transgender people, Culture, Health & Sexuality, 14, 537-548, 2012	Ineligible study design - qualitative study not social work supporting changing needs.
Casey Lion, K., Mangione-Smith, R., Britto, M. T., Individualized plans of care to improve outcomes among children and adults with chronic illness: A systematic review, Care Management Journals, 15, 11-25, 2014	Ineligible population - not social workers
Chouinard, M.C., Hudon, C., Dubois, M.F., Roberge, P., Loignon, C., Tchouaket, E., Fortin, M., Couture, E.M., Sasseville, M., Case management and self-management support for frequent users with chronic disease in primary care: a pragmatic randomized controlled trial, BMC Health Services Research, 13, 49-, 2013	Ineligible study design – protocol
Chuah, F. L. H., Haldane, V. E., Cervero-Liceras, F., Ong, S. E., Sigfrid, L. A., Murphy, G., Watt, N., Balabanova, D., Hogarth, S., Maimaris, W., Otero, L., Buse, K., McKee, M., Piot, P., Perel, P., Legido-Quigley, H., Interventions and approaches to integrating HIV and mental health services: a systematic review, Health policy and planning, 32, iv27-iv47, 2017	Ineligible intervention - not a social work approach to supporting changing needs
Clark, C., Guenther, C. C., Mitchell, J. N., Case Management Models in Permanent Supported Housing Programs for People with Complex Behavioral Issues Who Are Homeless, Journal of Dual Diagnosis, 12, 185-192, 2016	Ineligible study design - non-systematic review (narrative review)
Clark-Wilson, J., Holloway, M., Life care planning and long-term care for individuals with	Ineligible study design - non-systematic review (narrative review)

Study	Reason for exclusion
brain injury in the UK, NeuroRehabilitation, 36, 289-300, 2015	
Cochrane, A., Time-limited home-care reablement services for maintaining and improving the functional independence of older adults (review), 2016	Cochrane systematic review - references checked but none meet the PICO criteria
Coulter, A., Entwistle, V. A., Eccles, A., Ryan, S., Shepperd, S., Perera, R., Personalised care planning for adults with chronic or long-term health conditions, Cochrane Database of Systematic Reviews, 2015	Ineligible intervention - not a social work approach to supporting changing needs
Creative Local Action, Response, Engagement, Together we can make a difference: CLARE year 1 report 2014-2015, 2015	Ineligible intervention - not a social work approach to supporting changing needs
Cynthia, M. K., Optimization of individual adaptation and disability-related factors: considerations for the case manager, Professional case management, 15, 202-205, 2010	Ineligible study design - non-systematic review (narrative review)
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	Ineligible study design – qualitative research methods
Day, C. A., Demirkol, A., Tynan, M., Curry, K., Hines, S., Lintzeris, N., Haber, P. S., Individual versus team-based case-management for clients of opioid treatment services: An initial evaluation of what clients prefer, Drug and Alcohol Review, 31, 499-506, 2012	Ineligible population – included nurses and case managers
De Stampa, M., Vedel, I., Buyck, J. F., Lapointe, L., Bergman, H., Beland, F., Ankri, J., Impact on hospital admissions of an integrated primary care model for very frail elderly patients, Archives of gerontology and geriatrics, 58, 350-355, 2014	Ineligible population – included nurses and physicians
Dew, A., Collings, S., Dillon Savage, I., Gentle, E., Dowse, L., "Living the life I want": A framework for planning engagement with people with intellectual disability and complex support needs, Journal of applied research in intellectual disabilities : JARID, 32, 401-412, 2019	Ineligible intervention - not a social work approach to supporting changing needs
Dieterich, M., Irving, C. B., Bergman, H., Khokhar, M. A., Park, B., Marshall, M., Intensive case management for severe mental illness, Cochrane Database of Systematic Reviews, 2017 (1) (no pagination), 2017	Cochrane review - references checked but none meet the PICO criteria
Dieterich, M., Irving, C. B., Park, B., Marshall, M., Intensive case management for severe mental illness, Cochrane Database of Systematic Reviews, CD007906, 2010	Cochrane review - references checked but none meet the PICO criteria
Dunstan, D., Anderson, D., Applying Strengths Model principles to build a rural community-based mental health support service and achieve recovery outcomes, Rural & Remote Health, 18, 3708, 2018	Ineligible intervention - not a social work approach to supporting changing needs

Study	Reason for exclusion
Dunstan, D.A., Todd, A.K., Kennedy, L.M., Anderson, D.L., Impact and outcomes of a rural Personal Helpers and Mentors service, Australian Journal of Rural Health, 22, 50-55, 2014	Ineligible intervention - not a social work approach to supporting changing needs
Eicher, M., Ribi, K., Senn-Dubey, C., Senn, S., Ballabeni, P., Betticher, D., Interprofessional, psycho-social intervention to facilitate resilience and reduce supportive care needs for patients with cancer: Results of a noncomparative, randomized phase II trial, Psycho-Oncology, 27, 1833-1839, 2018	Ineligible population– included nurses or oncologists
Eichler, T., Thyrian, J. R., Dreier, A., Wucherer, D., Köhler, L., Fiß, T., Böwing, G., Michalowsky, B., Hoffmann, W., Dementia care management: going new ways in ambulant dementia care within a GP-based randomized controlled intervention trial, International psychogeriatrics, 26, 247-256, 2014	Ineligible outcomes - no critical/important outcomes data reported
Ekelund, C., Eklund, K., Longitudinal effects on self-determination in the RCT “Continuum of care for frail elderly people”, Quality in Ageing and Older Adults, 16, 165-176, 2015	Ineligible outcomes - no critical/important outcome data reported
Fitch, M.t, Bradley, H., Eaton, G., Giese-Davis, J., Sisler, J., Taylor-Brown, J., Implementing Survivorship Care Plans in the Canadian Cancer Setting, Psycho - Oncology, 23, 123, 2014	Ineligible study design - conference abstract
Fleisher, J., Barbosa, W., Sweeney, M. M., Oyler, S. E., Lemen, A. C., Fazl, A., Ko, M., Meisel, T., Friede, N., Dacpano, G., Gilbert, R. M., Di Rocco, A., Chodosh, J., Interdisciplinary Home Visits for Individuals with Advanced Parkinson's Disease and Related Disorders, Journal of the American Geriatrics Society, 66, 1226-1232, 2018	Ineligible country – study conducted in the US
Gallagher, N. A., Fox, D., Dawson, C., Williams, B. C., Improving care transitions: complex high-utilizing patient experiences guide reform, The American journal of managed care, 23, e347-e352, 2017	Ineligible country – study conducted in the US
Garrett, M. B., Incorporating Patient-Centeredness into Case Management Practice: Concepts, Interventions, and Measurement, Professional case management, 24, 17-25, 2019	Ineligible country – study conducted in the US
Georghiou, T., Keeble, E., Age UK's Personalised Integrated Care Programme: evaluation of impact on hospital activity, 74, 2019	Ineligible intervention - not a social work approach to supporting changing needs
Ghesquiere, A., Mackniak, M., Valentino, S., Outcomes of a model care coordination program for adults with mental illness under guardianship/conservatorship, Social Work in Mental Health, 17, 93-105, 2019	Ineligible country – study conducted in the US
Gilissen, J., Pivodic, L., Dael, Aw- V., Gastmans, C., Stichele, R. V., van Humbeeck, L., Deliens, L., van den Block, L., Implementing advance care planning in routine nursing home care: the	Ineligible intervention - not a social work approach to supporting changing needs

Study	Reason for exclusion
development of the theory-based ACP+ program, PloS one, 14, 2019	
Godwin, M., Gadag, V., Pike, A., Pitcher, H., Parsons, K., McCrate, F., Parsons, W., Buehler, S., Sclater, A., Miller, R., A randomized controlled trial of the effect of an intensive 1-year care management program on measures of health status in independent, community-living old elderly: The Eldercare project, Family Practice, 33, 37-41, 2016	Ineligible intervention - not a social work approach to supporting changing needs
Gordon, R. J., Rosenheck, R. A., Zweig, R. A., Harpaz-Rotem, I., Health and social adjustment of homeless older adults with a mental illness, Psychiatric Services, 63, 561-568, 2012	Ineligible country – study conducted in the US
Grover, C. A., Crawford, E., Close, R. J. H., The Efficacy of Case Management on Emergency Department Frequent Users: An Eight-Year Observational Study, Journal of Emergency Medicine, 51, 595-604, 2016	Ineligible country – study conducted in the US
Hammond, F. M., Gassaway, J., Abeyta, N., Freeman, E. S., Primack, D., Kreider, S. E., Whiteneck, G., Outcomes of social work and case management services during inpatient spinal cord injury rehabilitation: the SCIRehab project, Journal of Spinal Cord Medicine, 35, 611-23, 2012	Ineligible country – study conducted in the US
Hancock, N., Scanlan, J. N., Gillespie, J. A., Smith-Merry, J., Yen, I., Partners in Recovery program evaluation: changes in unmet needs and recovery, Australian health review : a publication of the Australian Hospital Association, 42, 445-452, 2018	Ineligible intervention - not a social work approach to supporting changing needs
Harkey, J., Young, J., Carter, J. J., Demoratz, M., Supporting the Support System: How Assessment and Communication Can Help Patients and Their Support Systems, Professional case management, 22, 174-180, 2017	Ineligible study design – non-systematic review (descriptive article)
Harvey, C.L., et al., Development, implementation and evaluation of nurse-led integrated, person-centred care with long-term conditions, Journal of Integrated Care, 25, 186-195, 2017	Ineligible intervention - not a social work approach to supporting changing needs
Hashi, I., Case Management Promotion of Social Media for the Elderly Who Live Alone, Professional case management, 21, 82-87, 2016	Ineligible study design - non-systematic review (narrative discussion)
Hawkins, E. J., Danner, A. N., Malte, C. A., Painter, J. M., Lott, A. M. K., Baer, J. S., Feasibility of a care management approach for complex substance use disorders and high acute services utilization, Journal of Substance Abuse Treatment, 92, 100-108, 2018	Ineligible country - study in conducted in the US
Henschen, B. L., Chapman, M., Toms, A., Barra, M., Hansen, L. O., The complex high admission management program (CHAMP): development and preliminary impact on hospital utilization,	Ineligible study design - conference abstract

Study	Reason for exclusion
Journal of General Internal Medicine, 32, S799-S800, 2017	
Herman, D. B., Conover, S., Gorroochurn, P., Hinterland, K., Hoepner, L., Susser, E. S., Randomized trial of critical time intervention to prevent homelessness after hospital discharge, Psychiatric services (Washington, D.C.), 62, 713-719, 2011	Ineligible country - study conducted in the US
Horvitz-Lennon, M., Zhou, D., Normand, S. L., Alegria, M., Thompson, W. K., Racial and ethnic service use disparities among homeless adults with severe mental illnesses receiving ACT, Psychiatric Services, 62, 598-604, 2011	Ineligible country - study conducted in the US
Hudon, C., Chouinard, M. C., Dubois, M. F., Roberge, P., Loignon, C., Tchouaket, É, Lambert, M., Hudon, É, Diadiou, F., Bouliane, D., Case Management in Primary Care for Frequent Users of Health Care Services: a Mixed Methods Study, Annals of family medicine, 16, 232-239, 2018	Ineligible intervention - not a social work approach to supporting changing needs.
Huffman, J. C., Mastromauro, C. A., Beach, S. R., Celano, C. M., DuBois, C. M., Healy, B. C., Suarez, L., Rollman, B. L., Januzzi, J. L., Collaborative care for depression and anxiety disorders in patients with recent cardiac events: The management of sadness and anxiety in cardiology (MOSAIC) randomized clinical trial, JAMA Internal Medicine, 174, 927-935, 2014	Ineligible country - study conducted in the US
Hughes, A.K., et al., Improving stroke transitions: development and implementation of a social work case management intervention, Social work in health care, 57, 95-108, 2018	Ineligible country - study conducted in the US
Hughes, N. R., Houghton, N., Nadeem, H., Bell, J., McDonald, S., Glynn, N., Scarfe, C., MacKay, B., Rogers, A., Walters, M., Smith, M., McDonald, A., Dalton, D., Salford alcohol assertive outreach team: A new model for reducing alcohol-related admissions, Frontline Gastroenterology, 4, 130-134, 2013	Ineligible outcomes – no critical/important outcome data reported
Iglesias, K., Baggio, S., Moschetti, K., Wasserfallen, J. B., Hugli, O., Daeppen, J. B., Burnand, B., Bodenmann, P., Using case management in a universal health coverage system to improve quality of life of frequent Emergency Department users: a randomized controlled trial, Quality of Life Research, 27, 503-513, 2018	Ineligible intervention - not a social work approach to supporting changing needs
Isrctn, CORE: crisis Team Optimisation and Relapse Prevention - Phase 3, http://www.who.int/trialsearch/Trial2.aspx?TrialID=ISRCTN01027104, 2012	Ineligible intervention - not a social work approach to supporting changing needs
Isrctn, Engager: evaluation of a collaborative care intervention for offenders, http://www.who.int/trialsearch/Trial2.aspx?TrialID=ISRCTN11707331, 2016	Ineligible study design - protocol
Jansen, A. P., van Hout, H. P., Nijpels, G., Rijmen, F., Dröes, R. M., Pot, A. M., Schellevis,	Ineligible intervention - not a social work approach to supporting changing needs

Study	Reason for exclusion
F. G., Stalman, W. A., van Marwijk, H. W., Effectiveness of case management among older adults with early symptoms of dementia and their primary informal caregivers: a randomized clinical trial, International journal of nursing studies, 48, 933-943, 2011	
Johnson, S., Lamb, D., Marston, L., Osborn, D., Mason, O., Henderson, C., Ambler, G., Milton, A., Davidson, M., Christoforou, M., et al., Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial, Lancet (London, England), 392, 409-418, 2018	Ineligible intervention - not a social work approach to supporting changing needs
Kathol, R. G., Lattimer, C., Gold, G., Perez, R., Gutteridge, D., Creating clinical and economic "wins" through integrated case management: lessons for physicians and health system administrators, Professional case management, 16, 290-8; quiz 299-300, 2011	Ineligible study design - non-systematic review (narrative review)
Kavalieratos, D., Moreines, L., Hoydich, Z., Ikejiani, D., Yabes, J., Dellon, E. P., Richless, C., Arnold, R., Pilewski, J., Embedded Specialty Palliative Care Is Feasible, Acceptable, and Perceived to Be Effective in Cystic Fibrosis: results of a Pilot Randomized Clinical Trial (TH371A), Journal of Pain and Symptom Management, 57, 396, 2019	Ineligible study design - conference abstract
King, J., O'Neill, B., Ramsay, P., Linden, M. A., Darweish Medniuk, A., Outtrim, J., Blackwood, B., Identifying patients' support needs following critical illness: A scoping review of the qualitative literature, Critical Care, 23, 2019	Ineligible study design - non-systematic review (qualitative scoping review)
Kirk, S., et al., The effectiveness of self-care support interventions for children and young people with long-term conditions: a systematic review, Child: Care, 39, 305-324, 2013	Ineligible population - children and young people aged 0 to 16 years
Lannin, N. A., Laver, K., Henry, K., Turnbull, M., Elder, M., Campisi, J., Schmidt, J., Schneider, E., Effects of case management after brain injury: a systematic review, NeuroRehabilitation, 35, 635-41, 2014	Systematic review - references checked but none meet the PICO criteria
Lee, S., Castella, Ad, Freidin, J., Kennedy, A., Kroschel, J., Humphrey, C., Kerr, R., Hollows, A., Wilkins, S., Kulkarni, J., Mental health care on the streets: An integrated approach, Aust N Z J Psychiatry, 44, 505-12, 2010	Ineligible study design - evaluation of audits
Leutwyler, H., Hubbard, E., Zahnd, E., Case management helps prevent criminal justice recidivism for people with serious mental illness, International journal of prisoner health, 13, 168-172, 2017	Ineligible country – study conducted in the US
Low, L. F., Baker, J. R., Harrison, F., Jeon, Y. H., Haertsch, M., Camp, C., Skropeta, M., The Lifestyle Engagement Activity Program (LEAP): Implementing Social and Recreational Activity into Case-Managed Home Care, Journal of the	Ineligible intervention - not a social work approach to supporting changing needs

Study	Reason for exclusion
American Medical Directors Association, 16, 1069-1076, 2015	
Manthorpe, J., et al., Multiple exclusion homelessness: the preventive role of social work, British Journal of Social Work, 45, 587-599, 2015	Ineligible intervention - not a social work approach to supporting changing needs
Marino, M., et al., Effectiveness and cost-effectiveness of integrated care models for elderly, complex patients: a narrative review. Don't we need a value-based approach?, International Journal of Care Coordination, 21, 120-129, 2018	Ineligible study design – non-systematic review (narrative review)
Mavandadi, S., Benson, A., DiFilippo, S., Streim, J. E., Oslin, D., A Telephone-Based Program to Provide Symptom Monitoring Alone vs Symptom Monitoring Plus Care Management for Late-Life Depression and Anxiety: a Randomized Clinical Trial, JAMA psychiatry, 72, 1211-1218, 2015	Ineligible country – study conducted in the US
Maybery, D. J., Goodyear, M. J., Reupert, A. E., Harkness, M. K., Goal setting within family care planning: families with complex needs, The Medical journal of Australia, 199, S37-S39, 2013	Ineligible Intervention – not a social work approach to supporting changing needs
Mayo ,N.E., Scott, S., Evaluating a complex intervention with a single outcome may not be a good idea: An example from a randomised trial of stroke case management, Age and Ageing, 40, 718-724, 2011	Ineligible population - nurse case-management
McBrien, K.A., et al., Patient navigators for people with chronic disease: a systematic review, PloS one, 13, 2018	Systematic review - references checked but none meet the PICO criteria
McNab, J., Paterson, J., Fernyhough, J., Hughes, R., Role of the GP liaison nurse in a community health program to improve integration and coordination of services for the chronically ill, Australian Journal of Primary Health, 22, 123-127, 2016	Ineligible study design - qualitative
Metzelthin, S. F., Bleijenberg, N., Blom, J. W., Imhof, L., Primary care strategies to maintain independence of frail older people: looking for evidence across borders, European Geriatric Medicine, 5, S31-S32, 2014	Ineligible study design - conference abstract
Miller, K. L., Patient centered care: A path to better health outcomes through engagement and activation, Neurorehabilitation, 39, 465-470, 2016	Ineligible study design - non-systematic review (narrative review)
Moore, M., Ekman, E., Shumway, M., Understanding the Critical Role of Social Work in Safety Net Medical Settings: Framework for Research and Practice in the Emergency Department, Social Work in Health Care, 51, 140-148, 2012	Ineligible study design - non-systematic review (narrative review)
Morandi, S., Silva, B., Golay, P., Bonsack, C., Intensive Case Management for Addiction to promote engagement with care of people with severe mental and substance use disorders: an	Ineligible study design - observational study.

Study	Reason for exclusion
observational study, Substance abuse treatment, prevention, and policy, 12, 26, 2017	
National Institute for Health & Care Excellence, Older people with social care needs and multiple long-term conditions: NG22, 2015	Ineligible study design - NICE guideline, references checked but none meet the PICO criteria
Nct, Specialized Community Disease Management to Reduce Substance Use and Hospital Readmissions, https://clinicaltrials.gov/show/NCT02059005, 2014	Ineligible country – study conducted in the US
Nct, Community Vascular and Multiple Chronic Conditions Intervention Study, https://clinicaltrials.gov/show/NCT02209285, 2014	Ineligible study design – protocol
NHS, England, Personalised care for veterans in England: a guide for clinical commissioning groups and local authorities, 2019	Ineligible study design – guidance
Ntr, The effects of a new care model for people aged 75 years and older, http://www.who.int/trialsearch/Trial2.aspx?TrialID=NTR3039, 2011	Ineligible study design – protocol
Ntr, Routine Risk Assessment and Care Evaluation (RACE) in outpatient forensic psychiatry, http://www.who.int/trialsearch/Trial2.aspx?TrialID=NTR1042, 2007	Ineligible study design - protocol
O'Donnell, A. E., Schaefer, K. G., Stevenson, L. W., DeVoe, K., Walsh, K., Mehra, M. R., Desai, A. S., Social Worker-Aided Palliative Care Intervention in High-risk Patients With Heart Failure (SWAP-HF): a Pilot Randomized Clinical Trial, JAMA cardiology, 3, 516-519, 2018	Ineligible country – study conducted in the US
O'Donnell, A. E., Schaefer, K. G., Stevenson, L. W., Mehra, M. R., Desai, A. S., A Randomized Controlled Trial of a Social Worker-Aided Palliative Care Intervention in High Risk Patients with Heart Failure (SWAP-HF), Journal of cardiac failure, 22, 940, 2016	Ineligible study design - conference abstract
Oestergaard, L. G., Christensen, F. B., Bunger, C. E., Sogaard, R., Holm, R., Helmig, P., Nielsen, C. V., Does adding case management to standard rehabilitation affect functional ability, pain, or the rate of return to work after lumbar spinal fusion? A randomized controlled trial with two-year follow-up, Clinical rehabilitation, 269215519897106, 2020	Ineligible intervention - not a social work approach to supporting changing needs
Park, T. W., Cheng, D. M., Samet, J. H., Winter, M. R., Saitz, R., Chronic care management for substance dependence in primary care among patients with co-occurring disorders, Psychiatric Services, 66, 72-79, 2015	Ineligible country – study conducted in the US
Pauley, T., Gargaro, J., Falode, A., Beben, N., Sikharulidze, L., Mekinda, B., Evaluation of an integrated cluster care and supportive housing model for unstably housed persons using the	Ineligible intervention - not a social work approach to supporting changing needs (clinician led intervention)

Study	Reason for exclusion
shelter system, Prof Case Manag, 21, 34-42, 2016	
Piercy, H., et al., Evaluation of an integrated service delivering post diagnostic care and support for people living with dementia and their families, Health and Social Care in the Community, 26, 819-828, 2018	Ineligible intervention - not a social work approach to supporting changing needs
Professional Record Standards Body, Digital care and support plan, 2018	Ineligible study design - non-systematic review (literature review)
Professional Record Standards Body, Digital care and support plan standard: final report, 72, 2018	Ineligible study design – guidance
Quilty, S., Wood, L., Scrimgeour, S., Shannon, G., Sherman, E., Lake, B., Budd, R., Lawton, P., Moloney, M., Addressing profound disadvantages to improve indigenous health and reduce hospitalisation: A collaborative community program in remote northern territory, International Journal of Environmental Research and Public Health, 16, 2019	Ineligible intervention - not a social work approach to supporting changing needs
Reilly, S., Miranda-Castillo, C., Malouf, R., Hoe, J., Toot, S., Challis, D., Orrell, M., Case management approaches to home support for people with dementia, Cochrane Database of Systematic Reviews, 2015	Cochrane review - references checked but none meet the PICO criteria
Rietkerk, W., Uittenbroek, R. J., Gerritsen, D. L., Slaets, J. P. J., Zuidema, S. U., Wynia, K., Goal planning in person-centred care supports older adults receiving case management to attain their health-related goals, Disability and rehabilitation, 1-10, 2019	Ineligible study design - observational study
Robertson, J., Fitts, M. S., Petrucci, J., McKay, D., Hubble, G., Clough, A. R., Cairns Mental Health Co-Responder Project: Essential elements and challenges to programme implementation, International Journal of Mental Health Nursing, 29, 450-459, 2020	Ineligible intervention - not a social work approach to supporting changing needs
Robinson, L., Iliffe, S., Brayne, C., Goodman, C., Rait, G., Manthorpe, J., Ashley, P., Moniz-Cook, E., Primary care and dementia: 2. Long-term care at home: Psychosocial interventions, information provision, carer support and case management, International Journal of Geriatric Psychiatry, 25, 657-664, 2010	Ineligible study design – non-systematic review (narrative review)
Robinson, L., et al., Primary care and dementia: 2. long-term care at home: psychosocial interventions, information provision, carer support and case management, International Journal of Geriatric Psychiatry, 25, 657-664, 2010	Systematic review - references checked but none meet the PICO criteria
Ruchlewska, A., Kamperman, A. M., Wierdsma, A. I., van der Gaag, M., Mulder, C. L., Determinants of Completion and Use of Psychiatric Advance Statements in Mental Health Care in the The Netherlands, Psychiatric services (Washington, D.C.), 67, 858-863, 2016	Ineligible intervention - not a social work approach to supporting changing needs

Study	Reason for exclusion
Ruikes, F. G. H., Zuidema, S. U., Akkermans, R. P., Assendelft, W. J. J., Schers, H. J., Koopmans, Rtcm, Multicomponent program to reduce functional decline in frail elderly people: a cluster controlled trial, Journal of the American board of family medicine, 29, 209-217, 2016	Ineligible intervention - not a social work approach to supporting changing needs
Sanon, M., Hwang, U., Abraham, G., Goldhirsch, S., Richardson, L. D., Gedi Wise Investigators, ACE Model for Older Adults in ED, Geriatrics, 4, 21, 2019	Ineligible country – study conducted in the US
Scheiner, N., Cohen, S., Davis, R., Gale, T., Agyare, A., The effect of integrated care on self-management and emergency department attendance, BJPsych Bulletin, 43, 117-122, 2019	Ineligible intervention - not a social work approach to supporting changing needs
Scherz, N., Bachmann-Mettler, I., Chmiel, C., Senn, O., Boss, N., Bardheci, K., Rosemann, T., Case management to increase quality of life after cancer treatment: A randomized controlled trial, BMC Cancer, 17 (1) (no pagination), 2017	Ineligible intervention - not a social work approach to supporting changing needs
Siskind, D., Dark, F., Carney, K., Gore-Jones, V., Kar Ray, M., Steginga, A., Suetani, S., Kisely, S., Placing rehabilitation at the core of assertive community treatment, Australasian Psychiatry., 2020	Ineligible intervention - not a social work approach to supporting changing needs
Slesnick, N., Guo, X., Brakenhoff, B., Bantchevska, D., A Comparison of Three Interventions for Homeless Youth Evidencing Substance Use Disorders: Results of a Randomized Clinical Trial, Journal of Substance Abuse Treatment, 54, 1-13, 2015	Ineligible population – includes ages 14-20
Smith, D., Harnett, S., Flanagan, A., Hennessy, S., Gill, P., Quigley, N., Carey, C., McGhee, M., McManus, A., Kennedy, M., Kelly, E., Carey, J., Concannon, A., Kennedy, H. G., Mohan, D., Beyond the walls: An evaluation of a pre-release planning (PReP) programme for sentenced mentally disordered offenders, Frontiers in Psychiatry, 9, 2018	Ineligible study design - observational study
Somers, J. M., Patterson, M. L., Moniruzzaman, A., Currie, L., Rezansoff, S. N., Palepu, A., Fryer, K., Vancouver At Home: pragmatic randomized trials investigating Housing First for homeless and mentally ill adults, Trials, 14, 2013	Ineligible outcomes - no critical/important outcomes reported
Sonola, L., et al., Oxleas advanced dementia service: supporting carers and building resilience, 32, 2013	Ineligible study design - case study
Spicer, B., Smith, D. I., Conroy, E., Flatau, P. R., Burns, L., Mental illness and housing outcomes among a sample of homeless men in an Australian urban centre, Australian and New Zealand Journal of Psychiatry, 49, 471-480, 2015	Ineligible intervention - not a social work approach to supporting changing needs
Spoorenberg, S. L., Reijneveld, S. A., Uittenbroek, R. J., Kremer, H. P., Wynia, K., Health-Related Problems and Changes After 1 Year as Assessed With the Geriatric ICF Core	Ineligible outcomes - no critical/important outcomes reported

Study	Reason for exclusion
Set (GeriatrICS) in Community-Living Older Adults Who Are Frail Receiving Person-Centered and Integrated Care From Embrace, Archives of Physical Medicine and Rehabilitation, 100, 2334-2345, 2019	
Spoorenberg, S. L., Uittenbroek, R. J., Middel, B., Kremer, B. P., Reijneveld, S. A., Wynia, K., Embrace, a model for integrated elderly care: study protocol of a randomized controlled trial on the effectiveness regarding patient outcomes, service use, costs, and quality of care, BMC geriatrics, 13, 62, 2013	Ineligible study design – protocol
Steffen, S., Kalkan, R., Völker, K., Freyberger, H., Janssen, B., Ramacher, M., Klein, H. E., Sohla, K., Bergk, J., Grempler, J., et al.,, RCT on discharge planning for high utilisers of mental health care: conduct and quality of the intervention, Psychiatrische praxis, 38, 69-76, 2011	Ineligible study - non-English language (German)
Stergiopoulos, V., Gozdzik, A., Cohen, A., Guimond, T., Hwang, S. W., Kurdyak, P., Leszcz, M., Wasylenki, D., The effect of brief case management on emergency department use of frequent users in mental health: Findings of a randomized controlled trial, PLoS ONE, 12, 2017	Ineligible intervention - not a social work approach to supporting changing needs
Stergiopoulos, V., Gozdzik, A., Misir, V., Skosireva, A., Connelly, J., Sarang, A., Whisler, A., Hwang, S. W., O'Campo, P., McKenzie, K., Effectiveness of housing first with intensive case management in an ethnically diverse sample of homeless adults with mental illness: A randomized controlled trial, PLoS ONE, 10 (7) (no pagination), 2015	Ineligible intervention - not a social work approach to supporting changing needs
Stergiopoulos, V., Hwang, S. W., Gozdzik, A., Nisenbaum, R., Latimer, E., Rabouin, D., Adair, C. E., Bourque, J., Connelly, J., Frankish, J., et al.,, Effect of scattered-site housing using rent supplements and intensive case management on housing stability among homeless adults with mental illness: a randomized trial, JAMA, 313, 905-915, 2015	Ineligible intervention - not a social work approach to supporting changing needs
Stergiopoulos, V., Mejia-Lancheros, C., Nisenbaum, R., Wang, R., Lachaud, J., O'Campo, P., Hwang, S. W., Long-term effects of rent supplements and mental health support services on housing and health outcomes of homeless adults with mental illness: extension study of the At Home/Chez Soi randomised controlled trial, The Lancet Psychiatry, 6, 915-925, 2019	Ineligible intervention - not a social work approach to supporting changing needs
Sumalinog, R., Harrington, K., Dosani, N., Hwang, S. W., Advance care planning, palliative care, and end-of-life care interventions for homeless people: A systematic review, Palliative Medicine, 31, 109-119, 2017	Systematic review - references checked but none meet the PICO criteria

Study	Reason for exclusion
Tahan, H. A., Sminkey, P. V., Motivational interviewing: building rapport with clients to encourage desirable behavioral and lifestyle changes, Professional Case Management, 17, 164-72; quiz 173-4, 2012	Ineligible study – non-systematic review (narrative review)
Taylor, J. E., Taylor, J. A., Person-Centered Planning: Evidence-Based Practice, Challenges, and Potential for the 21st Century, Journal of Social Work in Disability and Rehabilitation, 12, 213-235, 2013	Ineligible study design – non-systematic review (narrative review)
Thornicroft, G., Farrelly, S., Szmukler, G., Birchwood, M., Waheed, W., Flach, C., Barrett, B., Byford, S., Henderson, C., Sutherby, K., Lester, H., Rose, D., Dunn, G., Leese, M., Marshall, M., Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial, The Lancet, 381, 1634-1641, 2013	Ineligible intervention - not a social work approach to supporting changing needs
Torjesen, I., Tailored long term support. The next step of the journey, The Health service journal, 120, suppl 8-9, 2010	Ineligible study design - non-systematic review (narrative article)
Tse, S., Tsoi, E. W., Hamilton, B., O'Hagan, M., Shepherd, G., Slade, M., Whitley, R., Petrakis, M., Uses of strength-based interventions for people with serious mental illness: A critical review, Int J Soc Psychiatry, 62, 281-91, 2016	Systematic review - references checked but none meet the PICO criteria
Tyler, N., Wright, N., Waring, J., Interventions to improve discharge from acute adult mental health inpatient care to the community: systematic review and narrative synthesis, BMC health services research, 19, 883, 2019	Systematic review (references checked), references checked but none meet the PICO criteria
Vaiva, G., Walter, M., Al Arab, A. S., Courtet, P., Bellivier, F., Demarty, A. L., Duhem, S., Ducrocq, F., Goldstein, P., Libersa, C., ALGOS: the development of a randomized controlled trial testing a case management algorithm designed to reduce suicide risk among suicide attempters, BMC psychiatry, 11, 1, 2011	Ineligible study design – protocol
Vanderplasschen, W., Rapp, R. C., De Maeyer, J., Van Den Noortgate, W., A meta-analysis of the efficacy of case management for substance use disorders: A recovery perspective, Frontiers in Psychiatry, 10, 2019	Systematic review - references checked but none meet the PICO criteria
Viloria Jimenez, M. A., Chung Jaen, M., Vigara Garcia, M., Barahona-Alvarez, H., Decision-making in older people with dementia, Reviews in Clinical Gerontology, 23, 307-316, 2013	Ineligible study design – non-systematic review (narrative description)
Wales Welsh Assembly Government. Task, Finish Group on Care Pathways for Long Term Neurological, Conditions, Report of the task and finish group on care pathways for long term neurological conditions, 11p., 2010	Ineligible study design – non-systematic review (reports)
Whitehead, L. C., Trip, H. T., Hale, L. A., Conder, J., Negotiated autonomy in diabetes self-management: The experiences of adults with intellectual disability and their support	Ineligible study design - qualitative study

Study	Reason for exclusion
workers, Journal of Intellectual Disability Research, 60, 389-397, 2016	
Wideman, M., Geriatric care management: role, need, and benefits, Home Healthcare Nurse, 30, 553-9, 2012	Ineligible country – study conducted in the US
Wiechman, S. A., Carrougher, G. J., Esselman, P. C., Klein, M. B., Martinez, E. M., Engrav, L. H., Gibran, N. S., An expanded delivery model for outpatient burn rehabilitation, Journal of burn care & research, 36, 14-22, 2015	Ineligible country – study conducted in the US
Wilhelmson, K., Duner, A., Eklund, K., Gosman-Hedstrom, G., Blomberg, S., Hasson, H., Gustafsson, H., Landahl, S., Dahlin-Ivanoff, S., Design of a randomized controlled study of a multi-professional and multidimensional intervention targeting frail elderly people, BMC Geriatrics, 11, 2011	Ineligible study design – protocol
Wilhelmson, K., Duner, A., Eklund, K., Gosman-Hedström, G., Blomberg, S., Hasson, H., Gustafsson, H., Landahl, S., Dahlin-Ivanoff, S., Design of a randomized controlled study of a multi-professional and multidimensional intervention targeting frail elderly people, BMC geriatrics, 11, 24, 2011	Ineligible study design – protocol
Winchcombe, M., A life more ordinary: findings from the long-term neurological conditions research initiative: an independent overview report for the Department of Health, 104p., 2012	Ineligible study design - non-systematic review (overview report)
Wistow, G., Perkins, M., Knapp, M., Bauer, A., Bonin, E-M., Circles of Support and personalization, Journal of Intellectual Disabilities, 20, 194-207, 2016	Ineligible study design - non-systematic review (case studies)
Wittenberg, R., Malley, J., King, D., The long-term care system for the elderly in England, 46p., 2010	Ineligible study - non-systematic review (narrative overview)
Woltmann, E. M., Whitley, R., Shared decision making in public mental health care: perspectives from consumers living with severe mental illness, Psychiatric Rehabilitation Journal, 34, 29-36, 2010	Ineligible country – study conducted in the US
Wynia, K., Annema, C., Nissen, H., De Keyser, J., Middel, B., Design of a Randomised Controlled Trial (RCT) on the effectiveness of a Dutch patient advocacy case management intervention among severely disabled Multiple Sclerosis patients, BMC health services research, 10, 142, 2010	Ineligible study design - protocol
Wynia, K., Uittenbroek, R. J., van der Mei, S. F., Slotman, K., Reijneveld, S. A., Experiences of case managers in providing person-centered and integrated care based on the Chronic Care Model: A qualitative study on embrace, PLoS ONE, 13, 2018	Ineligible study design – qualitative
Zhang, J., Slesnick, N., Substance Use and Social Stability of Homeless Youth: A	Ineligible country – study conducted in the US

Study	Reason for exclusion
Comparison of Three Interventions, Psychology of addictive behaviors, 32, 873-884, 2018	
Zimmermann, T., Puschmann, E., Ebersbach, M., Daubmann, A., Steinmann, S., Scherer, M., Effectiveness of a primary care based complex intervention to promote self-management in patients presenting psychiatric symptoms: Study protocol of a cluster-randomized controlled trial, BMC Psychiatry, 14, 2014	Ineligible study design – protocol

Excluded studies for review questions C: Based on the views and experiences of everyone involved, what works well and what can be improved about case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

Excluded qualitative studies

Table 28: Excluded studies and reasons for their exclusion – qualitative review

Study	Reason for Exclusion
Abbott, P. J., Case management: ongoing evaluation of patients' needs in an opioid treatment program, Professional case management, 15, 145-152, 2010	Ineligible country – study conducted in the US
Abell, J., Hughes, J., Reilly, S., Case management for long-term conditions, J Integr Care, 18, 2010	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Abendstern, M., Care coordination for adults and older people: the role and contribution of the non-statutory sector, J Integr Care, 24, 271-281, 2016	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Abendstern, M., et al., CMHTs for older people: team managers' views surveyed, J Integr Care, 22, 209-219, 2014	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Agar, M., Chenoweth, L., Mitchell, G., Goodall, S., Beattie, E., Luscombe, G., Pond, D., Phillips, J., Luckett, T., Davidson, P., Implementing facilitated case conferencing for aged care residents with advanced dementia-development of a palliative care planning coordinator role, Palliative medicine, Conference, NP20160228-NP20160229, 2016	Ineligible study design - conference poster
Allen, J., et al., User experience and care for older people transitioning from hospital to home: patients' and carers' perspectives, Health Expect, 21, 518-527, 2018	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Balard, F., Corre, S. P., Trouve, H., Saint-Jean, O., Somme, D., Exploring representations and experiences of case-management users: towards difficulties and solutions to leading qualitative interviews with older people with complex living conditions, Quality in Primary CareQual Prim Care, 21, 229-35, 2013	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Baxter, K., Changing choices: disabled and chronically ill people's experiences of reconsidering choices, Chronic Illness, 9, 116-32, 2013	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Baxter, K., Glendinning, C., Making choices about support services: disabled adults' and older people's use of information, Health & social care in the community, 19, 272-9, 2011	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Bennett, M., von Treuer, K., McCabe, M. P., Beattie, E., Karantzas, G., Mellor, D., Sanders, K., Busija, L., Goodenough, B., Byers, J., Resident perceptions of opportunity for communication and contribution to care planning	Ineligible phenomenon of interest – not a social work approach to supporting changing needs

Study	Reason for Exclusion
in residential aged care, International journal of older people nursing, 15, e12276, 2020	
Booth, B. J., Zwar, N., Harris, M. F., Healthcare improvement as planned system change or complex responsive processes? a longitudinal case study in general practice, BMC Family PracticeBMC Fam Pract, 14, 51-62, 2013	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Bramley, G., Mangan, C., Conroy, M., Using telemonitoring to support personal care planning for adults with learning disabilities, Journal of telemedicine and telecare, 25, 602-610, 2019	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Brown, S., Vollm, B., Case formulation in personality disordered offenders: views from the front line, Criminal Behaviour & Mental HealthCrim, 23, 263-73, 2013	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Cameron, A., Johnson, E. K., Lloyd, L., Evans, S., Smith, R., Porteus, J., Darton, R., Atkinson, T., Using longitudinal qualitative research to explore extra care housing, International Journal of Qualitative Studies on Health and Well-Being, 14, 1593038, 2019	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Chen, L., Xiao, L. D., De Bellis, A., First-time stroke survivors and caregivers' perceptions of being engaged in rehabilitation, Journal of Advanced Nursing (John Wiley & Sons, Inc.), 72, 73-84, 2016	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Clark, C., Guenther, C. C., Mitchell, J. N., Case Management Models in Permanent Supported Housing Programs for People With Complex Behavioral Issues Who Are Homeless, Journal of Dual Diagnosis, 12, 185-192, 2016	Ineligible study design – non-systematic review (narrative review)
Davison, G., Shelby-James, T. M., Palliative care case conferencing involving general practice: an argument for a facilitated standard process, Australian Health Review, 36, 115-119, 2012	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Elder, N. C., Tubb, M. R., Diabetes in homeless persons: barriers and enablers to health as perceived by patients, medical, and social service providers, Social Work in Public HealthSoc, 29, 220-231, 2014	Ineligible country - study conduced in the US
Elissen, A., Nolte, E., Knai, C., Brunn, M., Chevreul, K., Conklin, A., Durand-Zaleski, I., Erler, A., Flamm, M., Frolich, A., Fullerton, B., Jacobsen, R., Saz-Parkinson, Z., Sarria-Santamera, A., Sonnichsen, A., Vrijhoef, H., Is Europe putting theory into practice? A qualitative study of the level of self-management support in chronic care management approaches, BMC Health Services ResearchBMC Health Serv Res, 13, 117, 2013	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Gore, N. J., Forrester-Jones, R., Young, R., Staff experiences of supported employment with the sustainable hub of innovative employment for people with complex needs, British Journal of Learning Disabilities, 42, 228-235, 2014	Ineligible phenomenon of interest – not a social work approach to supporting changing needs

Study	Reason for Exclusion
Hammond, F. M., Gassaway, J., Abeyta, N., Freeman, E. S., Primack, D., Kreider, S. E., Whiteneck, G., Outcomes of social work and case management services during inpatient spinal cord injury rehabilitation: the SCIRehab project, Journal of Spinal Cord Medicine, 35, 611-23, 2012	Ineligible country - study conduced in the US
Hawkins, E. J., Lott, A. M., Malte, C. A., Frank, A. N., Hamilton, B., Sayre, G. G., Painter, J. M., Baer, J. S., Patients' perspectives on care management services for complex substance use disorders, Journal of Addictive Diseases, 36, 193-206, 2017	Ineligible country - study conduced in the US
Herman, D. B., Transitional support for adults with severe mental illness: Critical time intervention and its roots in assertive community treatment, Research on Social Work Practice, 24, 556-563, 2014	Ineligible study design – non-systematic review (narrative review)
Hopkin, G., Evans-Lacko, S., Forrester, A., Shaw, J., Thornicroft, G., Interventions at the Transition from Prison to the Community for Prisoners with Mental Illness: A Systematic Review, Administration and Policy in Mental Health and Mental Health Services Research, 45, 623-634, 2018	Systematic review - references checked but none meet the PICO criteria
Hudon, C., Chouinard, M. C., Dubois, M. F., Roberge, P., Loignon, C., Tchouaket, É, Lambert, M., Hudon, É, Diadiou, F., Bouliane, D., Case Management in Primary Care for Frequent Users of Health Care Services: a Mixed Methods Study, Annals of family medicine, 16, 232-239, 2018	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Hughes, A. K., et al., Improving stroke transitions: development and implementation of a social work case management intervention, Social work in health care, 57, 95-108, 2018	Ineligible country - study conducted in the US
Isrctn, Engager: evaluation of a collaborative care intervention for offenders, http://www.who.int/trialsearch/Trial2.aspx?TrialID=ISRCTN11707331, 2016	Ineligible study design – protocol
Johnston, B., Patterson, A., Bird, L., Wilson, E., Almack, K., Mathews, G., Seymour, J., Impact of the Macmillan specialist Care at Home service: A mixed methods evaluation across six sites, BMC Palliative Care, 17 (1) (no pagination), 2018	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Kahan, D., Leszcz, M., O'Campo, P., Hwang, S. W., Wasylenki, D. A., Kurdyak, P., Wise Harris, D., Gozdzik, A., Stergiopoulos, V., Integrating care for frequent users of emergency departments: implementation evaluation of a brief multi-organizational intensive case management intervention, BMC health services research, 16, 156, 2016	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Kahan, D., Poremski, D., Wise-Harris, D., Pauly, D., Leszcz, M., Wasylenki, D., Stergiopoulos, V., Perceived case management needs and service	Ineligible phenomenon of interest – not a social work approach to supporting changing needs

Study	Reason for Exclusion
preferences of frequent emergency department users: Lessons learned in a large urban centre, PLoS ONE, 11, 2016	
Kupeli, N., Leavey, G., Moore, K., Harrington, J., Lord, K., King, M., Nazareth, I., Sampson, E. L., Jones, L., Context, mechanisms and outcomes in end of life care for people with advanced dementia, BMC Palliative Care, 15, 31, 2016	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Lakhani, A., Perspectives of self-direction: a systematic review of key areas contributing to service users' engagement and choice-making in self-directed disability services and supports, Health and Social Care in the Community, 26, 295-313, 2018	Systematic review - references checked but none meet the PICO criteria
Lamanna, D., et al., Promoting continuity of care for homeless adults with unmet health needs: the role of brief interventions, Health and Social Care in the Community, 26, 56-64, 2018	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Linskell, J., Bouamrane, M. M., Assisted-living spaces for end-users with complex needs: a proposed implementation and delivery model, Health informatics journal, 18, 159-170, 2012	Ineligible study design – non-systematic review (narrative review)
Lupari, M., Coates, V., Adamson, G., Crealey, G. E., 'We're just not getting it right'- how should we provide care to the older person with multi-morbid chronic conditions?, Journal of Clinical Nursing (John Wiley & Sons, Inc.), 20, 1225-1235, 2011	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Macnaughton, E., Townley, G., Nelson, G., Caplan, R., Macleod, T., Polvere, L., Isaak, C., Kirst, M., McAll, C., Nolin, D., Patterson, M., Piat, M., Goering, P., How does Housing First catalyze recovery?: Qualitative findings from a Canadian multi-site randomized controlled trial, American Journal of Psychiatric Rehabilitation, 19, 136-159, 2016	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Magwood, O., et al., Common trust and personal safety issues: a systematic review on the acceptability of health and social interventions for persons with lived experience of homelessness, PLoS ONE, 14, 2019	Systematic review - references checked but none meet the PICO criteria
Manthorpe, J., et al., Multiple exclusion homelessness: the preventive role of social work, British Journal of Social Work, 45, 587-599, 2015	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Mao, A Y., Willard-Grace, R, Dubbin, L, Aronson, L, Fernandez, A, Burke, N J., Finch, J, Davis, E, Perspectives of low-income chronically ill patients on complex care management, Fam Syst Health, 35, 399-408, 2017	Ineligible country - study conducted in the US
Martin, R., Levack, W. M. M., Sinnott, K. A., Life goals and social identity in people with severe acquired brain injury: An interpretative phenomenological analysis, Disability and Rehabilitation, 37, 1234-1241, 1234	Ineligible phenomenon of interest – not a social work approach to supporting changing needs

Study	Reason for Exclusion
Mayo, N.E., Scott, S., Evaluating a complex intervention with a single outcome may not be a good idea: An example from a randomised trial of stroke case management, Age and Ageing, 40, 718-724, 2011	Ineligible population - nurse case-management, not a social work approach
McBrien, K. A., et al., Patient navigators for people with chronic disease: a systematic review, PloS one, 13, 2018	Systematic review - references checked but none meet the PICO criteria
McEvoy, P., Escott, D., Bee, P., Case management for high-intensity service users: Towards a relational approach to care co-ordination, Health Soc Care Community, 19, 60-69, 2011	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
McMaster, R., Lopez, V., Kornhaber, R., Cleary, M., A qualitative study of a maintenance support program for women at risk of homelessness: Part 2: Situational factors, Issues in Mental Health Nursing, 38, 506-512, 2017	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Meranius, M. S., Josefsson, K., Health and social care management for older adults with multimorbidity: a multiperspective approach, Scandinavian Journal of Caring Sciences, 31, 96-103, 2017	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Moffatt, S., Steer, M., Lawson, S., Penn, L., O'Brien, N., Link Worker social prescribing to improve health and well-being for people with long-term conditions: Qualitative study of service user perceptions, BMJ Open, 7, 2017	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Morgan, H., et al., We need to talk about purpose: a critical interpretive synthesis of health and social care professionals-approaches to self-management support for people with long-term conditions, Health Expect, 20, 243-259, 2017	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Patterson, M. L., Currie, L., Rezansoff, S., Somers, J. M., Exiting homelessness: perceived changes, barriers, and facilitators among formerly homeless adults with mental disorders, Psychiatric rehabilitation journal, 38, 81-7, 2015	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Pollock, K., Wilson, E., NIHR Journals Library. Health Services and Delivery Research, 07, 07, 2015	Ineligible phenomenon of interest – not a social work approach to supporting changing needs.
Poremski, D., Harris, D. W., Kahan, D., Pauly, D., Leszcz, M., O'Campo, P., Wasylenki, D., Stergiopoulos, V., Improving continuity of care for frequent users of emergency departments: service user and provider perspectives, General Hospital Psychiatry, 40, 55-9, 2016	Ineligible phenomenon of interest – not a social work approach to supporting changing needs.
Redley, M., Mental Capacity Act (England and Wales) 2005: the emergent Independent Mental Capacity Advocate (IMCA) service, British Journal of Social Work, 40, 1812-1828, 2010	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Robinson, L., et al., Primary care and dementia: 2. long-term care at home: psychosocial interventions, information provision, carer support and case management, International	Systematic review - references checked but none meet the PICO criteria

Study	Reason for Exclusion
Journal of Geriatric Psychiatry, 25, 657-664, 2010	
Scholz Mellum, J., Martsolf, D., Glazer, G., Martsolf, G., Tobias, B., A mixed methods study of the experience of older adults with multimorbidity in a Care Coordination Program, International Journal of Care Coordination, 21, 36-46, 2018	Ineligible country - study conducted in the US
Shaw, L., et al., Experiences of interventions aiming to improve the mental health and well-being of children and young people with a long-term physical condition: a systematic review and meta-ethnography, Child: Care, 45, 832-849, 2019	Systematic review - references checked but none meet the PICO criteria
Sortedahl, C., Krsnak, J., Crook, M. M., Scotton, L., Case Managers on the Front Lines of Opioid Epidemic Response: Advocacy, Education, and Empowerment for Users of Medical and Nonmedical Opioids, Professional Case ManagementProf Case Manag, 23, 256-263, 2018	Ineligible study design - education activity
Turner, G. M., McMullan, C., Atkins, L., Foy, R., Mant, J., Calvert, M., TIA and minor stroke: a qualitative study of long-term impact and experiences of follow-up care, BMC family practice, 20, 176, 2019	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Tyler, N., Wright, N., Waring, J., Interventions to improve discharge from acute adult mental health inpatient care to the community: systematic review and narrative synthesis, BMC health services research, 19, 883, 2019	Systematic review - references checked but none meet the PICO criteria
Welch, N., Fernandes, A., Mental health and housing: developing a care and support pathway, Housing. Care and Support, 13, p16-22, 2010	Ineligible study design - description of on-going project
Wildman, J. M., Service-users' perspectives of link worker social prescribing: a qualitative follow-up study, BMC Public Health, 19, 2019	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Williams, V., Porter, S., Marriott, A., Your life, your choice: support planning led by disabled people's organisations, British Journal of Social Work, 44, 1197-1215, 2014	Ineligible phenomenon of interest – not a social work approach to supporting changing needs
Yu, K., Ng, T., Chan, A., Survivorship care models for breast cancer, colorectal cancer, and adolescent and young adult (AYA) cancer survivors: a systematic review, Supportive Care in Cancer, 26, 2125-2141, 2018	Systematic review - references checked but none meet the PICO criteria

Excluded economic studies

No economic evidence was identified for this review. See supplementary material 2 for further information.

Appendix K Research recommendations – full details

Research recommendations for review question C1: What is the effectiveness of case management and care planning approaches in social work (in relation to changing needs, wishes and capabilities)?

K.1.1 Research recommendation

What is the effectiveness and cost-effectiveness of early, preventative case management and care planning for people with complex needs?

K.1.2 Why this is important

The quantitative component of evidence review C was designed to locate evidence about the effectiveness of case management and care planning for adults with complex needs. Six studies were included but none of them reported data about case management and care planning to prevent a future escalation of needs. The committee were therefore unable to make recommendations for this area of practice and they agreed about the importance of generating evidence from future research to plug this evidence gap and provide a basis for recommendations when this guideline is updated. The committee agreed that case management and care planning to prevent the future escalation of needs is important for improving well-being, reducing the likelihood of an escalation of need, supporting carer quality of life and potentially achieving downstream savings and improving cost-effectiveness.

K.1.3 Rationale for research recommendation

Table 29: Research recommendation rationale

Importance to the population	Research in this area would improve people's experience of social work interventions if they are designed to take an early intervention approach so it can give greater scope to reduce people developing complex needs.
Relevance to NICE guidance	Generating quantitative evidence including evidence of cost-effectiveness will, subject to the results, provide the basis for making recommendations in future NICE guidance on preventative case management and care planning for adults with complex needs.
Relevance to the NHS and social care	Case management and care planning which prevents or minimises the future escalation of need can improve outcomes for the individual and their wider community which could reduce overall resource commitments required to manage the implications related to poor functioning and health and wellbeing, for example reducing crisis admissions.
National priorities	Such proactive interventions are in line with the NHS Long Term Plan, supporting people to age well, promoting living at home for longer and limiting the development of health needs leading to people not requiring extensive support and the associated costs.

	The Care Act, 2014 also sets out the statutory duty to prevent and delay the development of needs.
Current evidence base	The evidence review did not locate any UK based evidence about the effectiveness of case management and care planning to prevent a future escalation of need.
Equality considerations	Among the population of adults with complex needs, people experiencing intersectional discrimination experience particularly poor outcomes and they would benefit from improvements in earlier intervention.

NHS; National Health Service; NICE: National Institute for Health and Care Excellence

K.1.4 Modified PICO table

Table 29: Research recommendation modified PICO table

Population	18+ Adults with complex needs
Intervention	Case management and care planning specifically designed to prevent a future escalation of need.
Comparator	Standard case management and care planning
Outcome	• Physical and mental health related quality of life • Social care related quality of life including wellbeing • Unplanned care contacts, for example social work contact, A&E attendance, hospital admission or care home admission (either for respite or long term care). • Resource use • Cost-effectiveness • Community engagement
Study design	Controlled trial or prospective cohort study with controls for confounding alongside an economic evaluation.
Timeframe	The research should take place in time to inform future updates of this NICE guideline.
Additional information	-

A&E: Accident and Emergency; NICE: National Institute for Health and Care Excellence