National Institute for Health and Care Excellence

Final

Social work with adults experiencing complex needs

[E] Integrated working

NICE guideline NG216

Evidence reviews underpinning recommendations 1.1.9 and 1.7.1 to 1.7.8 in the NICE guideline

May 2022

Final

These evidence reviews were developed by the National Guideline Alliance

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This evidence report contains information on 2 reviews relating to integrated working among social workers and other practitioners, the first an effectiveness review and the second, a qualitative review.

- What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?
- Based on the views and experiences of everyone involved, what are the facilitators and barriers to integrated working between registered social workers and other practitioners to support adults with complex needs?

Integrated working

Review questions

- What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?
- Based on the views and experiences of everyone involved, what are the facilitators and barriers to integrated working between registered social workers and other practitioners to support adults with complex needs?

Introduction

The role of social workers within multidisciplinary teams was identified as a topic of key relevance for this guideline because people with complex needs require support and expertise from different services and teams. Multidisciplinary teams (MDTs) are often the mechanism for organising and coordinating health and care services to meet the needs of individuals with complex care needs. The teams bring together the expertise and skills of different professionals to jointly assess, plan and manage care. This approach ensures people with complex needs experience services in a more seamless way, with their needs placed at the centre. This review was designed to identify evidence about the effectiveness of integrated working involving social workers and also to understand the barriers and facilitators to integrated working between social workers and other practitioners.

Summary of the protocol

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

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	Integrated working among social workers and other practitioners (such as health and housing) to support adults with complex needs. The following arrangements are listed as possible forms of integrated working but the review will not be limited to these: • Collaborative arrangement (working together, better coordination, budgets not pooled. Teams may be virtual or working in one place. Legally separate). • More formal partnership (teams co-located, some degree of joint management. Some degree of sharing of budgets. Legally separate). • A formal partnership (pooled budgets. teams co-located, definite single management arrangements. Pooled budgets. Legally separate). • Integration (One organisation, for example, Care Trust. All staff employed by the Trust [or this is the intention]. One budget. Legally one).

	Integrated working may also feature: • Joint assessments. • Information sharing. • Single point of access through a named coordinator or key worker. • Access to a range of community services.
Comparison	Integrated working compared with: • Current practice. • Not using an integrated approach to working (no service). • Different integrated working arrangements.
Outcome	**Critical** Person focused outcomes: • Subjective quality of life – measured using a validated tool such as ASCOT, ICECAP-A, MANSA or the EQ-5D. • Subjective satisfaction with integrated support. Service focused outcomes: • Numbers of referrals between services or teams or hand-offs between professionals. • Delayed transfer from hospital to home or other community setting. • Waiting times for assessment or review. **Important** Person focused outcomes: • Unplanned care contacts, for example, emergency or unplanned admission to hospital, A&E attendance, street triage, ambulance call-outs, 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, for example, by changes in care co-ordinator or care manager.

A&E: accident and emergency; ASCOT: Adult Social Care Outcomes Toolkit; EQ-5D: EuroQol-5 Dimensions; 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	Views, perceptions and/or lived experiences about the barriers and facilitators to integrated working (involving social workers) to support adults with complex needs. In order to understand the facilitators and barriers to this range of integrated working between registered social workers and other professionals supporting adults with complex needs, the committee want to locate data about: **People's views or experiences about what enables particular aspects or a particular form of integrated working.**

	• Section 75 agreements between a local authority and NHS body. • Access to shared budgets, or pooled or 'aligned' budgets. • Co-location. • Shared visions and values. • Joint training opportunities. • Virtual team meetings. • Experiences of integrated working including holistic assessments. **People's views or experiences about barriers to integrated working.** • Lack of resources. • Lack of shared understanding. • Cultural differences. • Communication. • Information sharing. • Lack of time. • Experiences of integrated working including holistic assessments.

NHS: National Health Service.

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 6 and shows how some of the qualitative themes helped to explain or contextualise the effectiveness findings. 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. Methods specific to this review question are described in the review protocol 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, insufficient UK studies were located to support decision making and 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 (8 publications) were identified which met the inclusion criteria.

The included studies are summarised in Table 3.

Four randomised controlled trials (RCTs) (6 publications) (Berglund 2013 and 2015, Chung 2018, Stobbe 2014, Spoorenberg 2018, Uittenbroek 2017) and 2 non-RCTs (Franse 2018, Murphy 2017) were included. One RCT (Berglund 2013 and 2015) and 1 non-RCT (Franse 2018) assessed the effect of co-ordinated care interventions, developed to provide frail older adults with, for example, needs assessment, interprofessional collaboration and care

planning, on quality of care and life satisfaction (functional capacity, psychological health and financial situation) (Berglund 2013 and 2015) or on health-related quality of life (Franse 2018). Chung (2018) compared the effects of Housing First (intensive case management or assertive community treatment) versus usual care on quality of life (QoL) in older (50 years old) and younger (18 to 49 years old) adults with mental illness who were experiencing homelessness. One non-RCT (Murphy 2017) compared the effects of an integrated health and social care day unit intervention versus community nursing services on QoL in adults with health and social care needs. Stobbe (2014) assessed the effectiveness of assertive community treatment compared with treatment as usual on care service use among older adults living with severe mental illness.

The remaining RCT (Spoorenberg 2018, Uittenbroek 2017) assessed the impact of a population-based, person-centred and integrated care service compared with care as usual on QoL and quality of care in community-living older adults.

The included studies were conducted in Canada (Chung 2018), Europe (UK, Greece, Croatia, The Netherlands, Spain) (Franse 2018), Sweden (Berglund 2013 and 2015), The Netherlands (Stobbe 2014, Spoorenberg 2018, Uittenbroek 2017) and the UK (Murphy 2017).

The study populations included adults with health and social care needs (requiring short-term support to live independently), frail older adults (with or without at least 1 chronic illness and/or requiring assistance in at least 1 activity of daily living), and older adults (including older adults experiencing homelessness) living with mental illness.

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

- Subjective Quality of Life (QoL).
- Subjective satisfaction with integrated support.
- Unplanned care contacts.

No meta-analyses were conducted on the studies due to heterogeneity between interventions.

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
Berglund 2013 RCT Sweden	N=161 older people Intervention, n=85 Control, n=76	Comprehensive continuum of care • Early geriatric needs assessment shared which is shared with inter-	Usual care • Care planning/discharge planning.	• Subjective satisfaction with integrated working (quality of care) at 3, 6 and 12 months follow-up.

Study	Population	Intervention	Comparison	Outcomes
	Age (years) - n (%) 65 to 79: Intervention: 18 (24); control: 16 (23) ≥80: Intervention: 58 (76); control: 53 (77) Gender - n (%) Male: Intervention: 33 (43); control: 31 (45)	professional teams; case management and inter-professional co-ordination; support for relatives and organisation of care planning and meetings in older people's own homes; follow-up by case manager once a month for 12 months for ongoing support, a new care planning meeting held after 6 months if needed.	• Meetings involving inter-professional team.	
Berglund 2015 RCT Sweden	N=161 older people Intervention, n=85 Control, n=76 Age (years) - n (%) 65 to 79: Intervention: 20 (24); control: 18 (24) ≥80: Intervention: 65 (76); control: 58 (76) Gender - n (%) Male: Intervention: 38 (45); control: 34 (45)	See Berglund 2013	See Berglund 2013	• Subjective QoL (life satisfaction as a whole) at 3, 6 and 12 months follow-up.
Chung 2018 RCT Canada	N=2148 homeless adults living with mental illness (n=470 ≥50 years old;	Housing First (HF) • Intensive Case Management (ICM) (including scattered housing in conjunction with	Treatment as Usual (TAU) • Existing services available in participants' respective communities	• Generic QoL (EQ-5D) at 12 and 24 months follow-up. • Condition-specific QoL (QoLI-20 total

Study	Population	Intervention	Comparison	Outcomes
	n=1678 18 to 49 years old) Age (years) - mean (±SD): ≥50 years old 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) Gender - n (%) ≥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)	social work case management) for participants with moderate needs. • ACT (involving scattered housing and support from a team comprising psychiatrists, nurses, case managers, and peer support workers) for participants with high needs. • Case managers developed individualised care plans with participants.		score) at 12 and 24 months follow-up.
Franse 2018 Non-RCT Europe (UK, Greece, Croatia, The Netherlands, Spain)	N= 1844 persons living independently, aged 75 years or older. **Greece** Intervention, n=154 Control: n=124 **Spain** Intervention n=207 Control, n=190 Age (years) - mean (±SD)	Urban Health Centres Europe (UHCE) • Preventive multi-dimensional assessment of health risks (with co-ordinated follow-up health and social care, if required), targeting fall risk, appropriate medication use, loneliness and frailty in older adults; shared decision making and care planning	Care as Usual (CAU) • Access to existing care services delivered in the care pathways, but not for newly developed services.	• Subjective QoL (SF-12 MCS/PCS; SF-36 mental well-being) at 12 months follow-up.

Study	Population	Intervention	Comparison	Outcomes
	Intervention: 75.1 (5.4); control: 75.3 (5.6) Gender (female) Intervention: 54.5%; control: 54.8%	• Only outcome data from Greece and Spain eligible for inclusion according to the protocol. Data from the other countries were not eligible for inclusion because they did not assess interventions involving social workers.		
Murphy 2017 Non-RCT Wales	N=66 adults admitted to the Integrated Health and Social Care Day Unit (IHSCDU) Intervention, n=33 Control, n=30) Age (years) - mean (±SD) Intervention: 77.80 (9.43); control: 82.67 (8.83) Gender (male) - n/N (%) Intervention: 11/30 (36.7%); control: 10/33 (30.3%)	Integrated Health and Social Care Day Unit (IHSCDU) • Purpose-built health and social care day facility providing services by a multi-disciplinary team of health and social care professionals (nurses, doctors, social workers, physiotherapists and occupational therapists).	Community nursing services • Provision of nursing assessments and nursing interventions and referrals to other health and social care agencies, if required.	• Subjective QoL (SF-12 MCS/PCS) at 4 and 9 months follow-up.
Spoorenberg 2018 Study design RCT Country The Netherlands	See Uittenbroek 2017	Embrace See Uittenbroek 2017	Care as Usual (CAU) See Uittenbroek 2017	• Subjective QoL (EQ-5D-3L, EQ-VAS, general) at 12 months follow-up
Stobbe 2014	N= 62 older patients with presumed	Assertive Community Treatment (ACT)	Treatment as Usual (TAU)	• Unplanned care contacts (first care

Study	Population	Intervention	Comparison	Outcomes
RCT The Netherlands	severe mental illness (for example schizophrenia spectrum disorders or major affective disorders) Intervention, n=32 Control, n=30 <u>Age* (years) - mean (±SD)</u> Intervention: 74.4 (7.0); control: 75.1 (9.3) * Due to recruitment difficulties the inclusion criteria was amended after 1 year to include adults aged 60 years and older and were not required to have problems in various domains because participants often received no medical or psychiatric treatment <u>Gender - n (%)</u> Male: Intervention: 16 (50); control: 10 (33.3)	• Community based treatment approach; including multi-disciplinary team providing psychiatric, somatic and rehabilitation treatment.	• Regular mental health services, including psychiatric care on an outreach basis	contact, hospitalisation, crisis contacts) within 3 months and 2 years follow-up)
Uittenbroek 2017 Study design RCT Country The Netherlands	N=365 older adults with complex care needs Intervention, n=187 Control, n=178 <u>Age (years) - mean (±SD)</u>	<u>Embrace</u> • Care and support offered by a multi-disciplinary Elderly Care Team (elderly care physician (that is, a nursing home physician), a community	<u>Care as Usual (CAU)</u> • Care provided by GP and local health and social care organisations	• Quality of integrated care and support from the perspective of older people (PAIEC) at 12 months follow-up

Study	Population	Intervention	Comparison	Outcomes
	Intervention: 81.8 (4.6); control: 81.5 (4.9) Gender (female) - n (%) Intervention: 121 (64.7); control: 115 (64.6)	nurse, and a social worker)		

ACT: assertive community treatment; CAU: care as usual; EQ-5 D 3L: EuroQol-Five Dimension-3 Level version; EQ-VAS: EuroQol Visual Analogue Scale; HF: Housing First; IHSCDU: integrated health and social care day unit; MCS: mental component summary; PAIEC: patient assessment of integrated elderly care; PCS: physical component summary; QoL: quality of life; QoLI-20: Lehman Quality of Life Interview 20 Index; RCT: randomised controlled trial; SD: standard deviation; SF-12: short-form 12; SF-36: short-form 36; TAU: treatment as usual; UHCE: Urban Health Centres Europe.

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. Twenty studies, (Abendstern 2014, Abendstern 2016, Aspinal 2014, Bailey 2012, Beresford 2019, Bower 2018, Cornes 2011, Farrington 2015, Joseph 2019, Krayer 2018, Levin 2019, Mangan 2014, Mitchell 2020, Naqvi 2019, Phillipowsky 2018, Phillipowsky 2020, Round 2018, Sheaff 2015, Sonola 2013, Taylor 2018, Vicary 2018) with 2 papers reporting from the same study (Phillipowsky 2018, Phillipowsky 2020), were included in this review.

The included studies are summarised in Table 4.

The data provided evidence on the barriers and facilitators of integrated working between social workers and other practitioners. Data collection methods included interviews, focus groups, free text questionnaire responses, observations of team meetings and deliberation events, which are interaction discussions.

The studies included the views of social workers, and practitioners who are part of integrated teams with social workers, people using services, and carers of people using services.

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 2014 General qualitative inquiry England **Aim of study** To explore the views of managers of Community Mental Health Teams regarding how well the integrated team works	N=225 team managers from community mental health teams.	**Data collection:** Free text responses of a survey **Data analysis:** Content analysis	Barriers • lack of resources • work culture differences • information sharing.
Abendstern 2016 General qualitative inquiry England **Aim of study** To explore the social workers contributions to a multidisciplinary team working with older people with mental ill health.	N=21 health and social care practitioners Hybrid team (co-located team but separately managed health and social care departments) interviewed n=6: Professional role types: Team manager Consultant psychiatrist Nurse Occupational therapist Social worker Integrated team (co-located and health and social care departments under one manager) interviewed n=15: Professional role types: Team manager Consultant psychiatrist Nurse Occupational therapist Social worker Support worker	**Data collection:** Semi-structured interviews **Data analysis:** Grounded theory approach with subjective interpretations open for challenge.	Facilitators • co-location • information sharing • retaining the social work identity. Barriers • increased staff workload • work culture differences.
Aspinal 2014 General qualitative inquiry England **Aim of study** To understand models of integration in neurorehabilitation teams for adults with long term neurological conditions.	N=66 practitioners, people who access services, and carers of people who access services NHS organisational staff, n=4 Social care organisational staff, n=2 Neurorehabilitation team staff, n=27 Non-neurorehabilitation staff, n=2 People with long-term neurological conditions, n=25	**Data collection:** Semi-structured interviews and focus groups **Data analysis:** Thematic anaysis	Facilitators • co-location • information sharing • shared visions and aims • joint training opportunities • experiences of integrated working • retaining the social work identity. Barriers • lack of resources • lack of shared understanding

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	Carers of people with long-term neurological conditions s, n=6		• work culture differences • complicated bureaucracy • information sharing.
Bailey 2012 Ethnographic design England **Aim of study** To explore the perspectives of mental health professionals and service users on the social work contribution from a multidisciplinary point.	N=24 health and social care practitioners Team manager, n=1 Community psychiatric nurse, n=5 Link worker, n=1 Mental Health Social Worker, n=7 Approved Mental Health Practitioner, n=2 Occupational Therapist, Assistants and Technicians, n=2 Psychologist, n=1 Advanced practitioner, n=1 Support worker, n=1 Nurse consultant, n=1 Expert practitioner (Approved Mental Health Practitioner) n=1 Consultant Psychiatrist, n=1	**Data collection:** Team meeting observations and semi-structured interviews **Data analysis:** Grounded theory approach.	Facilitators • retaining the social work identity. Barriers • work culture differences • access to shared budgets • lack of training.
Beresford 2019 General qualitative inquiry England **Aim of study** To explore barriers to the delivery of reablement services.	N=24 reablement practitioners Service leads, n=8 Reablement workers, n=16	**Data collection:** Interviews **Data analysis:** Thematic anlysis using the framework approach.	Barriers • lack of shared understanding • lack of training.

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Bower 2018 General qualitative inquiry England **Aim of study** To understand the views of stakeholders such as commissioners and local authorities on the Salford Integrated Care Programme	N=59 practitioners, older people (≥ 65 years) with long-term conditions, and carers Foundation trust staff (all senior managers or programme managers), n=6 Clinical commissioning group staff (GPs and senior managers), n=6 Council staff (including senior management, management and public health), n=6 GP provider organisation, n=1 Mental health trust staff (all senior managers), n=3 Multidisciplinary group staff, n=27 Non-multidisciplinary group staff, n=5 Participants/carers, n=5	**Data collection:** Interviews **Data analysis:** Thematic analysis using a grounded theory approach	Facilitators • information sharing • shared visions and aims.
Cornes 2011 General qualitative inquiry England **Aim of study** To explore the boundaries between services and different professionals in regards to people with experience of multiple exclusion homelessness.	N=77 practitioners, people who access services, and carers Key workers, and experts by experience (people with first-hand experience of multiple exclusion homelessness), n=32 Social workers, mental health professional, drug and alcohol workers local authority housing staff and criminal justice staff, n=15 Service managers and commissioners, n=15 Focus groups Social workers, mental health professional, drug and alcohol workers local authority housing staff and criminal justice staff, n=15	**Data collection:** Interviews and focus groups **Data analysis:** An exploratory approach.	Barriers • information sharing.

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Farrington 2015 General qualitative inquiry England **Aim of study** To explore knowledge exchange in the intellectual disability partnership, and how it relates to providing an integrated service	N=24 health and social care practitioners and administrative support staff Nurse, n=5 Therapist, n=4 Psychologist, n=3 Psychiatrist, n=1 Admin. Support, n=4 Care manager, n=4 Manager (team and service), n=3	**Data collection:** Interviews **Data analysis:** Thematic analysis	Facilitators • information sharing. Barriers • information sharing.
Joseph 2019 General qualitative inquiry Scotland **Aim of study** To explore the collaboration between the police and health and social care professionals in Scotland, in relation to Adult Support and Protection.	N=101 practitioners from the police, health and social care Police, n=52 Health, n=18 Social care, n=31	**Data collection:** Focus groups **Data analysis:** Framework analysis to create themes.	Facilitators • co-location • joint training opportunities. Barriers • information sharing • lack of shared understanding.
Krayer 2018 General qualitative inquiry Wales **Aim of study** To explore the relationships, perceptions and barriers and facilitators of joint working between mental health services, social care services, third sector organisation and police forces in regards to anti-social behaviour, vulnerable adults and adults with	N=55 practitioners from the police, health and social care, local authorities and third sector organisations Manager/senior staff, n=4 Community Mental Health Team (includes 2 mental health social workers), n=14 Police and probation Manager/senior staff, n=3 Officers, n=15 Local authorities Manager/senior staff, n=4 Practitioners, n=1 Third sector organisations Manager/senior staff, n=7 Case worker, n=7	**Data collection:** Interviews and focus groups **Data analysis:** Framework analysis to create themes	Facilitators • Shared visions and aims • experiences of integrated working. Barriers • lack of resources • lack of shared understanding.

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
mental health problems.			
Levin 2019 General qualitative inquiry Scotland **Aim of study** To explore staff perspectives on the implementation of the Intermediate Care service.	N=25 health social care practitioners Social work staff - social workers and social care workers, n=6 Rehabilitation staff – physiotherapists and occupational therapists, n=4 Care home staff, n=6 Other practitioners (individual n not reported), n=9 Role types: Social work's head of transformational change Liaison nurse Service manager for older people in primary care Rehabilitation manager Speech and language therapist Service manager for older people and physical disability Consultant physician in medicine for the elderly GP working in two Intermediate Care units Discharge team lead for acute hospitals	**Data collection:** Semi-structured interviews and focus groups **Data analysis:** Thematic analysis	Facilitators • information sharing • shared visions and aims • joint training opportunities. Barriers • increased staff workload.

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Mangan 2014 General qualitative inquiry England **Aim of study** To explore the relationship between general practitioners and social workers, and how general practitioners work with social care services.	N=12 practitioners from health and social care, commissioning groups and public health roles Local authority social care roles, n=6 Clinical commissioning group roles, n=3 Public health role, n=2 Joint health/social care role, n=1	**Data collection:** Semi-structured interviews **Data analysis:** Not reported	Barriers • lack of shared understanding.
Mitchell 2020 General qualitative inquiry England **Aim of study** To explore the barriers and obstacles to integration between community NHS and council services.	N=24 health and social care practitioners Strategic level staff – social workers, n=3 Strategic level staff – nursing background, n=3 Social workers, n=9 Health professionals with nursing background, n=9	**Data collection:** Semi-structured interviews **Data analysis:** Thematic analysis using a coding framework	Facilitators • co-location • retaining the social work identity. Barriers • lack of shared understanding • work culture differences • information sharing.
Naqvi 2019 Phenomenological design England **Aim of study** To explore the perspectives of primary care staff on the barriers faced when working with social care.	N=25 primary care practitioners General practitioners, n=18 Practice Managers, n=7	**Data collection:** Semi-structured interviews **Data analysis:** Thematic analysis using codes generated from the data	Barriers • lack of resources • lack of shared understanding • work culture differences • communication difficulties • information sharing • lack of time • increased staff workload.

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Phillipowsky 2018 General qualitative inquiry (interpretive) England **Aim of study** To explore community professionals' opinions on social worker's roles within a multi-disciplinary team.	N=41 integrated trust practitioners Social workers, n=21 Occupational therapists, n=13 Nurses, n=7	**Data collection:** Free text responses from a questionnaire **Data analysis:** Thematic analysis using codes generated from the data	Facilitators • experiences of integrated working. Barriers • lack of resources • work culture differences.
Phillipowsky 2020 See Phillipowsky 2018 England **Aim of study** See Phillipowsky 2018	N=6 health and social care practitioners Social workers, n=5 Volunteer nurse, n=1	**Data collection:** Semi-structured interviews **Data analysis:** Thematic analysis using codes generated from the data	Facilitators • co-location. Barriers • lack of resources • lack of shared understanding • work culture differences.
Round 2018 General qualitative inquiry England **Aim of study** To identify what worked, what did not work, and the lessons learnt from the integrated care programme.	N=31 health and social care practitioners and providers, citizen representatives, charity partner/funder, local authorities, management and commissioning representatives. Citizen representatives, n=3 Central management team, n=2 Charity partner/funder, n=2 Local authorities, n=3 Local secondary care providers, n=6 Hospital consultants, n=3 General practitioners, n=5 Community providers, n=3 Commissioners/Clinical commissioning group representatives, n=4	**Data collection:** Semi-structured interviews and focus groups **Data analysis:** Thematic analysis	Facilitators • information sharing • experiences of integrated working. Barriers • lack of resources • lack of shared understanding • communication difficulties.

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Sheaff 2015 General qualitative inquiry England and Sweden **Aim of study** To explore the care-coordination mechanisms that are in use in the NHS	N=11 health and social care practitioners and management representatives General practice (GPs, other staff), n=2 Care network co-ordinators, n=3 NHS trust managers and clinicians, n=4 Social care, n=1 Other, n=1	**Data collection:** Interviews **Data analysis:** Analytic framework	Facilitators • experiences of integrated working. Barriers • work culture differences.
Sonola 2013 General qualitative inquiry England **Aim of study** To examine barriers and facilitators to successful care co-ordination in a model for dementia care.	N=14 health and social care practitioners and local commissioners Includes staff from the Greenwich and Bexley dementia teams, managers, local commissioners and a GP.	**Data collection:** Semi-structured interviews and observation of a team meeting. **Data analysis:** Not reported	Facilitators • information sharing • shared visions and aims.
Taylor 2018 General qualitative inquiry England **Aim of study** To explore the views of patients and professionals on collaborative care.	N=33 practitioners and people who access services GPs, n=12 Case managers, n=8 People using collaborative care , n=13	**Data collection:** Semi-structured interviews **Data analysis:** Thematic analysis using the framework approach.	Facilitators • experiences of integrated working. Barriers • communication difficulties • lack of time.
Vicary 2018 Deliberative, general research inquiry England **Aim of study** To examine the impact of integrated working on mental health social care.	N=40 practitioners and people who access services. People who access services, n=4 Social worker professionals, n=11 Non-social work professionals, n=25	**Data collection:** Deliberation events (interactive discussion) **Data analysis:** The data were analysed using 4 components for what constitutes effective mental health social work in integrated care, which are: clarity of role, access to professional development, effective operational management and leadership	Facilitators • retaining the social work identity. Barriers • work culture differences • information sharing.

See the full evidence tables in appendix D.

The themes identified through analysis of all the included studies are listed here:

Barriers:

- Access to shared budgets.
- Complicated bureaucracy.
- Communication difficulties.
- Work culture differences.
- Increase in staff workload.
- Information sharing.
- Lack of resources.
- Lack of shared understanding.
- Lack of time.
- Lack of training.

Facilitators

- Co-location.
- Experiences of integrated working.
- Information sharing.
- Joint training opportunities.
- Retaining the social work identity.
- Shared visions and aims.

The theme map (Figure 1 and Figure 2) illustrates these as overarching themes and their related themes. Overarching themes are shown below in orange and central themes in blue. Figure 1 presents the barriers and Figure 2 presents the facilitators.

Figure 1: Theme map - barriers

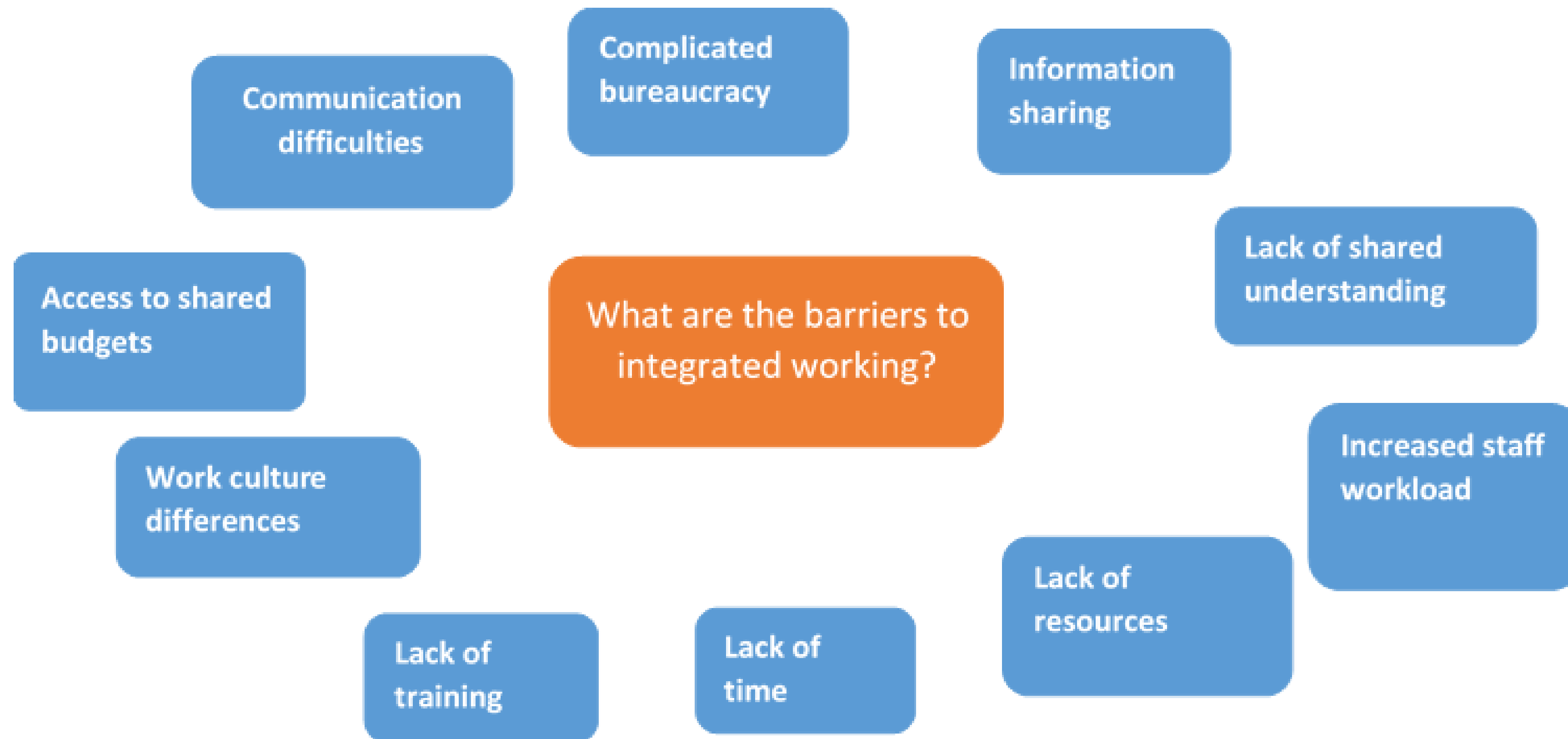
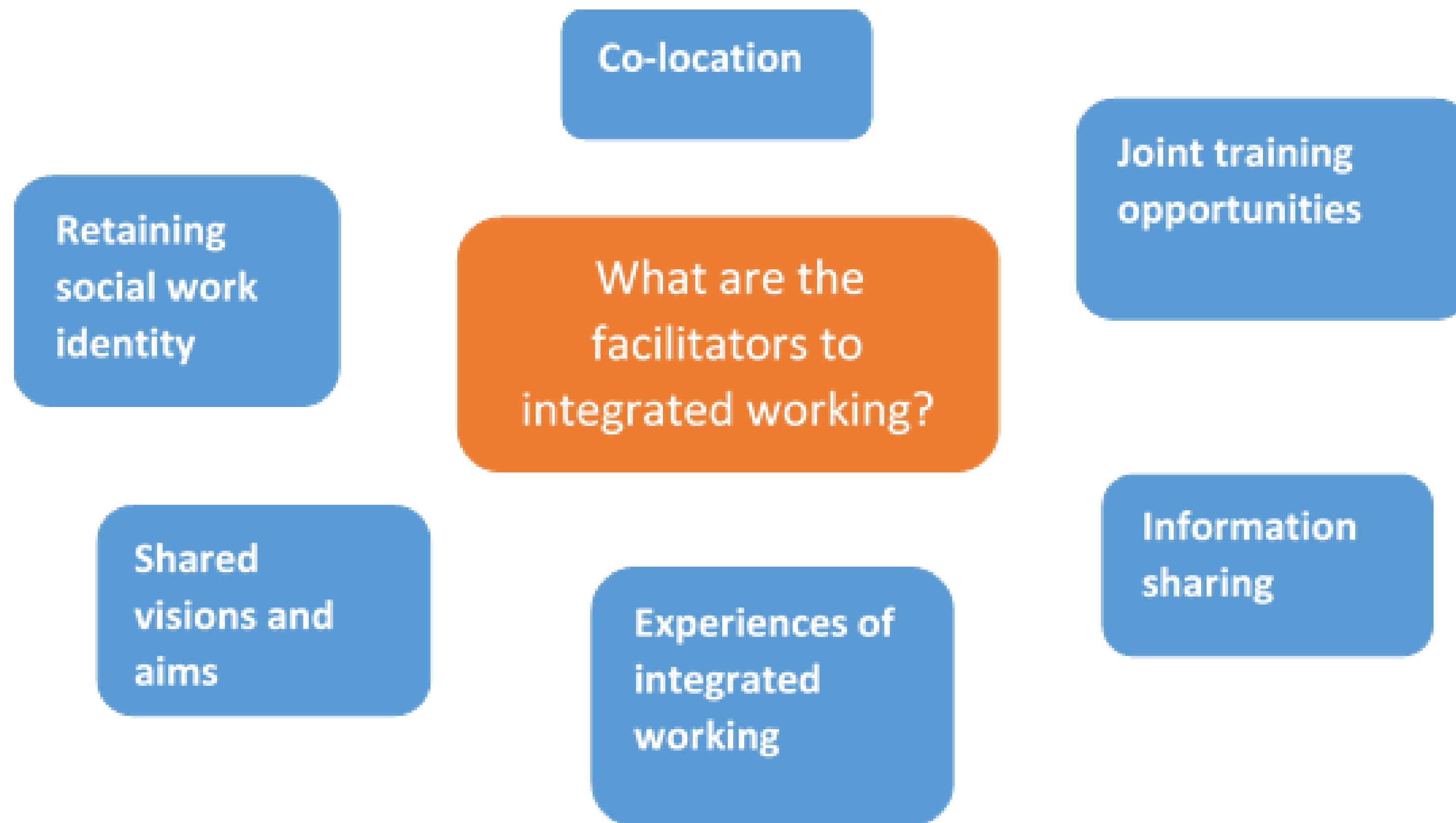


Figure 2: Theme map - facilitators



Summary of the evidence

Effectiveness evidence

Two RCTs and 1 cluster RCT reported data for the outcome ‘subjective quality of life (QoL)’. Data from these studies were not combined because the interventions were not sufficiently similar or different tools were used to measure QoL at different time points.

Community living older adults

Three RCTs and 2 non-RCTs provided data for community living older adults.

One RCT compared a Comprehensive continuum of care intervention to usual care. Data were identified for the critical outcome subjective QoL and subjective satisfaction with integrated working. The Continuum of care intervention had a possible important benefit over usual care in terms of subjective QoL, assessed using life satisfaction as a whole, at 12 months but not 3 or 6 months. The intervention appeared to have a statistically significant benefit over usual care in terms of subjective satisfaction with integrated working, measured using quality of care in frail older adults, measured at 3 months, but not at 6 or 12 months. One RCT compared the Embrace intervention (proactive, preventative primary care support) to care as usual. Data were identified for the critical outcomes subjective QoL and subjective satisfaction with integrated working. Embrace did not appear to have an important benefit over usual care in older adults with complex care needs, or frail older adults, in terms of QoL measured using EQ-5D-3L, EQ-VAS, or general quality of life at 12 months. Embrace appeared to have an important benefit over usual care in terms of subjective satisfaction with integrated working, measured using a patient assessment of integrated care, for frail older adults but not for older adults with complex needs measured at 12 months.

One non-RCT compared the intervention Urban Health Centres Europe (preventative multi-dimensional assessment of health risks) to care as usual. Data were identified for the critical outcome subjective QoL. The Urban Health Centres Europe did not appear to have an important benefit over care as usual in terms of subjective QoL in older adults at 12 months.

One non-RCT compared an integrated health and social care day unit to community services. Data were identified for the critical outcome subjective QoL. The integrated health and social care day unit did not appear to have an important benefit over community nursing in older adults at 9 months.

Older homeless adults living with mental illness

One RCT provided data for older people experiencing homelessness and living with mental illness. The RCT, comparing a Housing First intervention to treatment as usual, provided data for the critical outcome, subjective QoL. Housing First did not appear to have an important benefit over usual care in terms of changes from baseline in subjective QoL measured at 12 and 24 months.

Older adults living with severe mental illness

One RCT provided data for older adults living with severe mental illness. The RCT compared Assertive community treatment to treatment as usual. Data were identified for the important outcome unplanned care contacts. Assertive community treatment appeared to have an important benefit over treatment as usual in terms of first care contact at 3 months. However, there did not appear to be an important benefit in terms of the rate of hospital admissions or crisis contacts measured 2 years after the start of the intervention.

See appendix F for full GRADE tables.

Qualitative evidence

The evidence generated 10 themes regarding the barriers to integrated working, and 6 themes regarding the facilitators of integrated working.

One study provided evidence which suggested there were 'system' barriers to integrated working such as a lack of pooled budgets. Complicated bureaucracy was also identified as a barrier by 1 study, and reported to cause delays to services. Three studies provided evidence which showed that issues around communication created barriers to integration, which resulted from the busy and different schedules of practitioners. Ten studies provided evidence that contributed to themes around work cultural barriers to integration, for example having different organisational systems resulted in different sickness and pay grade policies which was said to lead to hostility between practitioners. There were also reports of a perceived power imbalance between health and social care which also had negative implications in practice. Having a manager from a different profession was also seen as a cultural barrier to integration. Eight studies provided evidence that generated themes around information sharing, with reports of a lack of formal sharing arrangements, a lack of information sharing protocols and a lack of joined up IT systems, all contributing to the barriers of integrated working. Another barrier, with evidence provided by 7 studies, to integrated working was a lack of financial resources. There was evidence from 9 studies that suggested that a lack of shared understanding created barriers to integrated working, and was said to lead to inter-organisational conflict. There was also evidence from 3 studies, around the theme of lack of time being a barrier to integrated working, which suggested that practitioners were not given enough time to work with other professionals.

In terms of facilitators for integrated working, evidence from 5 studies suggested that co-location of practitioners was an important factor because it was perceived to lead to faster referral processes, and better relationships between practitioners. Six studies identified evidence for sharing knowledge as a facilitator to integrated working and was said to enable a holistic approach to care. Seven studies provided evidence that generated themes around information sharing, which suggested that having an integrated IT system supported integrated working, as well as the use of both formal and informal ways of sharing information. Another theme, supported by 3 studies, which was identified as enabling a holistic approach to care was having joint training opportunities, as best practices could be shared between professionals. The evidence from 5 studies, also showed that retaining the social work identity was important for successful integrated working, as having a social worker's input in the team led to greater awareness of available services among other professionals, and taking a holistic approach to care. Themes were also generated, from 2 studies, around having shared values and aims as facilitators to integrated working, as it led to an increased understanding between organisations. Three studies provided evidence which showed that having a formal agreement in place also facilitated integrated working as it was reported to be a way in which practitioners could resolve disagreements.

Information sharing was identified as a theme under barriers and facilitators. When information sharing protocols and arrangements did not work well this created barriers to integrated working. However, the studies also provided evidence to show when information sharing worked well, this facilitated integrated working.

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 the effectiveness findings. In Table 6 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 6 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
E2.2 – Experiences of integrated working E2.2.1 – Shared learning Data from 6 studies (Aspinal 2014, Krayer 2018, Phillipowsky 2018, Round 2018, Sheaff 2015, Taylor 2018), suggested that through integrated working, different professionals were able to share knowledge, and this enabled a holistic approach to care.	MODERATE	*Outcome: Life satisfaction as a whole (follow-up 12 months).* Integrated working using the continuum of care model, showed a possible important benefit over usual care in terms of subjective QoL (assessed using life satisfaction as a whole; including measures relating to financial situation, leisure, friends and acquaintances, functional capacity, family life, physical health and psychological health) at 12 months.	VERY LOW (1 RCT)	An increase in life satisfaction as a whole could be explained by the qualitative evidence which suggests that by sharing knowledge through integrated working and incorporating a social worker's perspective, professionals were able to provide a more holistic approach to care. When compared to usual care, it might be suggested that care was provided to more aspects of someone's life in the group who had the continuum of care and this translated to an increase in life satisfaction.
E2.5 – Retaining professional identity Data from 5 studies (Abendstern 2016, Aspinal 2014, Bailey 2012, Mitchel 2020, Vicary 2018), suggested that when social workers retain their professional identity in an integrated team, they bring a different perspective which supports a person centred and holistic approach to care.	HIGH			
E2.1 – Co-location Data from 5 studies (Abendstern 2016, Aspinal 2014, Joseph 2019, Mitchell 2020, Phillipowsky 2020),	HIGH	*Outcome: Patient assessment of integrated care - Frail older adults (follow-up 12 months; Better indicated by higher values).*	MODERATE (1 RCT)	An increase in the subjective satisfaction of integrated care, which rated satisfaction in areas such as care planning meetings.

suggested that co-location enabled successful integrated working as it led to faster referrals and responses from social workers. Being co-located was also reported to improve the relationships and trust between organisations.		Integrated working using the Embrace model, showed an important benefit over usual care in subjective satisfaction of integrated care reported by frail older adults using the patient assessment of integrated care.		or responsiveness of needs, could be explained by the qualitative evidence that shows us that integrated working is successful when practitioners are co-located. Co-location leads to better relationships between professionals, and faster responses from social workers. The social workers in the Embrace group were co-located in a GP practice, which could be why the participants in the Embrace group experienced better integrated working.

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 Supplement 2 for details.

Excluded studies

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

Summary of included economic evidence

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 subjective quality of life, subjective satisfaction with integrated support, numbers of referrals between services or teams or hand-offs between professionals, delayed transfer from hospital to home or other community setting and waiting times for assessment or review were considered critical outcomes. Unplanned care contacts and continuity of care and support were considered important outcomes. These outcomes were

chosen for this review because they were considered to reflect the impact (successful or otherwise) that integrated working can have on adults with complex needs.

To address the issue of the barriers and facilitators to integrated working, 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.

Facilitators to integrated working:

- Section 75 agreements between a local authority and NHS body
- Access to shared budgets, or pooled or 'aligned' budgets
- Co-location
- Shared visions and values
- Joint training opportunities
- Virtual team meetings
- Experiences of integrated working including holistic assessments.

Barriers to integrated working.

- Lack of resources
- Lack of shared understanding
- Communication
- Information sharing
- Lack of time
- Experiences of integrated working including holistic assessments
- Work culture differences.

The quality of the evidence

Effectiveness evidence

The quality of the evidence for effectiveness outcomes was assessed with GRADE and was rated as very low to moderate. This was predominately because of serious overall risk of bias stemming from methodological limitations in the included studies, such as unclear randomisation and blinding or high attrition rates. In addition, imprecision around the effect estimate in some outcomes also contributed to the very low to moderate quality of the evidence. None of the outcomes 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 outcomes: numbers of referrals between services or teams or hand-offs between professionals; delayed transfer from hospital to home or other community setting; waiting times for assessment or review; continuity of care and support.

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

Qualitative evidence

The evidence was assessed using GRADE-CERQual methodology and the overall confidence in the findings ranged from low to high, with most of the evidence being of high and moderate quality, and only 3 findings of low quality. The review findings were generally downgraded because of methodological limitations of the included studies, including, for

example not enough information on data analysis or consideration of potential author bias. Some findings were also downgraded for adequacy because together, the relevant studies did not offer rich data. Some of the evidence were also downgraded for coherence, because the evidence was not generally considered ambiguous or contradictory. Finally, some findings were downgraded for relevance because in some cases it was unclear whether social-workers were included as part of the integrated team.

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

Benefits and harms

Principles of social work for adults with complex needs – for social workers

The committee discussed the evidence (E1.6 Information sharing; low to high quality and E2.3 Information sharing; moderate quality) around information sharing, which was a theme linked with both the facilitators and the barriers to integrated working. The evidence (E2.3 Information sharing; moderate quality) highlighted the importance of effective information sharing to enable integrated working between professionals, as well as enable a balance between confidentiality and safeguarding. The committee agreed that it was key that social workers inform people of the extent and content of information sharing that might take place between professionals in a multidisciplinary team. The committee were aware of the UK Data Protection Act 2018, chapter 2, which supports this recommendation.

Social workers and multidisciplinary teams: communication, support and collaboration

The committee discussed the effectiveness evidence which overall, showed that integrated working (including co-ordinated care provided on a continuum; intensive case management or assertive community treatment; an integrated health and social care day unit; and population-based, person-centred and integrated care service) did not have an important benefit over usual care in terms of subjective quality of life. This did not echo the committee's experience and they agreed that, in fact, integrated working had benefits for adults with complex needs mainly due to the availability of an array of different approaches to care, and the multidisciplinary input. Although the effectiveness evidence did show some benefit to integrated working compared with usual care for 'satisfaction' and 'unplanned care contacts', the committee felt that, overall, the effectiveness evidence was limited in its use for making recommendations for a specific model of integrated working. However, the committee discussed that the effectiveness evidence supported integrated working in general and could be beneficial. The committee agreed that they could use the qualitative evidence (E2.2 Experiences of integrated working; moderate quality, E2.5 Retaining the social work identity; high quality and E2.6 Shared visions and aims; low to moderate quality) to describe the key aspects which were important for achieving integrated working, and therefore decided to make recommendations supported by the evidence. The committee discussed the synthesis of the effectiveness and qualitative evidence. They agreed with the explanatory contribution of the qualitative evidence on the effectiveness evidence, which suggested certain aspects of integrated working that could have contributed to the increased subjective life satisfaction and subjective satisfaction with care outcomes. They felt it was important to consider the evidence in this way and to highlight which particular aspects (for example, shared learning, retaining the social work identity and shared visions and aims) lead to successful integrated working. The committee felt that the qualitative evidence provided a more in-depth understanding of these key aspects, and they agreed to use the qualitative evidence in general to support their recommendations. They agreed that recommendations to address certain aspects of integrated working would be more appropriate for current practice, where a wide range of approaches are taken.

The committee discussed the evidence (E2.6 Shared visions and aims; low to moderate quality) that suggested having shared visions and aims helped with integrated working. They agreed with the evidence and felt that in addition to sharing expertise and knowledge, integrated teams should share aims, supported by a shared statement of values, core

purposes and activities. The committee agreed the benefits to the individuals receiving care were likely to be a more streamlined approach to care, with things such as fewer inappropriate referrals, and fewer disagreements between practitioners, as they will all be working toward a common aim.

The evidence (E2.3.1 Joined up IT systems; moderate quality) showed that having shared IT systems supported successful integrated working. Although confidence in the findings was high, the committee agreed that the evidence did not support a particular system and felt they were unable to make a recommendation because a joined up IT system may not be practical or possible for every integrated setting. They agreed that the focus should instead be on working towards efficient information sharing when working in an integrated team. The committee used the evidence, and their experiential knowledge to list some practical examples that organisations could adopt to enable routine information sharing, such as joint working and forums or discussions.

The committee discussed the evidence (E1.3 Communication difficulties; moderate quality) related to communication barriers which highlighted the importance of clear communication within the multidisciplinary team. They made recommendations to address the barriers to integrated working created as a result of poor communication. The committee used the evidence (E1.3 Communication difficulties; moderate quality), supplemented by their expertise to suggest practical ways of achieving successful communication, for example holding multidisciplinary meetings and providing virtual means to stay in touch. They also agreed that this recommendation would highlight some of the issues discussed surrounding a lack of time and resources. They felt that effective communication would contribute to efficient ways of working and was a way of resolving these issues.

The committee discussed the evidence (E2.2.1 Shared learning; moderate quality and E2.4 Joint training opportunities; moderate quality) that suggested joint training was a facilitator for integrated working. They agreed that this reflected their practice experience and therefore recommended joint training, and they noted that this was also supported by the evidence (E2.2.1 Shared learning; moderate quality) that showed a shared understanding between different professionals within a team was beneficial to integrated working. The committee expanded on the recommendation to specify the purpose of the training. They felt the evidence supported an approach to training that aimed to create an understanding of other professionals' roles (be they within health and social care including or other relevant settings), responsibilities and skill sets but were clear this did not mean training professionals to carry out each other's duties. The committee felt that the evidence (E2.5 Retaining the social work identity; high quality) highlighted the importance of ensuring professionals retain their unique skills and diverse range of views, enabling them to work together to provide holistic care and support. However the committee also acknowledged possible disadvantages, namely that people being supported can sometimes find it confusing to have different professionals within a single team all taking a slightly different approach to care. However, they felt that the benefits of holistic care far outweighed these concerns, and in fact often resulted in a more streamlined provision of care. Noting the confidence in the findings used to make this recommendation, the committee agreed they could not make a strong recommendation. On the subject of integrated training, the committee agreed to recommend it should be co-produced with people with lived experience because on the basis of their experiential knowledge this results in more successful, relevant training courses. The committee also discussed from experience, the importance of following up all training with a plan for how to implement it, as this would be a way of ensuring the training is used in practice. The committee also used their expertise to recommend that training should be available on an ongoing basis, as this would ensure knowledge is retained and refreshed within teams and services. The committee highlighted the importance of ongoing formal training, but using the evidence they recognised that an informal approach to sharing knowledge was also beneficial. They agreed that routine sharing of professional expertise and lessons from training sessions would also be a key to the successful implementation of interdisciplinary training.

The committee felt there were a number of barriers, highlighted in the evidence (E1.4 Work culture differences; high quality and E1.8 Lack of shared understanding; moderate quality) around differences in work culture and barriers created by a lack of understanding of different professionals' roles and responsibilities. They agreed that the recommendations for joint training opportunities and shared learning practices would help overcome these barriers.

The committee discussed evidence (E1.4.3 Professional identity of team manager; high quality) that suggested that role blurring created barriers to integrated working and that it is improved when social workers can retain their professional identity. This echoed their own experiences so they agreed on a recommendation with several elements that would support social workers with role clarity and retaining their professional identity, in the context of integrated team working. For example, the committee discussed the evidence that suggested having a manager from a different professional background was a barrier to integrated working. They agreed that recommending social workers are always managed by professionals with a social work background would not be feasible in practice and not always achievable in integrated teams. However, they felt that the recommendation around support to retain professional identity, alongside appropriate access to a social worker for professional supervision would help to overcome those barriers. The committee felt that the recommendation to support social workers to maintain role clarity, would also address the barriers that an increase in staff workload hindered successful integrated working by helping to define boundaries around responsibilities. The committee also discussed the evidence (E1.4.1 Organisational systems; high quality) that suggested differences in health and social care systems with regards to policies such as pay and sickness, could create barriers to integrated care. They felt that although the confidence in the findings was high, they would not be able to make a recommendation to specifically address these differences as they are embedded in systems and structures which are beyond the scope of the guideline. However, the committee agreed that a recommendation which supported social workers by recognising these differences would be more appropriate. As well as being supported by their own experience as well as the evidence, the committee noted that this recommendation, to support social workers in defining their role, was also supported by the Social Work England professional standards.

The committee wanted to address the evidence (E1.2 Complicated bureaucracy; moderate quality) around complicated bureaucracy acting as a barrier to integrated working. They agreed with the evidence and used their expertise to make a recommendation. They agreed that there were times when bureaucratic processes could slow down referrals and make accessing care and services difficult. However, they recognised that bureaucratic processes may be necessary at times, so agreed to recommend that organisations aim to simplify processes where possible for example by having clear and simple eligibility criteria. They agreed that this recommendation would enable processes to be more flexible, and would give practitioners more time to focus on the care of people, and less on complicated systems.

The committee discussed evidence (E1.7 Lack of resources; high quality) that showed a lack of resources led to poorly designed services and a waste of skills, and agreed that recommendations on integrated training and co-location could address these barriers. As well as the recommendation made to support interdisciplinary training the committee agreed a recommendation to support co-location would also address some of these concerns. They used the evidence (E2.1 Co-location; high quality) that suggested being co-located led to increased efficiencies and better working relationships. The committee agreed with the evidence and discussed that being co-located would allow professionals to get to know each other and improve their working relationships. This would have benefits for people using services as they would only have to tell their story once since communication between professionals improves, and would also allow them to have one point of contact, making accessing care easier. Co-location would also enable a more comprehensive service for adults with complex needs, as practitioners become more readily aware of the work and services offered by other practitioners. This would enable a more holistic approach to care,

and would address multiple care needs for the person using services. The committee also discussed that referral processes would be more efficient with co-located services, as referrals would be sent to colleagues rather than outside services, which usually have long waiting lists, and therefore speeding up care access. Further efficiencies discussed by the committee involved practitioners being well-enough informed about others' work and able to cover when there were emergencies, which also creates a benefit for the person as any urgent care needs are met in time. The committee agreed that co-location may not be of benefit for every service and may not be feasible or practical for others therefore they did not make a strong recommendation. The committee suggested that organisations should consider whether this is achievable and beneficial and look to implement such working. Where physical co-location is not possible, virtual co-location could be achieved through changes such as diary sharing and remote meetings by tele-or videoconference. These should be practical in all services with a negligible impact on time or costs. They agreed that professionals and organisations should be aware of the particular benefits of co-location which were highlighted in the evidence, and that if relevant to them co-location should be supported.

Finally the committee discussed the evidence that suggested having formal agreements in place facilitated integrated working. They felt this was in line with their experience from practice so they agreed on a recommendation for formal agreements to support integrated teams, particularly in terms of shared decision making and accountability. The committee felt it was important to ensure this recommendation also covered agreements in terms of budgets, as the evidence (E1.1 Access to shared budgets; moderate quality) showed that a lack of access to pooled budgets could create barriers to integrated working. However the committee knew from their own experience that there are difficulties associated with implementing pooled budgets. They agreed that the focus of the recommendation on creating formal agreements would address these difficulties faced, and would lead to efficiencies and a more streamlined service. They also felt that by ensuring the recommendation wasn't limited to just pooled budgets, organisations could take an approach to budgets most appropriate for them. The committee also discussed the barriers to integrated working which seemed to stem from a lack of time and resources, but agreed it would be beyond the scope of the guideline to directly address these factors.

Cost effectiveness and resource use

There may be some short term costs if accommodation needs to be reconfigured to allow for co-location although there should be no difference in costs once this has been achieved and potential cost savings through working efficiencies and economies of scale. Physical co-location will not always be feasible and measures to allow virtual co-location, such as diary sharing and virtual meetings, should involve negligible costs if any. Again there are potential cost savings through more efficient and integrated working. There is unlikely to be any longer term differences in cost or resource use from these recommendations.

Joint training may be new practice in some areas but is already widely undertaken in others. Joint training should not increase costs as social workers undergo continued professional development throughout their career and would not lead to an increase in the amount of training needed to be provided or the time from social workers needed to attend. There may also be cost savings through economies of scale and allowing more people to attend each training opportunity. Joint training will also more effectively cover integrated working and the roles of other professionals potentially negating the need for further training in this area. There may also be further savings downstream from efficiency savings from staff being able to work in a more integrated fashion and prevent duplication of roles or tasks.

Other recommendations reinforce current legislation and usual practice and no resource impact is anticipated from these.

Other factors the committee took into account

In making the recommendations based on this evidence review, the committee drew upon their knowledge and experience of other NICE guidelines and relevant legislation. In particular, Chapter 2 of the Data Protection Act 2018, and Standard 4 of the Continuing Professional Development standards set out by Social Work England.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.1.9 and 1.7.1 to 1.7.8.

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Appendices

Appendix A Review protocols

Review protocol for review question E1: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

Table 6: Review protocol – effectiveness review

Field	Content
PROSPERO registration number	CRD42020221540
Review title	The effectiveness of integrated working.
Review question	E1 What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs? Note that this review is linked with E2, which is described in a separate review protocol: Based on the views and experiences of everyone involved, what are the facilitators and barriers to integrated working between registered social workers and other practitioners to support adults with complex needs?
Objective	To establish and compare the effectiveness of integrated working among social workers and other practitioners in supporting adults with complex needs.
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

Field	Content
	• Social Services Abstracts • Sociological Abstracts • Social Care Online Searches will be restricted by: • Date: 2010 • English language • Human studies 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. The full search strategies will be published in the final review.
Condition or domain being studied	Integrated working to support adults with complex needs.
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	Integrated working among social workers and other practitioners (such as health and housing) to support adults with complex needs.

<table>
<tr><th>Field</th><th>Content</th></tr>
<tr><td></td><td>The following arrangements are listed as possible forms of integrated working but the review will not be limited to these:

1. Collaborative arrangement (working together, better coordination, budgets not pooled. Teams may be virtual or working in one place. Legally separate).
2. More formal partnership (teams co-located, some degree of joint management, some degree of sharing of budgets. Legally separate).
3. A formal partnership (Pooled budgets, teams co-located, definite single management arrangements, pooled budgets. Legally separate).
4. Integration (One organisation, for example, Care Trust. All staff employed by the Trust [or this is the intention]. One budget. Legally one).

Integrated working may also feature:
• Joint assessments.
• Information sharing.
• Single point of access through a named coordinator or key worker.
• Access to a range of community services.</td></tr>
<tr><td>Comparator</td><td>Integrated working compared with:
• Current practice.
• Not using an integrated approach to working (no service).
• Different integrated working arrangements.</td></tr>
<tr><td>Types of study to be included</td><td>• Experimental studies (where the investigator assigned intervention or control) including:
o Randomised or quasi-randomised controlled trials.
o 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:</td></tr>
</table>

Field	Content
	• Observational studies (where neither control nor intervention were assigned by the investigator) including: ○ Systematic reviews of observational studies. ○ 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.
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. • 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: • Subjective quality of life – measured using a validated tool such as ASCOT, ICECAP-A, MANSA or the EQ-5D. • Subjective satisfaction with integrated support.

Field	Content
	Service focused outcomes: • Numbers of referrals between services or teams or hand-offs between professionals. • Delayed transfer from hospital to home or other community setting. • Waiting times for assessment or review.
Secondary outcomes **(important outcomes)**	Person focused outcomes: • Unplanned care contacts for example emergency or unplanned admission to hospital, A&E attendance, street triage, ambulance call-outs, 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 for example by changes in care coordinator or care manager.
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. • 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).

Field	Content
	'GRADEpro' will be used to assess the quality of evidence for each outcome. • Being a parallel review to E2, the NGA technical team will present findings from this review together with qualitative evidence (E2), 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 integrated working • Groups of people with different needs or conditions • 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 [E2] on the same issue.
Language	English
Country	England
Anticipated or actual start date	December 2020
Anticipated completion date	November 2021

Field	Content
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

Field	Content
	5b. Named contact e-mail SWIadults@nice/org.uk **5e 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.
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?ID=CRD42020221540
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, assessment, care management, integrated working.

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

A&E: accident and emergency; 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; EQ-5D: EuroQol 5 Dimensions; GRADE: Grading of Recommendations Assessment, Development and Evaluation; 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 E2: Based on the views and experiences of everyone involved, what are the facilitators and barriers to integrated working between registered social workers and other practitioners to support adults with complex needs?

Table 7: Review protocol – qualitative review

Field	Content
PROSPERO registration number	Unregistered.
Review title	Barriers and facilitators to integrated working.
Review question	E2. Based on the views and experiences of everyone involved, what are the facilitators and barriers to integrated working between registered social workers and other practitioners to support adults with complex needs? Note that this review is linked with E1, which is described in a separate review protocol: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

Field	Content
Objective	To establish what enables or hinders integrated working between registered social workers and other practitioners
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) • Social Policy and Practice • Social Science Database • Social Services Abstracts • Sociological Abstracts • Social Care Online Searches will be restricted by: • Date limit: 2010 • 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.

Field	Content
	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 about the barriers and facilitators to integrated working (involving social workers) to support adults with complex needs.
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	Views, perceptions and experiences are sought which relate to forms of integrated working including collaborative arrangements, formal partnerships or full integration (in a single organisation). Integrated working may also feature joint assessments, information sharing or a single point of access to a range of community services. In order to understand the facilitators and barriers to this range of integrated working between registered social workers and other professionals supporting adults with complex needs, the committee want to locate data about: People's views or experiences about what enables particular aspects or a particular form of integrated working.

Field	Content
	• **Section 75 agreements between a local authority and NHS body.** This refers to an agreement under the NHS Act 2006 which can include pooling resources and delegating certain NHS and health-related local authority functions to the other partner(s), if it is deemed that this would lead to an improvement in the way those functions are exercised. The committee expect that where s75 agreements are in place and where there is clarity about the agreement then this will support integrated working among social workers and other practitioners, particularly health colleagues. • **Access to shared budgets, or pooled or 'aligned' budgets.** Linked with having clear s75 agreements, the committee expect to locate data which describe pooled budgets as a means of enabling different organisations to fund and deliver truly integrated services. The committee are particularly interested in data published after the introduction of the Better Care Fund 2015, which required clinical commissioning groups and local authorities to operate a pooled budget (via s75). • **Co-location.** As noted above, the committee are interested in data about different forms of integration and they note that even if teams are not integrated in any legal sense, there may be local practice arrangements, for example co-locating social workers in health centres, while still being employed by the local authority. The committee think that people with experience of these arrangements will describe them as having all the benefits of integrating working without all the structural changes (and challenges) that 'full' integration might present. • **Shared visions and values.** The committee expect that positive accounts of integrated working will reflect on teams or groups of professionals who had a shared vision and shared values about working together to support adults with complex needs. • **Joint training opportunities.** Regardless of the form of integration, the committee anticipate that joint training and staff development will be seen as a means of enabling integration by promoting mutual understanding among professions and a shared approach to supporting adults with complex needs. • **Virtual team meetings.** The committee expect more recently published research to highlight the important and growing role of technology in supporting integrated working. Regardless of whether practitioners are located in the same place, the use of video conferencing technology enables people to meet virtually either for team meetings, one to one exchanges of information or potentially joint training.

Field	Content
	• **Experiences of integrated working including holistic assessments.** The committee hope for rich data about people's experiences of being supported by integrated teams or approaches. They believe these will identify a range of potential facilitators to ensuring integration is achieved and the potential benefits are experienced by adults with complex needs. People's views or experiences about barriers to integrated working. • **Lack of resources.** The committee believe that even where there is a clear, shared ambition among practitioners to work in an integrated way, it is possible their efforts will be frustrated by a lack of available resources. • **Lack of shared understanding.** The committee expect one of the barriers to successful integrated working to be the lack of a shared understanding between practitioners. Regardless of the form of integration, or even investment in it, if the practitioners involved do not understand each other's professional contribution to supporting adults with complex needs then this is likely to undermine joint working and cooperation. • **Cultural differences.** Linked with the above theme, the committee point out that one of the biggest challenges to integration is cultural and they expect the review to locate pertinent data. In particular, they highlight the traditionally different cultures and values in health compared with social work, the latter emphasising service user empowerment and the former being traditionally more paternalistic and focused on meeting individual and specific health needs. These cultural differences need to be addressed carefully and where they are not, this is likely to result in misinterpretation, difficulties integrating and poor care and support for adults with complex needs. • **Communication.** Poor communication between practitioners might result from a lack of understanding or cultural differences but it can also result from more practical considerations, inhibited by inadequate resources or poor IT. • **Information sharing.** Poor communication is in turn likely to undermine information sharing between practitioners which can be a source of immense frustration to people using services. Information sharing difficulties also arise when attempts are made to join or share IT systems and data.

Field	Content
	• **Lack of time.** Integrated working may feature the conduct of joint assessments and reviews, which are likely to be welcome by people using services. However, the committee anticipate there may be accounts of the practical challenges including available time or scheduling which make it impossible to conduct joint reviews or which result in reviews being delayed until practitioners can align with each other's diaries. • **Experiences of integrated working including holistic assessments.** The committee hope for rich data about people's experiences of being supported by integrated teams or approaches. They believe these will identify a range of potential barriers to ensuring integration is achieved and the potential benefits are experienced by adults with complex needs.
Comparator/Reference standard/Confounding factors	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: • 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.

Field	Content
	• 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 (14 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 Appraisal Skills 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 synthesised 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 E1, the effectiveness of needs assessment, the NGA technical team will present findings from the effectiveness (E1) and qualitative (E2) 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 integrated working, focused on different groups and delivered via different modes.
Type and method of review	☐ Intervention

Field	Content
	☐ Diagnostic ☐ Prognostic ☒ Qualitative ☐ Epidemiologic ☐ Service Delivery ☒ Other (please specify) This qualitative review is linked with an intervention review [E1] on the same issue.
Language	English
Country	England
Anticipated or actual start date	December 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	☑	☑

Field	Content		
	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 **5e 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.		
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.		

Field	Content
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	Not applicable (unregistered).
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, assessment, 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 ☐ Discontinued
Additional information	Not applicable.
Details of final publication	www.nice.org.uk

ASSIA: Applied Social Science Index and Abstracts; CASP: Critical Appraisal Skills Programme; CDSR: Cochrane Database of Systematic Reviews; CENTRAL: Cochrane Central Register of Controlled Trials; GRADE-CERQual: Grading of Recommendations Assessment, Development and Evaluation-Confidence in the Evidence from Reviews of Qualitative Research; IBSS: International Bibliography of the Social Sciences; NICE: National Institute for Health and Care Excellence.

Appendix B Literature search strategies

Literature search strategies for review question E1: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

Database(s): Embase 1980 to 2020 Week 46, Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to November 17, 2020

Multifile database codes: emez= Embase 1980 to 2020 Week 46; ppez= Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations and Daily 1946 to November 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.
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
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.

#	Searches
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
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.

#	Searches
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	exp "Delivery of Health Care, Integrated"/
113	Intersectoral Collaboration/
114	Interinstitutional Relations/
115	Interprofessional Relations/
116	(or/112-115) use ppez
117	integrated health care system/
118	collaborative care team/
119	intersectoral collaboration/
120	multidisciplinary team/
121	(or/117-120) use emez
122	((integrat* or collaborat* or colocat* or co locat* or cross sector* or interagenc* or inter agenc* or interdisciplin* or inter disciplin* or interinstitution* or inter institution* or interorgani?* or inter organi?* or intersector* or inter sector* or intraprofession* or intra profession* or joined up or joint or merged or multiagenc* or multi agenc* or multidisciplin* or multi disciplin* or multiprofession* or multi profession* or multisector* or multi sector* or overlap* or share* or sharing or transdisciplin* or trans disciplin*) adj3 (access* or assess* or care or communit* or consult* or model? or program* or review* or service* or staff* or system* or team* or transfer* or work*)).ti,ab.
123	((integrat* or align* or joint or partner* or pool* or share* or sharing) adj3 (budget* or financ* or fund* or payment* or resource*)).ti,ab.
124	partner*.ti,ab.
125	((integrat* or joint or share* or sharing) adj3 (approach* or communicat* or information or strateg* or understanding or value* or vision)).ti,ab.
126	(communicat* adj3 (multi* or inter*)).ti,ab.
127	((integrat* or joint or share* or sharing) adj2 (educat* or staff development or training)).ti,ab.
128	(key worker* or keyworker* or (named adj (contact* or coordinat* or co ordinat* or person*))).ti,ab.
129	(linkwork* or link work*).ti,ab.
130	(holistic adj (assess* or review*)).ti,ab.
131	((digital* or teleconferenc* or video* or virtual*) adj2 (assess* or communicat* or consult* or meeting? or model? or service* or team* or technolog* or work*)).ti,ab.
132	(section 75 agreement* or s75 agreement*).ti,ab.
133	((section 33 agreement* or s33 agreement*) and (wales or welsh)).ti,ab.
134	((local authorit* or local council*) and (nhs or national health service)).ti,ab.
135	better care fund.ti,ab.
136	or/116,121-135
137	111 and 136
138	Letter/ use ppez
139	letter.pt. or letter/ use emez
140	note.pt.
141	editorial.pt.
142	Editorial/ use ppez
143	News/ use ppez
144	exp Historical Article/ use ppez

#	Searches
145	Anecdotes as Topic/ use ppez
146	Comment/ use ppez
147	Case Report/ use ppez
148	case report/ or case study/ use emez
149	(letter or comment*).ti.
150	or/138-149
151	randomized controlled trial/ use ppez
152	randomized controlled trial/ use emez
153	random*.ti,ab.
154	or/151-153
155	150 not 154
156	animals/ not humans/ use ppez
157	animal/ not human/ use emez
158	nonhuman/ use emez
159	exp Animals, Laboratory/ use ppez
160	exp Animal Experimentation/ use ppez
161	exp Animal Experiment/ use emez
162	exp Experimental Animal/ use emez
163	exp Models, Animal/ use ppez
164	animal model/ use emez
165	exp Rodentia/ use ppez
166	exp Rodent/ use emez
167	(rat or rats or mouse or mice).ti.
168	or/155-167
169	137 not 168
170	limit 169 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]
171	170 use emez
172	169 not 171
173	limit 172 to english language
174	limit 173 to yr="2010 -Current"

The Cochrane Library: Cochrane Database of Systematic Reviews, Issue 11 of 12, November 2020; Cochrane Central Register of Controlled Trials, Issue 11 of 12, November 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: [Delivery of Health Care, Integrated] explode all trees
#23	MeSH descriptor: [Intersectoral Collaboration] this term only

ID	Search
#24	MeSH descriptor: [Interinstitutional Relations] this term only
#25	MeSH descriptor: [Interprofessional Relations] this term only
#26	((integrat* or collaborat* or colocat* or co locat* or “cross sector*” or interagenc* or “inter agenc*” or interdisciplin* or “inter disciplin*” or interinstitution* or “inter institution*” or interorgani?* or “inter organi*” or intersector* or “inter sector*” or intraprofession* or “intra profession*” or “joined up” or joint or merged or multiagenc* or “multi agenc*” or multidisciplin* or “multi disciplin*” or multiprofession* or “multi profession*” or multisector* or “multi sector*” or overlap* or share* or sharing or transdisciplin* or “trans disciplin*”) near/3 (access* or assess* or care or communit* or consult* or model? or program* or review* or service* or staff* or system* or team* or transfer* or work*)):ti,ab
#27	((integrat* or align* or joint or partner* or pool* or share* or sharing) near/3 (budget* or financ* or fund* or payment* or resource*)):ti,ab
#28	partner*:ti,ab
#29	((integrat* or joint or share* or sharing) near/3 (approach* or communicat* or information or strateg* or understanding or value* or vision)):ti,ab
#30	(communicat* near/3 (multi* or inter*)):ti,ab
#31	((integrat* or joint or share* or sharing) near/2 (educat* or staff development or training)):ti,ab
#32	(“key worker*” or keyworker* or (named next (contact* or coordinat* or co ordinat* or person*))):ti,ab
#33	(linkwork* or “link work*”):ti,ab
#34	(holistic next (assess* or review*)):ti,ab
#35	((digital* or teleconferenc* or video* or virtual*) near/2 (assess* or communicat* or consult* or meeting? or model? or service* or team* or technolog* or work*)):ti,ab
#36	("section 75 agreement*" or "s75 agreement*"):ti,ab
#37	("section 33 agreement*" or "s33 agreement*"):ti,ab
#38	((“local authorit*” or “local council*”) and (nhs or “national health service*”)):ti,ab
#39	“better care fund*”:ti,ab
#40	{or #22-#39}
#41	#21 and #40 with Cochrane Library publication date Between Jan 2010 and Dec 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	TI((integrat* OR collaborat* OR colocat* OR co locat* OR cross sector* OR interagenc* OR inter agenc* OR interdisciplin* OR inter disciplin* OR interinstitution* OR inter institution* OR interorgani* OR inter organi* OR intersector* OR inter sector* OR intraprofession* OR intra profession* OR joined up OR joint OR merged OR multiagenc* OR multi agenc* OR multidisciplin* OR multi disciplin* OR multiprofession* OR multi profession* OR multisector* OR multi sector* OR overlap* OR partner* OR share* OR sharing OR transdisciplin* OR trans disciplin*)) AND pd(20100101-20201231) AND la.exact("ENG")
S4	AB,TI((integrat* or align* or joint or partner* or pool* or share* or sharing) NEAR/3 (budget* or financ* or fund* or payment* or resource*)) AND pd(20100101-20201231) AND la.exact("ENG")
S5	AB,TI((integrat* or joint or share* or sharing) NEXT (approach* or communicat* or educat* or information or staff develop* or strateg* or train* or understanding or value* or vision)) AND pd(20100101-20201231) AND la.exact("ENG")
S6	AB,TI(key worker* or keyworker* or linkwork* or link work*) OR (named NEXT (contact* or coordinat* or co ordinat* or person*)) AND pd(20100101-20201231) AND la.exact("ENG")
S7	AB,TI((digital* or teleconferenc* or video* or virtual*) NEAR/2 (assess* or communicat* or consult* or meeting? or model? or service* or team* or technolog* or work*)) AND pd(20100101-20201231) AND la.exact("ENG")
S8	AB,TI((local authorit* or local council*) AND (nhs or national health service)) AND pd(20100101-20201231) AND la.exact("ENG")
S9	AB,TI(better care fund) AND pd(20100101-20201231) AND la.exact("ENG")
S10	AB,TI((holistic NEXT (assess* or review*))) AND pd(20100101-20201231) AND la.exact("ENG")
S11	AB,TI((section 75 agreement* or s75 agreement* OR section 33 agreement* or s33 agreement*)) AND pd(20100101-20201231) AND la.exact("ENG")
S12	3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11
S13	1 AND 2 AND 12

SOCIAL CARE ONLINE

Titles search:
- PublicationTitle:'social work* or social care*'

Titles search:
- 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:'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 PublicationTitle: 'integrat* or "better care fund*" or collaborat* or colocat* or co locat* or cross sector* or "holistic assess*" or "holistic review*" or interagenc* or inter agenc* or interdisciplin* or inter disciplin* or interinstitution* or inter institution* or interorgani?* or inter organi?* or intersector* or inter sector* or intraprofession* or intra profession* or joined up or joint or key worker* or keyworker* or linkwork* or link work* or merged or multiagenc* or multi agenc* or multidisciplin* or multi disciplin* or multiprofession* or multi profession* or multisector* or multi sector* or named or overlap* or partner* or pool* or "section 33 agreement*" or "s33 agreement*" or "section 75 agreement*" or "s75 agreement*" or share* or sharing or transdisciplin* or trans disciplin*'
- 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:'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 AbstractOmitNorms: 'integrat* or "better care fund*" or collaborat* or colocat* or co locat* or cross sector* or "holistic assess*" or "holistic review*" or interagenc* or inter agenc* or interdisciplin* or inter disciplin* or interinstitution* or inter institution* or interorgani?* or inter organi?* or intersector* or inter sector* or intraprofession* or intra profession* or joined up or joint or key worker* or keyworker* or linkwork* or link work* or merged or multiagenc* or multi agenc* or multidisciplin* or multi disciplin* or multiprofession* or multi profession* or multisector* or multi sector* or named or overlap* or partner* or pool* or "section 33 agreement*" or "s33 agreement*" or "section 75 agreement*" or "s75 agreement*" or share* or sharing or transdisciplin* or trans disciplin*'
- AND PublicationYear:'2010 2020'

Database(s): Social Policy and Practice 202007

#	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 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.

#	Searches
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.
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	((integrat* or collaborat* or colocat* or co locat* or interagenc* or inter agenc* or interdisciplin* or inter disciplin* or interinstitution* or inter institution* or interorgani?* or inter organi?* or intersector* or inter sector* or intraprofession* or intra profession* or joint or multiagenc* or multi agenc* or multidisciplin* or multi disciplin* or multiprofession* or multi profession* or multisector* or multi sector* or overlap* or share* or sharing or transdisciplin* or trans disciplin*) adj3

#	Searches
	(access* or assess* or care or communit* or consult* or model? or program* or review* or service* or staff* or system* or team* or transfer* or work*)).ti,ab.
76	((integrat* or align* or joint or partner* or pool* or share* or sharing) adj3 (budget* or financ* or fund* or payment* or resource*)).ti,ab.
77	partner*.ti,ab.
78	((integrat* or joint or share* or sharing) adj3 (approach* or communicat* or information or strateg* or understanding or value* or vision)).ti,ab.
79	(communicat* adj3 (multi* or inter*)).ti,ab.
80	((integrat* or joint or share* or sharing) adj2 (educat* or staff development or training)).ti,ab.
81	(key worker* or keyworker* or (named adj (contact* or coordinat* or co ordinat* or person*))).ti,ab.
82	(linkwork* or link work*).ti,ab.
83	(holistic adj (assess* or review*)).ti,ab.
84	((digital* or teleconferenc* or video* or virtual*) adj2 (assess* or communicat* or consult* or meeting? or model? or service* or team* or technolog* or work*)).ti,ab.
85	(section 75 agreement* or s75 agreement*).ti,ab.
86	((section 33 agreement* or s33 agreement*) and (wales or welsh)).ti,ab.
87	((local authorit* or local council*) and (nhs or national health service)).ti,ab.
88	better care fund.ti,ab.
89	or/75-88
90	74 and 89
91	(animal* or rat or rats or mouse or mice).ti.
92	90 not 91
93	limit 92 to yr="2010 -Current"

Literature search strategies for review question E2: Based on the views and experiences of everyone involved, what are the facilitators and barriers to integrated working between registered social workers and other practitioners to support adults with complex needs?

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

#	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

#	Searches
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.
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

#	Searches
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	(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

#	Searches
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 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

#	Query	Limiters/Expanders
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.

#	Searches
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.
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/

#	Searches
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
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")

Set#	Searched for
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.
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

#	Searches
	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.
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/

#	Searches
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

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.

#	Searches
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
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.

#	Searches
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 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.

#	Searches
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.
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

#	Searches
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/
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.

#	Searches
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
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
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

#	Query	Limiters/Expanders
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
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

#	Query	Limiters/Expanders
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
#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

ID	Search
#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

#	Searches
	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.
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

#	Searches
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.
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.

#	Searches
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 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/
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.

#	Searches
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.
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

#	Searches
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.
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.

#	Searches
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.
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

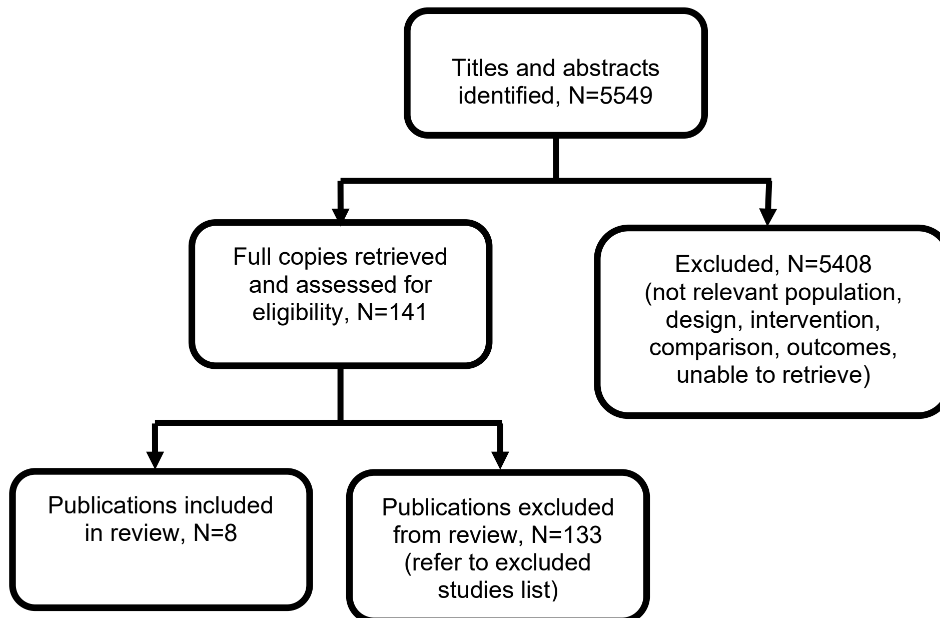
#	Searches
12	((chang* or develop* or enhanc* or initiative? or intervention? or program* or address* or improv* or target*) adj3 (employment or unemployment or unemploy*)).ti,ab.
13	(support* adj3 (employment? or work or vocational)).ti,ab.
14	(employment or unemploy* or underemploy* or under employ*).ti.
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.
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.

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

Appendix C Effectiveness and Qualitative evidence study selection

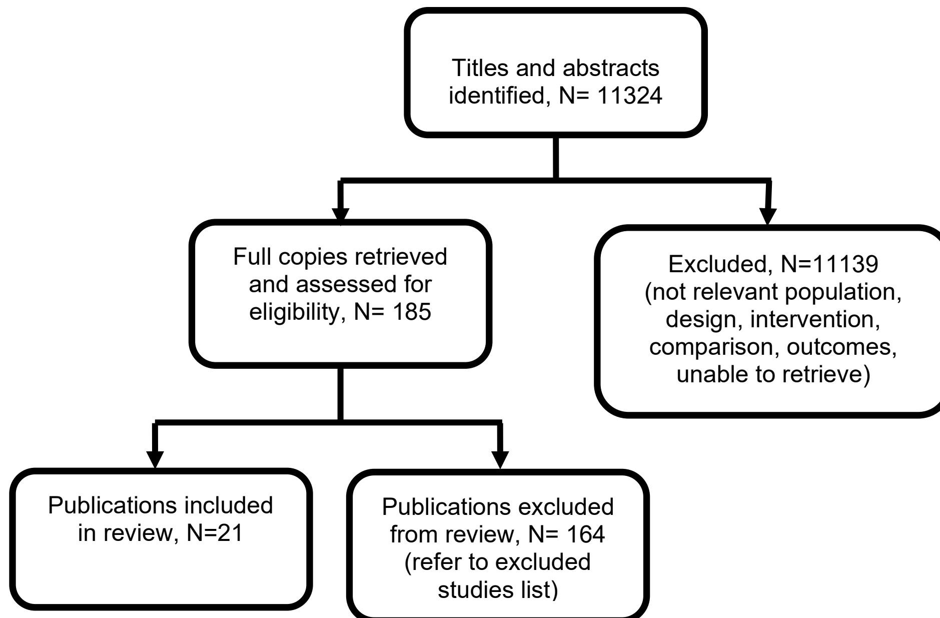
Study selection for review question E1: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

Figure 3: Study selection flow chart for effectiveness review



Study selection for review question E2: Based on the views and experiences of everyone involved, what are the facilitators and barriers to integrated working between registered social workers and other practitioners to support adults with complex needs?

Figure 4: Study selection flow chart for qualitative review



Appendix D Evidence tables

Evidence tables for review question E1: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

Table 8: Evidence tables – effectiveness evidence

Study details	Results and risk of bias assessment
Full citation Berglund, Helene, Wilhelmson, Katarina, Blomberg, Staffan, Duner, Anna, Kjellgren, Karin, Hasson, Henna, Older people's views of quality of care: a randomised controlled study of continuum of care, Journal of clinical nursing, 22, 2934-44, 2013 **Ref Id** 1301935 **Country/ies where the study was carried out** Sweden **Study type** Randomised controlled trial. **Study dates** January 2009 to October 2011. **Inclusion criteria** Frail older people at high risk of need for future health care: • Older adults living in their own homes. • Aged 80 years and older or 65 to 79 years with a need for assistance in at least one daily living and a minimum of one chronic illness. **Exclusion criteria** • Older people living with severe acute illness (in need of immediate medical treatment).	**Results** Quality of care (Pyramid Questionnaire)[2] **3 months follow-up** "I am satisfied with the planning that was done for me" Intervention (n=65): agree completely (86%); agree partly (6%); neither agree nor disagree (6%); disagree (2%); disagree completely (0%) Control (n=37): agree completely (60%); agree partly (5%); neither agree nor disagree (24%); disagree (3%); completely disagree (8%); p=0.001 **6 months follow-up** "I am satisfied with the home help service I receive" Intervention (n=27): agree completely (82%); agree partly (7%); neither agree nor disagree (4%); disagree (4%); disagree completely (3%) Control (n=18): agree completely (67%); agree partly (17%); neither agree nor disagree (5%); disagree (11%); completely disagree (0%); p=0.303 "I am satisfied with the home nursing care I receive" Intervention (n=16): agree completely (81%); agree partly (0%); neither agree nor disagree (13%); disagree (6%); disagree completely (0%) Control (n=8): agree completely (50%); agree partly (25%); neither agree nor disagree (25%); disagree (0%); completely disagree (0%); p=0.350 "I am satisfied with the rehabilitation, training, assistive technology and/or home modification I receive" Intervention (n=32): agree completely (81%); agree partly (7%); neither agree nor disagree (6%); disagree (6%); disagree completely (0%) Control (n=17): agree completely (77%); agree partly (0%); neither agree nor disagree (17%); disagree (6%); completely disagree (0%); p=0.654 **12 months follow-up** "I am satisfied with the home help service I receive"

Study details	Results and risk of bias assessment
• Older people living with dementia or severe cognitive impairment (according to medical records or as judged by registered nurses with geriatric expertise at the emergency department). • Older people requiring palliative care (according to medical records). **Participant characteristics** N=161 older people (Intervention: n=85; Control: n=76) Gender - n (%) Male: Intervention: 33 (43); control: 31 (45) Female: Intervention: 43 (57); control: 38 (55) Age (years) - n (%) 65 to 79: Intervention: 18 (24); control: 16 (23) ≥80: Intervention: 58 (76); control: 53 (77) Activities of daily living - n (%) Dependent in ≥1 activity in instrumental activities of daily living (I-ADL): Intervention: 59 (78); control: 52 (75) Dependent in ≥1 activity in personal activities of daily living (P-ADL): Intervention: 21 (28); control: 22 (32) Frailty - median (range)[1] Intervention: 3 (0.7); control: 4 (1 to 7) **Interventions** **Intervention (comprehensive continuum of care):** • Registered nurse with geriatric expertise assessed needs for health/social care and rehabilitation at the emergency department. • Assessment transferred to the hospital ward (if older person moved to a ward) and sent to a municipal inter-professional team (including case manager (that is, registered nurse), social worker, physiotherapist and/or occupational therapist. • The case manager co-ordinated the discharge planning with the older person, hospital professionals and municipal inter-professional team. • Case manager contacted relatives (if permission provided by the older person), to offer support and advice and to inform/involve them in the care planning. • Care planning meeting organised in older person's home after discharge or emergency department visit, with case manager and municipal inter-professional team.	Intervention (n=22): agree completely (82%); agree partly (5%); neither agree nor disagree (5%); disagree (4%); disagree completely (4%) Control (n=22): agree completely (68%); agree partly (18%); neither agree nor disagree (14%); disagree (0%); completely disagree (0%); p=0.430 "I am satisfied with the home nursing care I receive" Intervention (n=14): agree completely (100%); agree partly (0%); neither agree nor disagree (0%); disagree (0%); disagree completely (0%) Control (n=9): agree completely (100%); agree partly (0%); neither agree nor disagree (0%); disagree (0%); completely disagree (0%); p=1.000 "I am satisfied with the rehabilitation, training, assistive technology and/or home modification I receive" Intervention (n=25): agree completely (80%); agree partly (8%); neither agree nor disagree (8%); disagree (0%); disagree completely (4%) Control (n=19): agree completely (79%); agree partly (5%); neither agree nor disagree (6%); disagree (5%); completely disagree (5%); p=0.866 **Risk of bias assessment using Cochrane RoB tool v2.0** **1. Bias arising from the randomisation process (Low/High/Some concerns)** Some concerns - unclear whether allocation sequence random (but a system of sealed opaque envelopes used), no significant differences between **Participant characteristics** at baseline. **2. Bias arising due to deviations from intended interventions (Low/High/Some concerns)** Some concerns, unclear or lack of blinding; ITT analyses conducted. **3. Bias due to missing outcome data (Low/High/Some concerns)** Some concerns, attrition rates ranged from 3% to 11% at follow-up. **4. Bias in measurement of the outcome (Low/High/Some concerns)** Some concerns, potential bias because outcome assessors were aware of interventions received by participants. **5. Bias in selection of the reported result (Low/High/Some concerns)** Some concerns, data only reported for one outcome reported in the trial protocol. **Overall risk of bias (Low/High/Some concerns)** High risk of bias, the authors also stated that the study may not have been sufficiently powered to detect differences between intervention groups for items about satisfaction with services at 6 and 12 months follow-up.

Study details	Results and risk of bias assessment
• Within 1 week after care planning meeting, older person contacted by case manager for follow-up of needs and care. • Follow-up by case manager mainly a minimum of once a month for 12 months for ongoing support. • After 6 months, a new care planning meet held in older person's home, if needed. • Where a new admission to hospital occurred, a new care planning meeting in the older person's home was conducted after discharge. **Control (usual care):** • Care planning meeting/discharge planning took place at hospital if new home care services were required. • Meetings run by hospital professionals and a regular municipal inter-professional team (involving a social worker, municipal nurse, occupational therapist and/or physiotherapist). • No care planning meeting was held for individuals returning home directly after visiting the emergency department. **Follow-up** 3, 6 and 12 months.	**Source of funding** The Vårdal Institute, The Swedish Institute for Health Sciences and VinnVård. **Other information** The study forms part of a larger inter-disciplinary project (Continuum of Care for Frail Elderly People; Wilhelmson 2011). I-ADL: housework, shopping, community mobility and meal preparation. P-ADL: bathing, dressing, toileting, functional transferring and eating. [1]Amount of fulfilled frailty indicators, assessed as weakness, fatigue, weight loss, reduced physical activity, impaired balance, reduced gait speed, visual impairment, and impaired cognition. [2]Pyramid questionnaire covers care planning and meetings; older people's participation in and overall satisfaction with the care planning meeting; older people's knowledge of whom to contact with questions about care/service; satisfaction with home help service, home nursing care and rehabilitation, training, assistive technology and/or home modification.
Full citation Berglund, H., Hasson, H., Kjellgren, K., Wilhelmson, K., Effects of a continuum of care intervention on frail older persons' life satisfaction: a randomized controlled study, Journal of clinical nursing, 24, 1079-1090, 2015 **Ref Id** 1201204 **Country/ies where the study was carried out** Sweden **Study type** Randomised controlled trial. **Study dates** October 2008 to December 2011.	**Results** **Life satisfaction**[3] Life as a whole **Baseline to 3 months** Intervention (n=83): 72% (OR 0.93); control (n=76): 74% (OR 1.00); 95% CI 0.46 to 1.88; p=0.84 **3 to 6 months** Intervention (n=83): 59% (OR 0.75); control (n=76): 66% (OR 1.00); 95% CI 0.39 to 1.43; p=0.38 **6 to 12 months** Intervention (n=83): 78% (OR 1.88); control (n=76): 66% (OR 1.00); 95% CI 0.93 to 3.80; p=0.08 **Risk of bias assessment using Cochrane RoB tool v2.0**

Study details	Results and risk of bias assessment
Inclusion criteria Frail older people at high risk of need for future health care: • Older adults living in their own homes. • Visited the emergency department. • Aged 80 years and older or 65 to 79 years with a need for assistance in at least one daily living and a minimum of one chronic illness. **Exclusion criteria** • Older people living with severe acute illness (in need of immediate medical treatment). • Older people living with dementia or severe cognitive impairment (according to medical records or as judged by registered nurses with geriatric expertise at the emergency department). • Older people requiring palliative care (according to medical records). **Participant characteristics** N=161 older people (Intervention: n=85; Control: n=76) Gender - n (%) Male: Intervention: 38 (45); control: 34 (45) Female: Intervention: 47 (55); control: 42 (55) Age (years) - n (%) 65 to 79: Intervention: 20 (24); control: 18 (24) ≥80: Intervention: 65 (76); control: 58 (76) Activities of daily living - n (%) Dependent in ≥1 activity in I-ADL: Intervention: 66 (79); control: 55 (73) Dependent in ≥1 activity in P-ADL: Intervention: 27 (32); control: 23 (31) Missing responses: Intervention: 1; control: 1 Illness - n (%) ≤1 severe/constant disability or extremely severe clinical problem:[1] Intervention: 61 (72); control: 60 (79) ≥2 severe/constant disability or extremely severe clinical problem:[1] Intervention: 24 (28); control: 16 (21) Frailty - median (range)[2]	**1. Bias arising from the randomisation process (Low/High/Some concerns)** Some concerns, unclear whether allocation sequence random (but a system of sealed opaque envelopes used), no significant differences between **Participant characteristics** at baseline. **2. Bias arising due to deviations from intended interventions (Low/High/Some concerns)** Some concerns, unclear or lack of blinding; ITT analyses conducted. **3. Bias due to missing outcome data (Low/High/Some concerns)** Some concerns, attrition rates ranged from 15% to 22% at follow-up. **4. Bias in measurement of the outcome (Low/High/Some concerns)** Some concerns, the authors stated that the LiSat-11 scale was not developed to target older persons, but it was validated in a representative sample of people aged 18 to 74); potential bias because outcome assessors were aware of interventions received by participants. **5. Bias in selection of the reported result (Low/High/Some concerns)** Some concerns, data only reported for one outcome reported in the trial protocol. **Overall risk of bias (Low/High/Some concerns)** High risk of bias, the authors also stated that the intervention started prior to baseline measurements and there was a pattern of higher numbers of older people being satisfied in the intervention group at baseline. **Source of funding** The Vårdal Institute, The Swedish Institute for Health Sciences and VinnVård. **Other information** The study forms part of a larger inter-disciplinary project (Continuum of Care for Frail Elderly People; Wilhelmson 2011). I-ADL: housework, shopping, community mobility and meal preparation. P-ADL: bathing, dressing, toileting, functional transferring and eating. [1] Rated as number 3 or 4 on CIRS-G. [2]Amount of fulfilled frailty indicators, assessed as weakness, fatigue, weight loss, reduced physical activity, impaired balance, reduced gait speed, visual impairment, and impaired cognition. [3]Authors state that life satisfaction is closely related to quality of life and subjective well-being. Life satisfaction can be measured to collect data on, for example, emotion-related and

Study details	Results and risk of bias assessment
Intervention: 4 (0 to 7) Control: 4 (1 to 7) **Interventions** See Berglund (2013). **Follow-up** 3, 6 and 12 months.	social aspects of life where measurement tools for quality of life are weak (Borg et al. 2010). LiSat-11 scale measured satisfaction with work, financial situation, leisure, friends and acquaintances, sexual life, functional capacity, family life, partner relationship, physical health, and psychological health.
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 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**	**Results** Generic QoL (EQ-5D) - difference in mean changes between HF and TAU from baseline (95% CI) **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 Condition-specific QoL (QoLI-20 total score) - difference in mean changes between HF and TAU from baseline (95% CI) **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 Physical component summary score (SF-12) - difference in mean changes between HF and TAU from baseline (95% CI) **12 months**

Study details	Results and risk of bias assessment
N=2148 homeless adults living with mental illness (≥50 years: n=470; 18 to 49 years: n=1678) 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) 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)	≥50 years old (n=470): -0.59 (-2.85 to 1.66) 18 to 49 years old (n=1,678): -0.17 (-1.38 to 1.04) Difference in difference of mean changes from baseline between age groups (95% CI):[5] -0.43 (-2.98 to 2.13); p=0.744 **24 months** ≥50 years old (n=470): 0.37 (-2.01 to 2.76) 18 to 49 years old (n=1,678): -0.11 (-1.37 to 1.15) Difference in difference of mean changes from baseline between age groups (95% CI):[5] +0.49 (-2.21 to 3.18); p=0.724 Mental component summary score (SF-12) - difference in mean changes between HF and TAU from baseline (95% CI) **12 months** ≥50 years old (n=470): 4.19 (1.35 to 7.03) 18 to 49 years old (n=1,678): -1.25 (-2.77 to 0.27) Difference in difference of mean changes from baseline between age groups (95% CI):[5] +5.44 (2.22 to 8.66); p=0.001 **24 months** ≥50 years old (n=470): 2.18 (-0.79 to 5.15) 18 to 49 years old (n=1,678): -1.64 (-3.22 to -0.07) Difference in difference of mean changes from baseline between age groups (95% CI):[5] +3.82 (0.46 to 7.19); p=0.026 **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)**

Study details	Results and risk of bias assessment
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** 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**	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. [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: 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) **Interventions** **Intervention** 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]	

Study details	Results and risk of bias assessment
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 Franse, C. B., van Grieken, A., Alhambra-Borrás, T., Valía-Cotanda, E., van Staveren, R., Rentoumis, T., Markaki, A., Bilajac, L., Marchesi, V. V., Rukavina, T., et al.,, The effectiveness of a coordinated preventive care approach for healthy ageing (UHCE) among older persons in five European cities: a pre-post controlled trial, International journal of nursing studies, 88, 153-162, 2018 **Ref Id** 1288235 **Country/ies where the study was carried out** Europe (UK, Greece, Croatia, The Netherlands, Spain).[1] **Study type** Non-randomised controlled trial (international multi-centre, before-and-after controlled trial). **Study dates** May 2015 to June 2017. **Inclusion criteria** • Individuals aged 75 years and older (or 70 years and older for Greece and Spain) and living independently. • Able to participate in the study for at least 6 months (according to their physician). **Exclusion criteria**	**Results** HRQoL PCS (SF-12) - mean (±SD)[3] **Greece** Intervention: 42.5 (12.6); control: 42.9 (10.4) β (95% CI): -0.19 (-2.56 to 2.18); p=NS **Spain** Intervention: 44.3 (11.7); control: 43.9 (11.0) β (95% CI): 2.00 (0.20 to 3.80); p<0.05 HRQoL MCS (SF-12) - mean (±SD)[3] **Greece** Intervention: 47.8 (10.3); control: 46.1 (9.6) β (95% CI): -0.14 (-2.64 to 2.37); p=NS **Spain** Intervention: 52.2 (11.4); control: 51.8 (10.7) β (95% CI): 0.32 (-1.62 to 2.25); p=NS Mental well-being (SF-36) - mean (±SD)[3] **Greece** Intervention: 63.4 (18.0); control: 61.2 (17.8) β (95% CI): -0.28 (-4.16 to 3.61); p=NS **Spain** Intervention: 74.9 (22.3); control: 76.0 (20.3) β (95% CI): 1.65 (-1.69 to 4.99); p=NS **Risk of bias assessment using ROBINS-I** **1. Bias due to confounding (Low/Moderate/Serious/Critical/No information)**

Study details	Results and risk of bias assessment
• Individuals unable to understand the information provided in the local language. • Unable to cognitively evaluate the risks and benefits of taking part in the study and not expected to make an informed decision regarding participation. **Participant characteristics** **Greece** N=376 older people (Intervention: n=190; Control: n=186) **Spain** N=500 older people (Intervention: n=241; Control: n=259) **Greece** Age (years) - mean (±SD) Intervention: 75.1 (5.4); control: 75.3 (5.6) Gender (female) Intervention: 54.5%; control: 54.8% Severely limited functioning (GALI) Intervention: 21.1%; control: 17.6% Loneliness (short JG) - mean (±SD) Intervention: 0.7 (0.7); control: 0.7 (0.7) Frailty (TFI) - mean (±SD) Intervention: 5.9 (3.0); control: 5.4 (3.1) HRQoL PCS (SF-12) - mean (±SD) Intervention: 43.4 (12.1); control: 45.5 (11.6) HRQoL MCS (SF-12) - mean (±SD) Intervention: 49.5 (10.2); control: 48.4 (9.8) Mental well-being (SF-36) - mean (±SD) Intervention: 66.6 (18.2); control: 62.1 (19.9)	Moderate risk of bias, the authors stated that the non-randomised study design makes results subject to confounding. However, differences between individuals in the control and intervention groups at baseline were small. **2. Bias in selection of participants into the study (Low/Moderate/Serious/Critical/No information)** Moderate risk of bias, authors stated that there may be selective inclusion because targeted sample size not reached for control groups, especially in Greece, but differences between intervention and control groups at baseline were small. **3. Bias in classification of interventions (Low/Moderate/Serious/Critical/No information)** Moderate risk of bias, different control groups were implemented for different countries and were not clearly defined for Greece and Spain; no other information provided. **4. Bias due to deviations from intended interventions (Low/Moderate/Serious/Critical/No information)** No information. **5. Bias due to missing data (Low/Moderate/Serious/Critical/No information)** Moderate risk of bias, similar reasons for drop-out at follow-up in intervention and control groups; authors reported 0 missing data for Greece and Spain. **6. Bias in measurement of outcomes (Low/Moderate/Serious/Critical/No information)** Serious risk of bias, subjective measures used to assess outcomes; outcome assessors aware of intervention received. **7. Bias in selection of the reported result (Low/Moderate/Serious/Critical/No information)** Moderate risk of bias. **Overall risk of bias (Low/Moderate/Serious/Critical/No information)** Serious risk of bias. **Source of funding** European Union, CHAFEA, third health programme. **Other information** [1]Only outcome data from Greece and Spain eligible for inclusion; data from other countries included in the study were not eligible for inclusion because they did not assess interventions involving social workers. Greece included a health professional or social worker as the care co-ordinator. Spain included a social support group led by a social worker to address loneliness as part of the intervention.

Study details	Results and risk of bias assessment
Spain Age (years) - mean (±SD) Intervention: 76.6 (5.1); control: 77.3 (5.1) Gender (female) Intervention: 64.7%; control: 61.1% Severely limited functioning (GALI) Intervention: 6.8%; control: 4.7% Loneliness (short JG) - mean (±SD) Intervention:0.5 (0.6); control: 0.4 (0.6) Frailty (TFI) - mean (±SD) Intervention: 5.0 (3.1); control: 4.2 (2.5) HRQoL PCS (SF-12) - mean (±SD) Intervention: 44.9 (11.0); control: 47.0 (10.6) HRQoL MCS (SF-12) - mean (±SD) Intervention: 52.6 (11.2); control: 52.2 (10.9) Mental well-being (SF-36) - mean (±SD) Intervention: 73.8 (23.1); control: 76.8 (19.4) **Interventions** **Intervention (UHCE):** • Older people received a health assessment of fall risk, polypharmacy, loneliness, and frailty to identify need for a follow-up care pathway. • Shared decision making involving discussion of assessment between the older person, a person in charge of care co-ordination* and a physician. Older people were encouraged to involve an informal caregiver in the shared decision making process. • Decision on care plan made and care pathways implemented which aimed to promote healthy ageing. • Other health care not included in the care pathway could be provided where necessary. • Follow-up visits were scheduled if needed. **Control (care as usual):**	[2]For Greece and Spain, the availability of existing care was limited or the referral to existing care was difficult. New care provisions were therefore developed which did not involve co-ordinated preventive referral or monitoring of health. [3]Values were derived from linear regression models adjusted for age, gender, education, living situation and baseline status of the outcome measure. Care use was included as a secondary outcome, but data were not reported separately for Greece and Spain and are therefore not reported here.

Study details	Results and risk of bias assessment
• Access to existing care services delivered in the care pathways, but not for newly developed services.[2] **Follow-up** 12 months.	
Full citation Murphy, F., Hugman, L., Bowen, J., Parsell, F., Gabe-Walters, M., Newson, L., Jordan, S., Health benefits for health and social care clients attending an Integrated Health and Social Care day unit (IHSCDU): a before-and-after pilot study with a comparator group, Health & social care in the community, 25, 492-504, 2017 **Ref Id** 1289201 **Country/ies where the study was carried out** UK (Wales). **Study type** Non-randomised controlled trial (before-and-after controlled trial). **Study dates** November 2010 to September 2012. **Inclusion criteria** • Aged over 18 years. • Willing and able to provide informed consent. • Physically and psychologically fit to tolerate assessment. • Intervention group were required to attend the unit at least 1 day each week and those in the comparator group had to receive at least 1 visit a week from the community nursing services. **Exclusion criteria** • Individuals in the intervention group were excluded if they were only able to attend the unit for <10 months.	**Results** Quality of life (SF-12 PCS) - n (mean, ±SD) Intervention (n=30): baseline: 29 (30.65, 7.81); 4 months: 29 (30.31, 8.50); 9 months: 24 (31.66, 8.72) Control (n=33): baseline: 29 (32.11, 8.72); 4 months: 29 (28.11, 6.90); 9 months: 25 (29.16, 7.59) Change in SF12-PCS score from baseline to 9 months: MD: 5.31 (SE: 2.63), 95% CI 0.01 to 10.60 Quality of life (SF-12 MCS) - n (mean, ±SD) Intervention (n=30): baseline: 29 (48.15, 10.02); 4 months: 29 (46.66, 12.95); 9 months: 24 (49.12, 11.95) Control (n=33): baseline: 29 (41.84, 12.88); 4 months: 29 (45.07, 11.52); 9 months: 25 (45.57, 10.9) Change in SF12-MCS score from baseline to 9 months: MD: -1.87 (SE: 3.53), 95% CI -8.97 to 5.23 **Risk of bias assessment using ROBINS-I** **1. Bias due to confounding (Low/Moderate/Serious/Critical/No information)** Serious risk of bias, the authors stated that the interventions provided to individuals were not standardised because they were designed to meet individual needs, therefore authors could not fully isolate the factors which may or may not have made a difference; individuals in the intervention group may have received more than one intervention. **2. Bias in selection of participants into the study (Low/Moderate/Serious/Critical/No information)** Serious risk of bias, intervention group comprised all adults admitted to the unit between November 2010 and September 2012; comparator arm comprised adults of similar age and geographical location receiving community nursing services. **3. Bias in classification of interventions (Low/Moderate/Serious/Critical/No information)**

Study details	Results and risk of bias assessment
• Individuals in the comparator group were excluded if they were receiving palliative care or were on the community nursing caseload for <10 months. **Participant characteristics** N=63 older people (Intervention: n=30; Control: n=33) Age (years) - mean (±SD) Intervention: 77.80 (9.43); control: 82.67 (8.83) Gender (male) - n/N (%) Intervention: 11/30 (36.7%); control: 10/33 (30.3%) Physical health component score - mean (±SD) Intervention: 30.54 (7.70); control: 31.69 (8.62) Mental health component score - mean (±SD) Intervention: 48.52 (10.05); control: 42.37 (13.47) Number of current clinical problems - median (IQR) Intervention: 3 (3 to 3); control: 3 (2 to 3) **Interventions** **Intervention (integrated health and social care day unit):** • Purpose-built health and social care day facility. • Services provided by a multi-disciplinary team of health and social care professionals (nurses, doctors, social workers, physiotherapists, and occupational therapists). • Individuals required short-term (<18 months) therapeutic support to live independently. • Comprehensive initial assessment carried out to identify needs and tailor programmes to individuals (including assistance with activities of daily living, occupational therapy and physiotherapy, other nursing, and social work interventions; referrals to specialist services were also provided). • Optimum nutrition (lunch provided). • Programme of activities provided to avoid social isolation.	Moderate risk of bias. **4. Bias due to deviations from intended interventions (Low/Moderate/Serious/Critical/No information)** Moderate risk of bias, individuals in the intervention group may have received more than one intervention. **5. Bias due to missing data (Low/Moderate/Serious/Critical/No information)** Moderate risk of bias, 20% of more participants did not complete follow-up; the authors stated that they did not impute missing data. **6. Bias in measurement of outcomes (Low/Moderate/Serious/Critical/No information)** Serious risk of bias, subjective measures used to assess outcomes; analysts blinded to treatment allocation. **7. Bias in selection of the reported result (Low/Moderate/Serious/Critical/No information)** Moderate risk of bias. **Overall risk of bias (Low/Moderate/Serious/Critical/No information)** Serious risk of bias. **Source of funding** Hywel Dda Health Board Wales UK.

Study details	Results and risk of bias assessment
• GP visit to unit at least once per week. **Control (Community nursing services):** • Nursing assessments and appropriate nursing interventions provided. • Referrals to other health and social care agencies, and specialist services, if required. • Frequency of district nursing team visits depended on individual health care needs. **Follow-up** 4 and 9 months.	
Full citation Spoorenberg, S. L. W., Wynia, K., Uittenbroek, R. J., Kremer, H. P. H., Reijneveld, S. A., Effects of a population-based, person-centred and integrated care service on health, wellbeing and self-management of community-living older adults: A randomised controlled trial on Embrace, 13, e0190751, 2018 **Ref Id** 1204386 **Country/ies where the study was carried out** The Netherlands. **Study type** Stratified randomised controlled trial. **Study dates** October 2011 to March 2013 (follow-up January 2012 to March 2013). **Inclusion criteria** Adults aged 75 years and older from 15 participating GP practices, living at home or in a home for the elderly. **Exclusion criteria** • Long-term admission to a nursing home (not just for rehabilitation). • Receiving an alternative type of integrated care.	**Results** **Older adults with complex needs (adults with complex care needs and at risk for assignment to a hospital or nursing home)** Quality of life (EQ-5D-3L)[1] - mean (±SD) Intervention (n=187): 0.65 (0.16); control (n=178): 0.64 (0.17) Difference in change between intervention and control: β -0.01 (95% CI -0.04 to 0.02); p=0.521 (effect size 0.07) Quality of life (EQ-VAS)[2] - mean (±SD) Intervention (n=187): 56.8 (16.8); control (n=178): 53.8 (19.4) Difference in change between intervention and control: β -1.54 (95% CI -4.60 to 1.52); p=0.323 (effect size 0.10) Quality of life (self-rated QoL from RAND-36)[3] - mean (±SD) Intervention (n=187): 3.43 (0.80); control (n=178): 3.47 (0.79) Difference in change between intervention and control: β 0.04 (95% CI -0.10 to 0.17); p=0.587 (effect size 0.06) Quality of life (versus 1 year ago)[3] - mean (±SD) Intervention (n=187): 3.45 (0.81); control (n=178): 3.51 (0.71) Difference in change between intervention and control: β -0.06 (95% CI -0.23 to 0.10); p=0.471 (effect size 0.08) **Frail older adults (adults at risk of complex care needs)**

Study details	Results and risk of bias assessment
• Participating in another research study. **Participant characteristics** See Uittenbroek 2017. **Interventions** See Uittenbroek 2017. **Follow-up** 12 months.	Quality of life (EQ-5D-3L)[1] - mean (±SD) Intervention (n=122): 0.74 (0.11); control (n=115): 0.74 (0.13) Difference in change between intervention and control: β -0.02 (95% CI -0.04 to 0.01); p=0.223 (effect size 0.16) Quality of life (EQ-VAS)[2] - mean (±SD) Intervention (n=122): 67.2 (15.7); control (n=115): 70.0 (13.7) Difference in change between intervention and control: β 1.45 (95% CI -1.84 to 4.74); p=0.387 (effect size 0.11) Quality of life (self-rated QoL from RAND-36)[3] - mean (±SD) Intervention (n=122): 2.99 (0.71); control (n=115): 2.97 (0.79) Difference in change between intervention and control: β 0.02 (95% CI -0.16 to 0.21); p=0.818 (effect size 0.03) Quality of life (versus 1 year ago)[3] - mean (±SD) Intervention (n=122): 3.02 (0.63); control (n=115): 3.03 (0.59) Difference in change between intervention and control: β -0.08 (95% CI -0.28 to 0.12); p=0.425 (effect size 0.10) **Risk of bias assessment using Cochrane RoB too v2.0** **1. Bias arising from the randomisation process (Low/High/Some concerns)** Some concerns, the authors stated that allocation concealment after stratification was anonymised, but no further details were provided, no statistically significant differences in demographic characteristics. **2. Bias arising due to deviations from intended interventions (Low/High/Some concerns)** See Uittenbroek 2017. **3. Bias due to missing outcome data (Low/High/Some concerns)** Some concerns, attrition rates 22% and 31%; missing scale scores were imputed using the mean change in deterioration of completed cases. **4. Bias in measurement of the outcome (Low/High/Some concerns)** See Uittenbroek 2017. **5. Bias in selection of the reported result (Low/High/Some concerns)**

Study details	Results and risk of bias assessment
	See Uittenbroek 2017. **Overall risk of bias (Low/High/Some concerns)** High risk of bias, the authors also stated that randomising participants within GP practices may have led to some contamination. **Source of funding** See Uittenbroek (2017). **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 (Groningen Frailty Indicator, 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 discussed here as they are case managed by a social worker. [1]EQ-5D-3L scale scores (range -0.33 to 1.00) with higher scores representing improvement. Difference in change between intervention and control - regression coefficients (B) adjusted for age and sex. [2]EQ-VAS scale scores (range 0 to 100) with higher scores representing improvement. Difference in change between intervention and control - regression coefficients (B) adjusted for age and sex. [3]QoL scale scores (range 0 to 5) with higher scores representing deterioration. Difference in change between intervention and control - regression coefficients (B) adjusted for age and sex.
Full citation Stobbe, J., Wierdsma, A. I., Kok, R. M., Kroon, H., Roosenschoon, B. J., Depla, M., Mulder, C. L., The effectiveness of assertive community treatment for elderly patients with severe mental illness: A randomized controlled trial, BMC Psychiatry, 14, 2014 **Ref Id** 1204434 **Country/ies where the study was carried out** The Netherlands. **Study type** Parallel group randomised controlled trial.	**Results** First care contact within 3 months - n (%) Intervention (n=32): 31 (96.9); control (n=30): 20 (66.7); p=0.002 Hospitalisation - n[2] 2 years before intervention: Intervention: n=2; control: n=1 After start of intervention: Intervention: n=4; control: n=4 Crisis contacts - n[2] Before intervention: Intervention: n=7; control: n=0 2 years after start of intervention: Intervention: n=5; control: n=4 [2]The authors did not perform statistical analysis because of very low number of participants admitted or who had crisis contacts.

Study details	Results and risk of bias assessment
Study dates July 2008 to July 2010. **Inclusion criteria** • Aged 65 years and older. • Presumed to be living with severe mental illness (for example, schizophrenia spectrum disorders or major affective disorders). • Problems in 4 or more areas: daily functioning (for example, personal hygiene, social relationships), daytime activities, addition, financial problems, housing, somatic problems, or police contacts. • Difficulties in engaging in treatment (for example, participants who were unwilling to use mental health services, or who had a history of involuntary admission or of drop-out from mental healthcare).[1] **Exclusion criteria** • Older adults living with presumed moderate to severe cognitive impairment. **Participant characteristics** N=62 older people living with severe mental illness (Intervention: n=30; Control: n=32) Age (years) - mean (±SD) Intervention: 74.4 (7.0); control: 75.1 (9.3) Gender - n (%) Male: Intervention: 16 (50); control: 10 (33.3) Female: Intervention: 16 (50); control: 20 (66.7) Diagnosis axis I - n (%) Schizophrenia spectrum disorders: Intervention: 11 (34.4); control: 11 (36.7) Mood disorder: Intervention: 5 (15.6); control: 3 (10.0) Cognitive impairment: Intervention: 4 (12.5); control: 7 (23.3) Other disorders: Intervention: 12 (37.5); control: 9 (30.0)	**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, unclear study blinding; ITT analyses conducted. **3. Bias due to missing outcome data (Low/High/Some concerns)** High risk of bias, high attrition rates and difference between intervention and control groups (27% and 44%, respectively); loss to follow-up mainly because participants did not open the door or refused contact. **4. Bias in measurement of the outcome (Low/High/Some concerns)** Some concerns, data were analysed anonymously, but the authors stated that raters could not be blinded to treatment allocation because of practical issues. **5. Bias in selection of the reported result (Low/High/Some concerns)** Low risk of bias. **Overall risk of bias (Low/High/Some concerns)** High risk of bias, the authors acknowledged that the differences in numbers of participants who dropped out of care, could suggest that those who dropped out of the control group had worse psychosocial outcomes which led to a selection bias in the control group; the intervention may have caused selection bias by preventing the dropout of participants with worse prognoses than others; the control group received components of the intervention group, therefore differences between intervention and control groups were small. **Source of funding** BavoEuropoort. **Other information** [1]Because of problems with recruitment to the study, the inclusion criteria were changed after 1 year to include adults aged 60 years and older and were not required to have problems in various domains because participants often received no medical or psychiatric treatment.

Study details	Results and risk of bias assessment
Total unmet needs score - median (range) Intervention: 7.5 (1 to 15); control: 6.5 (2 to 13) **Interventions** **Intervention (assertive community treatment):** Community-based treatment approach for outpatients whose severe mental illness resulted in difficulties in daily living activities and social functioning, who were high users of inpatient hospital services and unwilling to use mental health services. A multi-disciplinary team (trained in psychiatry, social work, nursing, substance abuse, and rehabilitation) provides psychiatric, somatic and rehabilitation treatment. Team staffed by a substance-abuse specialist, a rehabilitation worker, a social worker, a psychiatric nurse, a specialised in somatic care, a community mental health nurse and a psychiatrist (both specialised in treating older people). The key features include: • Assertive engagement. • Small caseload (maximum of 10 participants per clinician). • Shared caseload (that is, all clinicians collaborate closely on each participant using one treatment plan). • Community-based and assertive services on a time-unlimited basis. **Control (treatment as usual):** Provided by 3 community mental health teams for older people (2 teams for people living with primary psychiatric disorders and one for people living with cognitive disorders). • Teams provide regular mental health services, including psychiatric care on an outreach basis (including community mental health nurses, a psychiatrist, and a psychologist). • No shared caseload. • Caseload included more than 25 participants per practitioner). • All clinicians specialised in treating older people. **Follow-up** 3, 9 and 18 months.	

Study details	Results and risk of bias assessment
Full citation Uittenbroek, R. J., Kremer, H. P. H., Spoorenberg, S. L. W., Reijneveld, S. A., Wynia, K., Integrated Care for Older Adults Improves Perceived Quality of Care: Results of a Randomized Controlled Trial of Embrace, Journal of General Internal Medicine, 32, 516-523, 2017 **Ref Id** 1204631 **Country/ies where the study was carried out** The Netherlands. **Study type** Stratified randomised controlled trial. **Study dates** January 2012 to March 2013. **Inclusion criteria** Adults aged 75 years and older from 15 participating GP practices. **Exclusion criteria** • Long-term admission to a nursing home. • Involved in a similar integrated care service. • Participating in another scientific study. **Participant characteristics**[1] **Older adults with complex care needs** N=365 (Intervention: n=187; Control: n=178) Age (years) - mean (±SD) Intervention: 81.8 (4.6); control: 81.5 (4.9) Gender (female) - n (%) Intervention: 121 (64.7); control: 115 (64.6) Chronic conditions - median (IQR) Intervention: 3 (2 to 5); control: 3 (2 to 5)	**Results** **Older adults with complex care needs (adults with complex care needs and at risk for assignment to a hospital or nursing home) (n=365)** Quality of care (Patient Assessment of Integrated Elderly Care; PAIEC)[2] total score - mean (±SD) Intervention (n=187): baseline: 3.52 (2.24); follow-up: 3.94 (2.34); change: 0.36 (2.62) Control (n=178): baseline: 3.48 (2.06); follow-up: 3.45 (2.34); change: -0.19 (2.28) Difference between baseline and follow-up between intervention and control groups: unstandardised regression coefficient (β) 0.44 (95% CI: 0.01 to 0.87); p=0.044 (effect size: 0.21) **Frail older adults (adults at risk of complex care needs) (n=237)** Quality of care (Patient Assessment of Integrated Elderly Care; PAIEC)[2] total score - mean (±SD) Intervention (n=122): baseline: 2.75 (2.19); follow-up: 3.55 (2.41); change: 0.69 (2.14) Control (n=115): baseline: 2.64 (1.90); follow-up: 2.55 (1.86); change: -0.06 (2.20) Difference between baseline and follow-up between intervention and control groups: β 0.89 (95% CI: 0.42 to 1.37); p<0.001 (effect size: 0.48) **Risk of bias assessment using Cochrane RoB tool v2.0** **1. Bias arising from the randomisation process (Low/High/Some concerns)** Some concerns, the authors stated that allocation concealment after stratification was concealed, but no further details were provided; no statistically significant differences in demographic characteristics, with the exception of 'home help received during the past year' in older adults with complex care needs. **2. Bias arising due to deviations from intended interventions (Low/High/Some concerns)** Some concerns, participants and Elderly Care Team members aware of intervention group assignment; no deviations reported; ITT analyses conducted. **3. Bias due to missing outcome data (Low/High/Some concerns)** Some concerns, attrition rates 22% and 31%; last observation carried forward methods used to address missing outcome data. **4. Bias in measurement of the outcome (Low/High/Some concerns)** Some concerns, outcome assessors aware of intervention received by participants.

Study details	Results and risk of bias assessment
Complexity of care needs (IM-E-SA) - median (IQR) Intervention: 19 (17 to 22); control: 19.5 (17 to 24) Frailty (GFI) - median (IQR) Intervention: 7 (5 to 8); control: 7 (5 to 9) EQ-5D-3 L - mean (±SD) Intervention: 0.65 (0.16); control: 0.64 (0.17) EQ-5D-VAS - mean (±SD) Intervention: 56.7 (16.7); control: 53.8 (19.4) **Frail older adults** N=237 (Intervention: n=122; Control: n=115) Age (years) - mean (±SD) Intervention: 81.6 (5.1); control: 82.8 (5.5) Gender (female) - n (%) Intervention: 82 (67.2); control: 80 (69.6) Chronic conditions - median (IQR) Intervention: 3 (1 to 4); control: 3 (2 to 4) Complexity of care needs (IM-E-SA) - median (IQR) Intervention: 12 (10 to 14); control: 12 (9 to 13) Frailty (GFI) - median (IQR) Intervention: 6 (5 to 7); control: 6 (5 to 7) EQ-5D-3 L - mean (±SD) Intervention: 0.74 (0.11); control: 0.74 (0.13) EQ-5D-VAS - mean (±SD) Intervention: 67.2 (15.6); control: 70.0 (13.5) **Interventions** **Intervention (Embrace):** Integrated, person-centred, proactive, and preventive primary care and support which combines the Chronic Care Model with risk profiles based on a population health management model (the Kaiser Permanente Triangle).	**5. Bias in selection of the reported result (Low/High/Some concerns)** Some concerns, protocol available, but other reported in the protocol that were not reported in this publication. **Overall risk of bias (Low/High/Some concerns)** High risk of bias, the authors also stated that randomising participants within GP practices may have led to some contamination of the control group because the Elderly Care Team members received extensive training and were unblinded, which may have caused some underestimation of the effects of the intervention. **Source of funding** Part of the Dutch National Care for the Elderly Programme and funded by The Netherlands Organisation for Health Research (ZonMw) and the Dutch Healthcare Authority (NZA). **Other information** [1]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 (Groningen Frailty Indicator, 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 discussed here as they are case managed by a social worker. GPs completed initial training focusing on team and population management and essential themes such as multi-morbidity and polypharmacy; Social workers and district nurses completed training in areas such as case management and shared decision making; All team members received monthly on-the-job coaching during team meetings. [2]The PAIEC is a modified version of the Patient Assessment of Chronic Illness Care and consists of 20 items divided into: Patient activation and contextual information; Goal-**Setting** and problem-solving; and Co-ordination and follow-up. Higher scores reflect better perceived quality of care. Difference in change between intervention and control - regression coefficients (B) adjusted for age and sex.

Study details	Results and risk of bias assessment
• Care and support offered by a multi-disciplinary Elderly Care Team (elderly care physician (that is, a nursing home physician), a community nurse, and a social worker). • Older adults stratified into risk profiles ('Robust', 'Frail', and 'Complex care needs')*, with intensity of care dependent on risk profile in terms of number of contacts, main focus, health-related versus social problems, and individual versus group approach. • Older adults within the 'Frail' and 'Complex care needs' profiles received individual care and support from a case manager (a social worker and community nurse, respectively). • Case managers visited older adults at home once or twice a month, and focused on problems experienced by older adults, that is, emotional and exercise tolerance functions. • Older adults within the 'Robust' profile had their medical files, medications, and self-reported levels of frailty and case complexity reviewed once a year. They were encouraged to contact the Elderly Care Team if their health or life situation changed and the team acted proactively where suspected deterioration was suspected. • All older adults offered a self-management support and prevention programme (for example, community meetings and newsletters emphasising the need for prevention and healthy lifestyles while maintaining self-management abilities). **Control (care as usual):** • As provided by GP and local health and social care organisations (in The Netherlands, municipalities are responsible for social care and health promotion, which is government (tax)-funded). • GP acts as a gatekeeper for specialised medical care. • GP visits increase with age, from 4 visits per year for older adults aged 45 to 64, to 10 visits annually at ages 75 years and older. **Follow-up** 12 months.	

ACT: assertive case management; CI: confidence interval; CIRS-G: Cumulative Illness Rating Scale for Geriatrics; DSM-IV: Diagnostic and Statistical Manual IV; EQ-5D: EuroQol-Five Dimensions; EQ-5D VAS: EuroQol-Five Dimensions Visual Analogue Scale; GALI: global activity limitation indicator; HF: Housing First; HRQoL: health-related quality of life; I-ADL: instrumental activities of daily living; ICM: intensive case management; IHSCDU: integrated health and social care day unit; IM-E-SA: INTERMED for the elderly self-assessment; IQR: interquartile range; ITT: intention-to-treat; LiSat-11: Life Satisfaction Questionnaire; MCAS: Multnomah community ability scale; MCS: mental component summary; MHCC: Mental Health Commission of Canada; MINI: mini international neuropsychiatric interview; N: number; NS: not significant; OR: odds ratio; P-ADL: personal activities of daily living; PAIEC: patient assessment of integrated elderly care; PCS: physical component summary; QoL: quality of life; QoLI-20: Lehman Quality of Life Interview 20 Index; RoB: risk of bias; SD: standard deviation; RAND-36: research and development- 36 item health survey; ROBINS-I: risk of bias in non-

randomised studies – of interventions; SE: standard error; SF-12: short form survey 12; SF-36: short form survey 36; TAU: treatment as usual; TFI: Tilberg Frailty indicator; UHCE: Urban Health Centres Europe.

Evidence tables for review question E2: Based on the views and experiences of everyone involved, what are the facilitators and barriers to integrated working between registered social workers and other practitioners to support adults with complex needs?

Table 9: Evidence tables – qualitative evidence

Study details	Methods and participants	Results	Limitations
Full citation Abendstern, M., CMHTs for older people: team managers' views surveyed, Journal of Integrated Care, 22, 209-219, 2014 **Ref Id** 1220526 **Country/ies where the study was carried out** UK **Study type** General qualitative inquiry. **Study aims** To find out from the views of team managers, how community mental health teams worked, and what is important to the delivery of good practice. **Study dates** 2009.	**Recruitment strategy** A national survey sent to Community Mental Health Team managers. No further details provided. **Setting** Community Mental Health Teams. **Participant characteristics** N=225 Community Mental Health Team managers (of teams that included a social worker). **Data collection and analysis** Data collection Data collection were part of a larger anonymous service evaluation. Free text responses were used from a national survey sent to Community Mental Health Team managers. Data analysis Content analysis of free text survey responses. Three researchers were involved in coding the responses. Themes emerged by dividing statements into content areas.	**Findings (including author's interpretation)** Staffing and teamwork It was reported that clarity around professional roles was needed, and that role blurring was wasteful of skills and expertise. It was suggested that if teams were properly resources, role blurring would not be an issue. "Nursing team model keeps role as a practising clinician and not have time taken away from this in doing a social work role. Avoids dilution of mental health nursing skills, facilitates team to provide service to primary and secondary care." "We have tried mixing and matching social workers and nurses however due to staff shortages we have gone back to doing what we know best." p.213. Management and supervision, documentation and location Respondents thought having a single team manager was needed for integrated health and social care teams. Management without a single manager for the whole integrated team was described as "difficult" and "messy." p.214. The lack of a single shared database system was said to create inefficiency and extra work for social workers who often had to input data onto two systems. '"Having to record on different systems takes away from time available to spend on clinical work, particularly for social workers, having one system of recording patient information is preferable to	**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, the author has justified why the method chosen would help meet the aims of the study. **4. Was the Recruitment strategy appropriate to the aims of the research?** Can't tell, the author has stated that the survey was sent to Community Mental Health Team managers, but has not explained why they were chosen in particular and why their views are best placed to reflect good practice. **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, there is no information regarding how the survey questions were formulated or whether

Study details	Methods and participants	Results	Limitations
		ensure all patient information is in one place and reduce the level of recording". p.214	researcher bias was considered during formulation of questions. **7. Have ethical issues been taken into consideration?** Yes, approval was received from the National Research Ethics Service for the larger service evaluation, from which this study uses data. **8. Was the data analysis sufficiently rigorous?** Yes, methods of data analysis are detailed and it is clear how the themes were derived. The author describes 3 researchers taking part in the analysis process. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the author has considered how the findings contribute to existing literature. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor. **Source of funding** Not industry funded (grant by National Institute for Health Research). **Other information** Total number of Community Mental Health Team respondents was 376. 60% (225) of those had at least one social worker as part of the team. Data was extracted for responses specific to social workers and social care only. Data collection in 2009, which is 1 year before the publication date limits set in the protocol.

Study details	Methods and participants	Results	Limitations
Full citation Abendstern, M., Social workers as members of community mental health teams for older people: what is the added value?, British Journal of Social Work, 46, 63-80, 2016 **Ref Id** 1287493 **Country/ies where the study was carried out** England, UK. **Study type** General qualitative inquiry. **Study aims** To explore social workers' contributions to multidisciplinary teams working with older people with mental ill health. **Study dates** January - August 2011.	**Recruitment strategy** Team managers were asked to provide a list of their team members by occupation. The researcher randomly chose 3 members, usually 1 from each staff group. The members were asked by their managers if they wanted to participate, and if yes they were sent relevant information and consent details. **Setting** Mental Health Trusts in England covering urban, rural and mixed communities. **Participant characteristics** Total participants interviewed: N=21 Hybrid team (co-located team but separately managed health and social care departments) interviewed n=6: Professional role types interviewed: Team manager Consultant psychiatrist Nurse Occupational therapist Social worker Integrated team (co-located and health and social care departments under one manager) interviewed n=15: Professional role types interviewed: Team manager Consultant psychiatrist Nurse Occupational therapist Social worker Support worker **Data collection and analysis** Data collection Semi-structured interviews took place, they	**Findings (including author's interpretation)** Generic or specialist workers In two of the integrated teams that had nurse managers, social workers reported role blurring. In the team managed by a social worker, the social worker experienced more evenly balanced role blurring The social worker from team D felt that she was protected by her manager from taking on more than was appropriate in a way the social workers in the other two integrated teams did not. "The expectation is that social workers will kind of blur . . . for instance medication, all the kind of mental health professional identity whereas . . . there's a lot of reluctance within the rest of the team to take on the social care roles". (social worker, team A). "Our manager is from a social work background, so she knows what our limitations are . . . . So . . . you wouldn't necessarily be taking on something that you wouldn't be trained to do". (social worker, team D). "There's a scary boundary that I feel that I should be very, very careful not to cross". (social worker, team A). [Quotes p.70-71] Communication pathways Ready access to social workers within integrated teams could increase pressure on social workers' caseloads. "No such thing as full up. We don't have a waiting list . . . I think that the new revised caseload weighting tool shows that we were far exceeding the expectations of what we should be doing. . . but . . . We just take it". (social worker, team C) p.74. An advantage of social work team membership was the ability to refer directly to	**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, the author explained how interviews and a thematic analysis approach would explore the role of the social worker. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author describes that the team members were randomly chosen from a range of occupations that make up the community mental health teams, although the random selection was not explained in detail. **5. Was the data collected in a way that addressed the research issue?** Yes, method of data collection is clear but no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, there is no mention of the relationship between the researcher and participants in the formulation of questions or data collection.

Study details	Methods and participants	Results	Limitations
	were recorded and then professionally transcribed. Data analysis 3 members of the research team were involved in data analysis. The transcripts were coded to themes. A grounded theory approach was taken for the analysis, with subjective interpretations open for challenge.	social workers where social care input was needed. This meant both a faster referral to and response from social workers. ”You are referring to a colleague, which is a lot quicker because you are not sending it out of the office, onto a waiting list”. (manager of health staff). ”I think the integration for the service user has possibly made it quicker . . . for different disciplines to become involved . . . because we haven’t got an external referral system . . ..You can come back and you can have the discussion . . . so that process has quickened up now because it’s all within the team”. (social worker, team C). [Quotes p.74] The informal access and communication that social work membership enabled meant that discussions could take place at an early stage rather than only at the time when decisions needed to be made. This was reported as promoting reflective practice and aiding decision making. 1) In relation to working with an approved mental health professional: “. . . very useful in having some of the discussions about at what stage would we need to think about using the Mental Health Act for somebody in the community who has dementia . . . to have that sort of conversation is invaluable”. (consultant, team A). 2) The work would ”flow much better” and that the “person in the middle knows exactly where they are”. (social worker, team D). [Quotes [73-74] Social work identity, knowledge and qualities Community Mental Health Team social workers were recognised as having undergone a degree of specialist training	**7. Have ethical issues been taken into consideration?** Yes, ethical approval was granted by the Cambridgeshire Research Ethics Committee. **8. Was the data analysis sufficiently rigorous?** Yes, there was an in-depth description of the analysis process, and the author describes that 3 researchers were involved in the analysis to avoid bias. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the researchers have provided information for the implication of the findings for service users and community mental health teams. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor. **Source of funding** Not reported.

Study details	Methods and participants	Results	Limitations
		which those outside the teams tended not to have had. There was concern if the team did not understand mental health.	
Full citation Aspinal, F., Outcomes assessment for people with long-term neurological conditions: a qualitative approach to developing and testing a checklist in integrated care, 4, 2014 **Ref Id** 1220816 **Country/ies where the study was carried out** England, UK. **Study type** General qualitative inquiry. **Study aims** To understand models of integration in neurorehabilitation teams for adults with long term neurological conditions, and to explore views on an outcomes checklist. **Study dates** 2010 to 2012.	**Recruitment strategy** Primary Care Trusts were invited to participate if they have a neurorehabilitation team (NRT) that was based in a community setting. An initial interview was taken with a key contact in each case study site. Snowball approach then used for sampling. The key contact identified other staff members involved in commissioning services for adults with long-term neurological conditions (LTNCs). All subsequent interviewees were asked to identify relevant individuals to approach. Organisational staff, NRT staff and staff they were integrated with, people with LTNCs and their carers were all asked to participate using the snowball approach. **Setting** 4 Primary Care Trusts in England. **Participant characteristics** Total participants interviewed or took part in focus groups (from sites A and B) N=66 NHS organisational staff, n=4 Social care organisational staff, n=2 NRT team staff, n=27 non-NRT staff, n=2 People with LTNCs, n=25 Carers of people with LTNCs, n=6 **Data collection and analysis** Data collection Participants were given the choice of a face-to-face or a telephone interview. Interviews were audio recorded and transcribed verbatim. Participants were given the option to view their transcript. Interviews lasted	**Findings (including author's interpretation)** <u>Practice-level (micro) influences</u> In site A, bureaucratic referral processes between health and social care, and waiting times for social care assessments, created delays for people with long-term neurological conditions in getting access to services. Team integration could be hindered when the team responsibilities were being line-managed outside the team. Despite formal integration between health and social care, administration procedures and information technology systems remained separate and different contractual arrangements for health and social care staff within the team led to a perceived divide. Difficulties were reported during referrals to other services when there was a limited understanding of the different roles and responsibilities that different services and professionals adopted. Different legal responsibilities and different approaches to care between health and social care staff were all seen to impede integrated working. Co-location was reported as a helpful factor for team integration in both sites. Having a multidisciplinary clinic situated in a local health and social care centre was valued and said to provide access to a range of disciplines. Integrated sites reported team meetings as useful opportunities to share information within teams.	**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, the author describes how they decided which methods to use. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author describes how and why the participants were chosen, there are also discussions around why some chose not to take part. **5. Was the data collected in a way that addressed the research issue?** Yes, the author describes the methods of data collection and has justified why they were chosen. There is mention of the use of a topic guide for the interview structure, and also mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** Yes, the author has considered bias during data collection and has described the methods taken to counter interview bias.

Study details	Methods and participants	Results	Limitations
	between 30 minutes and 1.5 hours. Participants were recruited and data collected until data saturation was achieved. All people with LTNCs and carers of people with LTNCs chose face-to-face interviews. People with LTNCs and carers were given information about support organisations at the end of the interview. NRT staff took part in focus groups which were held in the NRT's office and last 1.5 hours. They were audio-recorded and transcribed verbatim. For people who did not consent to audio-recording, the responses were captured by field notes and analysed alongside the transcripts. Data analysis A thematic framework approach was taken for data analysis. Frameworks were developed using the topic guide and themes emerging from the data. Data from transcripts were mapped onto framework and the research team discussed them throughout to ensure accuracy.	The social worker in the integrated team was seen to be essential in enhancing a holistic team perspective as well as providing a link with social care. Having regular interdisciplinary work-based training within the team was felt to facilitate integrated working by promoting a holistic view of care. "It's very much presenting the whole person back [as] an individual case study, and how the individual elements affect the outcome of what we're doing and the goals that we're working towards and whether they're achieved or not achieved". (NRT9B) p.45. <u>Organisational-level (macro) influences</u> In one integrated site, organisational staff described the culturally distinct nature of health and social care as being a barrier to integration: different political agendas, different financial systems, different approaches to care, and different commissioning structures. Structures that hindered integration at the organisational level included separate finance and accountability systems. NHS restructuring mean that joint forums that has facilitated integrated working had ended. "Now those meetings have come to a grinding halt, again, because there's so much crisis at the upper levels, and key personnel are missing. So all the personnel who I said would have absolute responsibility, and there were four of them, are no longer with us, so we have got this huge hole at a strategic level at the moment". (organisational staff social care) p.44. Developing relationships was key to maintaining integrated working and was	**7. Have ethical issues been taken into consideration?** Yes, ethical approval was granted by the University of York's Humanities and Social Science Committee and the Research Ethics Committee (REC) for Wales. (The location of the REC was chosen because it reviewed a previous study to which this research was linked and does not necessarily reflect the location of case sites). **8. Was the data analysis sufficiently rigorous?** Yes, the methods of data analysis are described in detail and it is clear how themes were derived. The author mentions the discussion of themes with the research team. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the author has described the implications of the research in policy and practice. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** No or minor. **Source of funding** Not industry funded (The National Institute for Health Research, Health Services and Delivery Research programme).

Study details	Methods and participants	Results	Limitations
		facilitated by colocation and regular meetings. Senior organisational staff suggested that relationships between agencies were a greater influence on joint working than arrangements such as contracts or pooled budgets. Participants reported shared objectives and plans were facilitators to integration. Understanding the motivations, processes and structures of different organisations was noted by organisational staff as important when working with other agencies. <u>Service processes and outcomes</u> Service users described how the team would identify functional and home-based issues, but these were broadened to the wider environment and the client's personal goals. This view was common across the teams that adopted a holistic approach to service user problems. Effective co-ordination of services and joined-up working within the team was often seen as key to finding solutions to problems. An interviewee in site A described how the team had arranged a social care assessment, helped him find assistance with domestic tasks and assisted with his application for equipment.	
Full citation Bailey, D., Liyanage, L., The Role of the Mental Health Social Worker: Political Pawns in the Reconfiguration of Adult Health and Social Care, British Journal of Social Work, 42, 1113-1131, 2012 **Ref Id** 1081608	**Recruitment strategy** Participants were selected for interview using a snowball sampling and judgemental sampling. Respondents were asked early on to name team members that could contribute a different disciplinary perspective. As the fieldwork progressed and knowledge of systematic relationships expanded, specific team members were purposively selected. **Setting** Mental Health Trusts and Local Authority Social Service Departments	**Findings (including author's interpretation)** <u>Organisational dominance</u> The lack of pooled budgets was identified as a 'system' barrier to integration. "We've always had integrated staff but we've never had integrated budgets. I've got two budgets that I've got to look at so I can't just look at one budget and think oh we've overspent here, we'll pinch from out of there, I've got to look at 2, one's social care, one's health". (team manager 1) p.1121.	**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.

Study details	Methods and participants	Results	Limitations
Country/ies where the study was carried out England, UK. **Study type** Ethnographic. **Study aims** To explore the perspectives of mental health professionals and service users on the social work contribution from a multidisciplinary point. **Study dates** Not reported.	**Participant characteristics** Total participants N=24 Team manager, n=1 Community psychiatric nurse (CPN), n=5 Link worker, n=1 Mental Health Social Worker, n=7 Approved Mental Health Practitioner (AMHP), n=2 Occupational Therapist (OT), OT Assistants and Technicians, n=2 Psychologist, n=1 Advanced practitioner, n=1 Support worker, n=1 Nurse consultant, n=1 Expert practitioner (AMHP), n=1 Consultant Psychiatrist, n=1 **Data collection and analysis** Data collection Data was collected during participant observations in 4 initial meetings with senior managers in the Mental Health Trusts and Local Authority Social Service Departments, and with two managers of the four specialist teams (crisis resolution teams, assertive outreach teams, early intervention teams and affective disorder and psychosis disorder teams). The researcher collected data over 6 months, and was immersed for two to three days a week in each team, undertaking home visits, interviews or participant observations of team meetings. Semi-structured interviews took place. The interview guides were piloted with a social worker and CPN to ensure questions were clear and relevant. Data analysis Data were analysed using a grounded theory approach. Themes were generated and the	Respondents felt a lack of service integration was due to the imbalance of power between a weak local authority and a dominant mental health trust. “We feel that Social Services just don’t figure in this organization at all. Every kind of thing we get is from health. Social Services say you are the lead agency therefore you manage the model”. (AMHP) p.1120. “There’s a very weak local authority in this area. It’s not the same throughout the Trust. In this area it’s a much more uncomfortable relationship”. (community psychiatric nurse) p.1120. “That process to move over to an Affective and Psychosis model was driven very forcibly by Health”. (AMHP) p.1120. Care co-ordination was seen as key to integrated working. Respondents felt that co-ordinator staff should retain their professional specialism. “‘I think we should remain integrated, joint working, joint teams. But I think each profession should have the opportunity to show their qualities and not make everybody the same. So I think we all should be care co-ordinators, but the social workers perhaps get the opportunity to do some of the most complex family work and the nurses get the opportunity to do the complex therapy or prescribing and the OTs get the opportunity to use their skills for OT assessments”. (CPN) p.1121. “I think an integrated team is really, really good, working kind of side by side, but I don’t think we need to be doing the same job because I think we’re losing the kind of individual skills of each profession”. (OT 1) p.1121. <u>Abandonment by the LA</u> Colleagues and managers stated that mental health social workers (MHSWs) had been	**3. Was the research design appropriate to address the aims of the research?** Yes, the author describes how an ethnographic approach would explore the aims of the study. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author describes how participants were recruited. **5. Was the data collected in a way that addressed the research issue?** Can't tell, methods of data collection are clear, however no mention of the form of the data or data saturation. **6. Has the relationship between researcher and participants been adequately considered?** Yes, the researcher piloted the questions with a social worker and community psychiatric nurse which led to changes in some of the questions. **7. Have ethical issues been taken into consideration?** Yes, ethical approval was sought from ethics committees in the NHS, Local Authority Social Service Departments and a university where the researcher was employed. **8. Was the data analysis sufficiently rigorous?** Yes, there is an in depth description of the analysis process, and the author has explained that 2 researchers were involved in the data analysis process. **9. Is there a clear statement of findings?** Yes.

Study details	Methods and participants	Results	Limitations
	coding of the data was checked by both researchers to ensure reliability and validity.	abandoned by the LASSD ..evidenced by differences in sickness absence policies through to treatment as valued professionals. There were differences in pay and conditions compared to health colleagues which reinforced the devaluing of the social work contribution in the teams. "I think it's really difficult because I manage staff that work for two different organisations. Sickness, disciplinary, appraisal policies are different . . .. The MHSWs would say they feel abandoned by their home organisation. They've said that to me on frequent occasions and I think that's quite sad . . . they do talk about this feeling like they're not wanted by their own organisation because they've been left to the mercies of the Mental Health Trust". (team manager). "I think in the last 10 years social workers have been badly let down by their leaders. I think this affects the mind-set of the social workers. I think they get into this sort of poor relation, so they always feel that they don't get the support from the LA that they'd like to get . . ., in this area they get paid less than anywhere else in the Trust that tells you what LA thinks of them really". (CPN). "I think we're forgotten sort of, . . . compared to other services within the LA and . . . think it's just we'll just let Health get on and manage that and I think sometimes, that we're setback to the LA to a degree, which is a shame". (MHSW). "I don't feel like I'm part of social services anymore, it's all health orientated. We don't feel part of health. In the same time we don't really feel part of social services because we feel almost like they don't actually want us". (AMHP). "X [name of the LA] don't seem to have a clue or a care what happens to any of the social work staff . . . I would not work for that money for those holidays. I mean the SWs are the	**10. How valuable is the research?** Valuable, the researcher has discussed how the study has contributed to existing knowledge around mental health social work. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor. **Source of funding** Not reported.

Study details	Methods and participants	Results	Limitations
		worst paid in the whole region; they're on £2,000 less every grade than anywhere else and there is no support and no training". (MHSW 5). "There are issues around pay and conditions, I can be sitting here with a nurse, she gets more annual leave than me, she gets paid more than me, the career options that are available to me as a SW are less than they would be for the nurse". (AMHP 3). [Quotes: p.1124-1125] There was also evidence of structural oppression that was reflected in social workers' perceptions of their value as professionals. "Health has the lead and they say what's going to happen. It feels more dictatorial and they say 'this is what's going to happen and we're going to do this' and the nurses go along with 'yes, ok', and then our managers go 'yes, that's ok' but no one comes to us and says 'how do you feel about x, y and z'". (AMHP) p.1124. <u>Specialist teams</u> Staff felt there was a knock-on effect of the specialisation on staff workloads. (Specialisation: community mental health teams have been replaced by the specialist teams identified in the Policy Implementation Guide (PIG). These include crisis resolution teams, assertive outreach teams, early intervention teams, and separate teams for affective disorder and psychosis disorder). Some felt this was because the policy was not clear and conflicts arose because guidelines were being followed in an ad hoc way. Staff wanted training to support the clinical specialisation but this had not been forthcoming. "'I think everybody has got amazingly busier but I can't see for what	

Study details	Methods and participants	Results	Limitations
		reason, the work was covered before but it doesn't seem to be now. So I don't understand it". (MHSW) p.1122. Disciplinary contribution Participants agreed that combining the medical and social models was the best approach underpinned best practice and, in this respect, the MHSW contribution was valued. "It's important to get both. I mean yes the medication will stop the mood, but the social model in mental health that means help them to build confidence to go out and meet the people and to live lives to the full. I think it's important to work together both medical and social model". (MHSW). "I would take it back and I might say to one of the SWs 'what do you think' and they would give us their benefit because they've come from a different professional background". (team manager). "Although I would have said the team didn't work from a medical model in the first place, I think having the SWs present has moved the team further towards a more social model of care because the SWs will say 'have you thought about this, have you thought about that' so it opens it up wider so I would have said that having SWs on board has improved patient care". (OT 2). [Quotes: p.1127]	
Full citation Beresford, B., Reablement services for people at risk of needing social care: the MoRe mixed-methods evaluation, Health Services and Delivery Research, 7, 2019 **Ref Id**	**Recruitment strategy** Information relevant for work package 3. Reablement services that accepted referrals of people with dementia were contacted for interview. Service leads were approached via email and telephone. They were also asked to nominate two reablement workers in their service. Those willing to participate returned consent forms. **Setting**	**Findings (including author's interpretation)** Commissioners' and other services' understanding of reablement for people with dementia Some service leads believed that incorrect assumptions were being made as to the appropriateness of referring a person with dementia to reablement. Misperceptions were that people with dementia may not be offered	**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.

Study details	Methods and participants	Results	Limitations
1221051 **Country/ies where the study was carried out** England, UK. **Study type** General qualitative inquiry (within a mixed methods evaluation). **Study aims** To explore the barriers to the delivery of reablement and achievement of positive outcomes for groups in generic reablement services. **Study dates** January to July 2016.	Eight reablement services in England. **Participant characteristics** Information relevant for work package 3. Total participants N=24 Service leads, n=8 Reablement workers, n=16 **Data collection and analysis** Data has been extracted for work package 3 only as other packages were not qualitative research or the themes were not relevant to barriers or facilitators to integrated working. Data collection Topic guides, one for service lead interviews and one for interviews with reablement workers, were developed by the research team, informed by existing literature and findings from WP1 (WP1 not extracted). Consent was secured before the start of the interview. Interview length ranged from 60 to 75 minutes. Interviews were audio-recorded and subsequently transcribed. Data analysis Data was analysed thematically using the framework approach. Lead author led the analysis, with other team members involved during the different stages.	reablement is it should only be offered if someone can be fully reabled, and people with dementia cannot learn new things. <u>Staff training and access to dementia expertise</u> All managers highlighted the importance of dementia training, but none of the reablement workers interviewed said that they had received training specific to reabling an individual with dementia. Managers reported training available on dementia but it was not specific to delivering reablement to this population. In one service, advanced dementia training had only been made available to senior workers. "..they do have the basic video on dementia..but it's not enough for, we need specific training on reablement with dementia.. 'cos if you don't understand dementia then you're not gonna know what to do..to reable them.." p.98.	**3. Was the research design appropriate to address the aims of the research?** Yes, the author has justified the research design. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, how the participants were recruited is described. **5. Was the data collected in a way that addressed the research issue?** Yes, it is clear how the data was collected. The author described the use of a topic guide and the form of the data but has not mentioned data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the researcher has not critically examined their own role during formulation of questions or data collection. **7. Have ethical issues been taken into consideration?** Yes, ethics approval was obtained from the North East York Research Ethics Committee. **8. Was the data analysis sufficiently rigorous?** Yes, there is an in-depth description of the analysis and it is clear how the themes were derived. The author has described other researchers' involvement in the data analysis process. **9. Is there a clear statement of findings?** Yes.

Study details	Methods and participants	Results	Limitations
			10. How valuable is the research? Valuable, the researcher describes the value of the results for practice. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor. **Source of funding** Not industry funded (National Institute for Health Research)
Full citation Bower, P., Improving care for older people with long-term conditions and social care needs in Salford: the CLASSIC mixed-methods study, including RCT, Health Services and Delivery Research, 6, 2018 **Ref Id** 1221201 **Country/ies where the study was carried out** England, UK. **Study type** General qualitative inquiry. **Study aims** To understand how stakeholders such as commissioners and local authorities view the Salford Integrated Care	**Recruitment strategy** Not reported. **Setting** Salford, north-west England. **Participant characteristics** Total participants interviewed N=59 Foundation trust staff (all senior managers or programme managers), n=6 CCG staff (GPs and senior managers), n=6 Council staff (including senior management, management and public health), n=6 GP provider organisation, n=1 Mental health trust staff (all senior managers), n=3 Multidisciplinary group staff, n=27 Non-multidisciplinary group staff, n=5 Participants/carers, n=5 Data from the Integrated Care Centre was not extracted as the population under the care of this centre was not adults with complex needs. **Data collection and analysis**	**Findings (including author's interpretation)** <u>Alliance agreement</u> Respondents stated that the process of developing the Alliance Agreement (non-legal document that outlined how the organisations would work together as a system of commissioners and providers) had been as important in supporting the early development of the programme. Knowing that there was a formal process, allowed the key organisations to feel secure in decision-making. The process of development allowed the organisations time and resources to think about what they wanted to achieve, outlining risks and benefits for the organisations. They stated that stakeholder organisations were more likely to work through issues when disagreements arose. "But the benefit of the Alliance Agreement was primarily the process we went through to agree it. It was refining a shared vision. It was having the difficult conversations about, you know, what are our anxieties, what do we want to achieve. It codified the things we were setting out to do and our expectations of each other". (ID 4 senior foundation trust manager). "So it's a big deal, you know, you sort of owe the other stakeholders once you've agreed	**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, the author has justified the methods they have chosen. **4. Was the Recruitment strategy appropriate to the aims of the research?** No, the author has not reported how the participants were selected for interview. **5. Was the data collected in a way that addressed the research issue?** Can't tell, the author has mentioned data collection but not in sufficient detail. There is not enough detail of the form of the data or how the questions were formulated.

Study details	Methods and participants	Results	Limitations
Programme and what they expect from it. **Study dates** November 2014 to September 2016.	Data collection Transcripts from the interviews were coded and organised into themes. Data analysis Thematic analysis using a grounded theory approach was taken. Members of the team met monthly to discuss emerging themes and to agree the final stage of coding.	this. Because people will walk away without any of that control, they always have, and will do. So hence there has to be an overbearing focus on governance, it dominates everything". (ID 3 senior CCG manager) p.56. <u>Enablers of integrated care and the SICP</u> Salford already has the Salford Integrated Record, so sharing information was perceived to be a strength of the local working practices.	**6. Has the relationship between researcher and participants been adequately considered?** No, the author has not critically examined potential for bias or influence during data collection. **7. Have ethical issues been taken into consideration?** Yes, ethics approval was obtained from the National Research Ethics Service North West Lancaster. **8. Was the data analysis sufficiently rigorous?** Yes, the author has provided an in-depth description of the data analysis. It is clear how the themes were derived. The author has explained that the team met monthly to discuss the themes emerging and to agree on the analysis. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the author has examined the role of the findings to existing literature. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate. **Source of funding** Not industry funded (National Institute for Health Research).
Full citation Cornes, M., Joly, L., Manthorpe, J., O'Halloran,	**Recruitment strategy** Fieldwork sites were selected purposefully based on applications made to Homeless	**Findings (including author's interpretation)** <u>Collaboration on the ground</u>	**Limitations (assessed using the CASP checklist for qualitative studies). Answer**

Study details	Methods and participants	Results	Limitations
S., Smyth, R., Working Together to Address Multiple Exclusion Homelessness, Social Policy and Society, 10, 513-522, 2011 **Ref Id** 1301934 **Country/ies where the study was carried out** UK, England. **Study type** Exploratory, general qualitative inquiry. **Study aims** To explore how policy frameworks work to support people with experience of multiple exclusion homelessness, and explore the boundaries between services and different professionals. **Study dates** July 2009 - June 2011.	Link. Participants from the selected fieldwork sites were interviewed. **Setting** Three different **Setting**s were used: a housing support and homeless prevention service for offenders; a rent deposit scheme; a non-direct access hostel. **Participant characteristics** Total participants N=77 Key workers, and experts by experience (people with first-hand experience of multiple exclusion homelessness), n=32 Social workers, mental health professional, drug and alcohol workers local authority housing staff and criminal justice staff, n=15 Service managers and commissioners, n=15 Focus groups Social workers, mental health professional, drug and alcohol workers local authority housing staff and criminal justice staff, n=15 **Data collection and analysis** Data collection Data were collected by reflective interviews of key workers and experts by experience. A case study vignette was also used for further interviews and focus groups. Data analysis An exploratory approach was taken for data analysis. The host projects met regularly to discuss the findings and how they can be developed for practice.	Housing support workers and their managers found it extremely difficult to draw on the support of social workers and their employing authority. In one case where a person had a learning disability and social workers were involved, this did not lead to integrated care planning in that there was no overview plan bringing together the different aspects of support. The housing support worker reported poor information sharing and described feeling forgotten when review meetings were being arranged.	**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, the author describes how an exploratory approach will help to address the research aims. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author has explained how participants were recruited. **5. Was the data collected in a way that addressed the research issue?** Yes, the author has described the data collection method and explained that a case study vignette was used to guide the discussions, but there is no mention of the form of the data. **6. Has the relationship between researcher and participants been adequately considered?** No, the author has not critically examined their role and potential bias during data collection. **7. Have ethical issues been taken into consideration?** Can't tell, the author has not sought ethical approval, nor explained how participants gave consent nor how the research was explained to participants.

Study details	Methods and participants	Results	Limitations
			8. Was the data analysis sufficiently rigorous? Can't tell, the author has described the methods of data analysis, but has not provided detail as to how bias would be addressed. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the researcher has considered how the research can be used in practice. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate. **Source of funding** Not industry funded (Economic and Social Research Council funded).
Full citation Farrington, C., Clare, I. C. H., Holland, A. J., Barrett, M., Oborn, E., Knowledge exchange and integrated services: experiences from an integrated community intellectual (learning) disability service for adults, Journal of intellectual disability research: 59, 238-47, 2015 **Ref Id** 1077206 **Country/ies where the study was carried out**	**Recruitment strategy** Purposive sampling was used to recruit participants. The lead author visited each team to explain the purpose of the study and to distribute study information sheets. Members from each staff group were randomly selected and received emails inviting them to participate. **Setting** An English county. **Participant characteristics** Total participants interviewed N=24 Nurse, n=5 Therapist, n=4 Psychologist, n=3 Psychiatrist, n=1 Admin. Support, n=4	**Findings (including author's interpretation)** <u>Formal and informal knowledge exchange solutions</u> Emails and phone calls were see as useful but second-best compared with face-to-face communication. There were potentially negative aspects raised regarding a predominantly informal knowledge exchange culture, principally relating to issues of arbitrariness and sustainability. Informal knowledge exchange was seen as not fulfilling that members of the team reach all the knowledge. One healthcare practitioner mentioned the potential for information to get lost. In regards to sustainability, there was a concern that this method relies of the tacit knowledge of individual team members, the temporary absence or permanent departure of	**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, the author has explained that using the perspectives of team members would help answer the research question.

Study details	Methods and participants	Results	Limitations
England, UK. **Study type** General qualitative inquiry. **Study aims** To explore knowledge exchange in the intellectual disability partnership, and how it relates to the attempt to provide an integrated service. **Study dates** Not reported.	Care manager, n=4 Manager (team and service), n=3 **Data collection and analysis** Data collection The lead author conducted interviews that lasted between 30-80 minutes. They interviews were audio recorded and transcribed. Data analysis Data was analysed using thematic analysis. Academic colleagues with a range of healthcare and care management roles were consulted with for the final analysis.	these team members represents a loss of 'team knowledge'. "I feel that if [the person who works next to me is] not there and maybe I miss the next meeting or whatever, somehow the information seems to get lost". (HP1). "[s]ometimes there is information out there, which is not necessarily . . . made accessible to everybody who needs to know . . . [T]here is information with different people, [so] it's very ad hoc as to who passes on . . . what to whom". (HP2). "The Urban team only functions from a positive perspective because of the personalities in it . . . you've only got to get somebody leave and somebody else come in . . . are they going to affect the culture? I do wonder sometimes whether there is sufficient attention paid to that". (care manager). "The benefit of people being together for twenty years . . . is actually they've come up with a lot of informal kind of relationships . . . that kind of cover the way things need covering. So I've come in to formalise them, because . . . well, if [they] all do move on, I want people to [work together] not for favours but because it's the culture of the place and it's part of our policy". (urban team manager) p.244 to 245. Team meetings with different staff groups were considered to be opportunities for knowledge exchange. Informal mechanisms of exchange, such as telephone calls, personal emails, conversations, impromptu meetings were seen as supplementing team meetings. "[W]e do formally meet and have kind of multidisciplinary discussions about [service users] . . . I think it's really important for the team to have a view of what someone's problem is and how to help them . . . in a formal kind of way, get it in black and white". (HP). "[B]ecause there seems to be a lack of formal	**4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author has described the Recruitment strategy. **5. Was the data collected in a way that addressed the research issue?** Yes, the author has explained methods of data collection but there is no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the researcher has not considered their relationship to the participants during the formulation of the questions or during data collection. **7. Have ethical issues been taken into consideration?** Yes, an opinion regarding ethical status was sought from the appropriate National Research Ethics Service (NRES) committee, which confirmed the study did not require formal ethical approval. **8. Was the data analysis sufficiently rigorous?** Yes, methods of data analysis are clear and the author sought the opinions of colleagues to validate the final analysis. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, although the study is limited in that there are no service user perspectives, the

Study details	Methods and participants	Results	Limitations
		information sharing . . . we go around in person [instead] . . . I mean, our systems, being what they are, it's very frustrating". (care manager). "I think people are always open to somebody just walking over and saying can I have a quick word with you about this". (HP) p.244. <u>Formal barriers to explicit knowledge exchange</u> Participants were concerned over the accessibility of care records which was compromised by different recording systems between healthcare and care management...leading to issues around confidentiality. The combination of a mix of paper and electronic records and the lack of a single shared IT system has led to significant formal barriers to explicit knowledge exchange. Office arrangements also create barriers; as the Rural team is based in a county council rather than NHS building, healthcare staff in the Rural team cannot access NHS electronic resources (including NHS email, e-learning modules and updates). "Health files, the information is still on paper files, we've got . . . [an] electronic database with recording for [care management] . . . and ne'er the twain shall meet". (service manager for rural team). "I think it's really hard because I think the systems don't help us . . . the fact that you have to anonymise all your emails and stuff . . . [It] can sometimes be confusing, particularly if you've got [service users] in the same team with the same initials". (HP) p.242 to 243.	author has suggested practical ways in which the research can be used. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor. **Source of funding** Not industry funded (funded by National Institute for Health Research [NIHR]).
Full citation Joseph, S., Inter-agency adult support and protection practice: a realistic evaluation with police, health and social	**Recruitment strategy** Participants were invited to participate in the focus groups via the different Adult Support and Protection committees, the Health Boards, and Police Command Areas across Scotland. Representative number of	**Findings (including author's interpretation)** <u>Information sharing</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?**

Study details	Methods and participants	Results	Limitations
care professionals, J Integr Care, 27, 50-63, 2019 **Ref Id** 1288672 **Country/ies where the study was carried out** Scotland, UK. **Study type** General qualitative inquiry. **Study aims** To explore the inter-agency collaboration between the police and health and social care professionals in Scotland, in relation to Adult Support and Protection. **Study dates** Not reported.	professionals from each of the disciplines involved in Adult Support and Protection were invited. **Setting** 14 police divisions across Scotland **Participant characteristics** Total participants N=101 Police n=52 Health n=18 Social care n=31 **Data collection and analysis** Data collection 13 focus groups were conducted and facilitated by different team members. Focus groups used a case study developed from anonymised real cases to guide discussions. They were audio recorded and transcribed verbatim. Data analysis Framework analysis was used to create themes.	Participants identified challenges with information sharing across the different professional that was exacerbated by the need to protect confidentiality. Police and social work reported frustration at healthcare professionals' reluctance to share information. Respondent PO3FG1 (Police): "[…] there is a well-established format within the police to pass on information to our partner agencies […] but it doesn't always flow back to us in a way that we would want it […]" p.55 People and processes When protocols and processes were 'unfit for purpose' this was a demotivating factor for collaborative working... the 3 point test for identifying vulnerable adults in Scotland was criticised...perceived police over-reporting of persons who may not "fit" the test resulted in some social workers reporting less scrutiny of police reports. Conversely, when more than one agency was involved in a case there was a perceived reliance on the police to submit the report, when all agencies should have submitted their own concerns. SW4FG2 (social work): "We actually had one (case) recently and it was someone that didn't meet the 3 point test, but round the table the consultant Psychiatrists and people are saying 'he's a likely candidate to kill himself' and the Police are going 'well do something about it' what? Do you know and it's that bit they don't (do) because they're so risk averse […]" p.55. Referrals There were professional differences in terms of the number and value of referrals. Police described consistent referral practices which referred the most vulnerable to social	Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes, the author describes why the study design is appropriate to explore the research aims. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author has described how the participants were recruited. **5. Was the data collected in a way that addressed the research issue?** Yes, the author has described data collection methods, and has described how the case study used in the focus groups facilitated discussion. However there is no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, there is no mention of the author critically examining their potential bias or influence during the focus groups. **7. Have ethical issues been taken into consideration?** Yes, ethical approval was granted by the Ethics Committee at Robert Gordon University. **8. Was the data analysis sufficiently rigorous?** Can't tell, the author described the analysis but not in-depth. There is no mention of how the

<table>
<tr><th>Study details</th><th>Methods and participants</th><th>Results</th><th>Limitations</th></tr>
<tr><td></td><td></td><td>services. Social care workers described practices that prioritised police referrals into those that were high priority only as they did not feel they had the resource capacity to manage them all. Health described low referrals to police or social services. The difference in professional practices might lead to potential risks to adults in need of support and protection.

<u>Relationships</u>

Team work and information sharing were improved when organisations were co-located and/or informal relationships established. This resulted in greater collaborative working and the development of trust for information sharing.

“PO1FG1 (Police): “when we had a social care worker dedicated in our office […] it worked really well, we were finding out all the information we had on the family” p.55

<u>Education and training</u>
Themes from responses to a case study: Social workers recommended joint investigation training. Police officers felt they may not know the criteria; agreed police should be trained in Adult Support and Protection with other professionals</td><td>researchers addressed potential bias during the analysis.

9. Is there a clear statement of findings?
Yes.

10. How valuable is the research?
Valuable, the author has used the findings to make recommendations for the future practice, as well as future research in the field.

Overall methodological limitations (No or minor/Minor/Moderate/Serious)
Moderate.

Source of funding
Not industry funded (by the Scottish Institute for Policing Research).</td></tr>
<tr><td>Full citation
Krayer, A.., Robinson, C. A., Poole, R., Exploration of joint working practices on anti-social behaviour between criminal justice, mental health and social care agencies: a qualitative study, Health and Social Care in the Community, 26, e431-e441, 2018</td><td>Recruitment strategy
Participants were recruited sing purposive sampling. Organisation were recruited with input from the Project Reference Group. Participants were approached by chief executives/directors who passed on the study information provided by the research team.

Setting</td><td>Findings (including author’s interpretation)

<u>Willingness to work towards shared goals and outcomes</u>

Reluctance to develop joint working was set in the context of a tightening of criteria as a way of coping with limited resources. Lack of funding can lead to organisations looking to focus on their specific service tasks rather than the needs of individuals.</td><td>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.</td></tr>
</table>

Study details	Methods and participants	Results	Limitations
Ref Id 1225508 **Country/ies where the study was carried out** Wales, UK. **Study type** General qualitative inquiry. **Study aims** To explore the relationships, perceptions and barriers and facilitators of joint working between mental health services, social care services, third sector organisation and police forces in regards to anti-social behaviour, vulnerable adults and adults with mental health problems. **Study dates** April 2014 to August 2016.	Two sites, an urban area with low level anti-social behaviour, and a rural area with high level anti-social behaviour. **Participant characteristics** Total participants N=55 (n=39 face-to-face interviews, n=16 participants in focus groups) Manager/senior staff, n=4 Community Mental Health Team (includes 2 mental health social workers), n=14 Police and probation Manager/senior staff, n=3 Officers, n=15 Local authorities Manager/senior staff, n=4 Practitioners, n=1 Third sector organisations Manager/senior staff, n=7 Case worker, n=7 **Data collection and analysis** Data collection Interviews and focus groups lasted on average 80 minutes and used a topic guide. They were audio recorded and transcribed, apart from 1 interview and 1 focus group where detailed notes were taken. Labels were assigned to quotes to avoid identifying participants. Data analysis Transcribed data were coded and a thematic approach was taken to create themes. The analysis and interpretation of the data was discussed within the researcher team, a group of service users and carers and the Project Reference Group	"You know, there's sixteen thousand less officers in the country than there were 4 years ago, so we are saying "no that's your [mental health team] role, you do that". (ASB_I.35, Police). "They [Health Board] tend to stick religiously to the way that they've got to function […] it's so, "no we can't touch that, it doesn't tick the box". Well, they're individuals and it's not going to be a tick box exercise. It's not like going shopping. So there just needs to be that flexibility". (ASB_I.27 Local, Authority) p.438. Participants suggested that some people focused on their organisational goals and criteria to the detriment of the person with mental health problems. This can lead to serious inter-organisational tension. A number of issues were suggested: the right of the individual versus the community; managing risk versus promoting recovery; and planning management of the person in the community to prevent crisis and relapse versus ad hoc crisis intervention. "You know, we're struggling for appointments for people who are—are low and medium risk, so I—I get there has to be some kind of cut off, but it's just a shame sometimes when you can see the way things are going and you know as soon as that person triggers a high risk, they get everything they need. Well, you know, wouldn't it be nice if we could give them that a few months before and save everyone going through the pain". (ASB_I.9, Police) p.438. <u>Understanding of each other's' roles and responsibilities</u> Understanding of each other's' roles and responsibilities was essential for joint working, but often missing. A lack of understanding can	**3. Was the research design appropriate to address the aims of the research?** Yes, the author describes how the study design will help to explore the relationships and perceptions of joint working. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author has described how participants were recruited. **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?** Can't tell, the author has described the use of a topic guide during data collection but has no critically examined their role in potential bias. **7. Have ethical issues been taken into consideration?** Yes, ethical approval from the Wales Research Ethics Committee was received. **8. Was the data analysis sufficiently rigorous?** Yes, there is an in-depth description of the analysis. It is clear how the themes emerged, and the analysis was discussed within the team as well as with service users and a project reference group. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?**

Study details	Methods and participants	Results	Limitations
		lead to inter-organisational conflict. There were inconsistencies across professional regarding the role of the police in mental health; some feeling they should purely deal with criminal matters and others that they should fulfil safeguarding duties. “I think it could be useful for the police, and—and for us as well to really understand what each, team does, because I think that is still limited”. (ASB_I.13, Mental Health). “And it’s really hard, I think sometimes, because we sometimes get some very angry people [police] on the phone saying “Well, we can’t do that, you’re asking us to do something that would be a breach of duty for us. You know, I don’t care if they’ve [patient] signed a care plan, it’s not our care plan and we don’t know what to do.” And you are stuck in a really challenging situation then”. (ASB_I.22, Mental Health). “I suppose ours is a safeguarding role as well isn’t it?” (ASB_I.21 Police) p.438. <u>Being aware of and valuing other professionals' contributions</u> Some of the participants did not view others as important partners, and there was a lack of enthusiasm for creating working relationships to support joint working practices with shared goals. This was often accompanied by stereotype and negative perceptions. Some mental health professionals felt the police did not understand recovery, and police officers were perceived to interpret signs of distress as mental health problems and call for assessments unnecessarily. Reluctance to engage in joint working was associated with a	Valuable, the author discusses the contribution of the study to existing knowledge and presents ideas for future research. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor. **Source of funding** Not industry funded (National Institute for Social Care and Health Research, Welsh Government).

Study details	Methods and participants	Results	Limitations
		strict role adherence and a concern to protect organisational boundaries. “I could probably speak for most police officers in that our, practical, um, experience of social services is really, really poor. […] We quite often get what we call hit and runs, so on a Friday at half four they’ll phone up reporting a problem […]”. (ASB_I.9, Police). “Sometimes as well is that they tell individuals, you need a service from the mental health team, and you know they wouldn’t reach our criteria for a service”. (ASB_I.37, Mental Health Social Worker). “We’ve had what we perceive as a mission creep into areas that should be the health service”. (ASB_I.36 Police) p.438. <u>The continuum of joint working</u> Professionals had developed a shared recognition that complex needs demanded input from a range of organisations. Relationships had developed over time with awareness of roles and responsibilities and the development of trust. <u>The relationship between anti-social behaviour and mental health</u> There was considerable variation in professionals' perceptions about the nature of anti-social behaviour and the roles and responsibilities in responding to it. Variation in interpretation can be a major barrier to joint working. “I guess it [anti-social behaviour] would be a broad spectrum, it would be behaviour that was to be deemed unacceptable within a set of norms and that would change depending on where you lived”. (ASB_I.6, Mental Health). “A lot of our clients do behave in a way that is different to the norm, we wouldn’t class that as antisocial behaviour, we would probably be	

Study details	Methods and participants	Results	Limitations
		inclined to think to ourselves, "Oh, that's probably symptomatic of their mental illness". (ASB_I.15, Third Sector Organisation). What drives joint working The main drivers for joint working were legal requirements to protect the most vulnerable and at risk. Feedback from staff, and in particular senior and management, indicated that organisations find it hard to neglect their responsibilities as expectations of roles and processes are clearly documented in policy and guidance. These frameworks facilitate joint working. "MAPPA [Multi-Agency Public Protection Arrangements, statutory arrangement for managing sexual and violent offenders] has made that a lot easier […] the police will let us know if she's rung up with any self-harm, so that we can update our risk assessments and our management plans, etc., […] that's worked really well. And again that's—having a really good relationship with the police and […] where there's big risks, and that's worked really well." (ASB_I.14, Mental Health) p.437	
Full citation Levin, K. A.., Implementing a step down intermediate care service, J Integr Care, 27, 276-284, 2019 **Ref Id** 1225770 **Country/ies where the study was carried out** Scotland, UK.	**Recruitment strategy** Staff were selected for interview from each of the agencies involved in Intermediate Care. Intermediate Care is a time limited placement in a care home, for assessment and rehabilitation following discharge from hospital. It involves health and social care services, with social care services leading. **Setting** Glasgow City. **Participant characteristics** Total participants N=25	**Findings (including author's interpretation)** Wider context and replicability IC was seen to increase the workload of social services and many primary care staff. An integrated workforce working towards a common goal Having the technological systems in place to allow sharing of information between social work, acute and GPs and rehabilitation staff was considered critical to joint working.	**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?**

Study details	Methods and participants	Results	Limitations
Study type General qualitative inquiry. **Study aims** To explore the implementation of the Intermediate Care service from the perspective of staff, to understand what worked well and what could be improved. **Study dates** May to October 2016.	Participants interviewed n=9: Social work's head of transformational change Liaison nurse Service manager for older people in primary care Rehabilitation manager Speech and language therapist Service manager for older people and physical disability Consultant physician in medicine for the elderly GP working in two Intermediate Care units Discharge team lead for acute hospitals Participants from focus groups: Social work staff - social workers and social care workers, n=6 Rehabilitation staff – physiotherapists and occupational therapists, n=4 Care home staff, n=6 **Data collection and analysis** Data collection Semi-structured interviews and focus groups took place. They were digitally recorded and transcribed verbatim. Researchers made notes of non-verbal observations. Data analysis Data were analysed using a thematic framework approach. Data were coded and then organised into themes. Overarching themes from the interviews and focus groups were indented and these were brought together in a meta-synthesis.	Bringing frontline staff together and sharing best practice and novel methods was found to be beneficial. Training care home staff in a reablement approach encouraged a move away from long-term care methods, and ongoing education of acute staff, GPs and social workers were important due to staff turnover. Having a joint accountability framework were considered to be critical to joint working and having governance in place describing joint aims and accountability were raised as beneficial in overcoming challenges. "If you can do it and you can move to the next step of their journey, do it, then you work out why somebody else hadn't done it later on. And people were shying away from that at first because they'd worked in very clear silos, "oh no they pay for that and I'm not doing that. I've sent it back for them to order." (Participant TL1NS) p.279.	Yes, the author explained how the study design would allow for staff views to be explored. **4. Was the Recruitment strategy appropriate to the aims of the research?** Can't tell, there is information provided on the recruitment but not enough detail and no explanation of how the participants were selected. **5. Was the data collected in a way that addressed the research issue?** Yes, data collection methods are clear but there is no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, there is no explanation of whether the researcher examined their role during the formulation of the questions of collection methods, in regards to potential bias or influence. **7. Have ethical issues been taken into consideration?** No, there is no mention of ethical approval being sought, nor consent gained from participants. No explanation of why ethical approval was not needed. The author has not described how they explained the research to participants. **8. Was the data analysis sufficiently rigorous?** Can't tell, the methods of data analysis are detailed, but the author has not explained how potential bias or influence was addressed during the analysis. **9. Is there a clear statement of findings?**

Study details	Methods and participants	Results	Limitations
			Yes. **10. How valuable is the research?** Valuable, the author has considered the contribution the study makes to existing literature, and has considered the findings in relation to policy and practice. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate. **Source of funding** Not reported.
Full citation Mangan, C., Miller, R., Cooper, J., Time for some home truths: exploring the relationship between GPs and social workers, Journal of Integrated Care, 22, 51-61, 2014 **Ref Id** 1221497 **Country/ies where the study was carried out** England, UK. **Study type** General qualitative inquiry. **Study aims** To explore the relationship between general practitioners and social workers, and how	**Recruitment strategy** 6 sites in England were recruited, interviews were conducted with the key stakeholders from the sites. **Setting** 6 sites in England: Barnsley, London Borough of Croydon, Hertfordshire, Redcar and Cleveland, Wiltshire and Wolverhampton. **Participant characteristics** Total participants interviewed N=12 Local authority social care roles, n=6 CCG roles, n=3 Public health role, n=2 Joint health/social care role, n=1 **Data collection and analysis** Data collection Evaluation team conducted semi-structured interviews.	**Findings (including author's interpretation)** <u>GP perspectives on current joint working with social workers</u> GPs did not know about the preventative services that exist to support older people to live independently in their own homes. Where GPs were aware of the services social services offered, they had a lack of understanding or wrong assumptions about them. Some respondents reported that GPs were referring people to social care for inappropriate services. It was suggested this lack of knowledge regarding referrals and assessments was exacerbated by a lack of feedback to GPs. "GPs know very little about social care and probably feel they don't need to know much about social care." (social Care). "... it's really more about a perception of gaps more than service gaps so, in other words, GPs are not necessarily aware of all the opportunities, all the services that are out there to keep people independent in their own homes". (CCG). "Probably one of the things which struck me	**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, the author described that the interviews would help explore perceptions of working between GPs and social care. **4. Was the Recruitment strategy appropriate to the aims of the research?** Can't tell, there is some information regarding who was selected for interview (key stakeholders), but no explanation on why the 6 sites were chosen.

Study details	Methods and participants	Results	Limitations
general practitioners work with social care services. **Study dates** Not reported.	Data analysis Not reported.	was [..] how many GPs didn't know what Social Care could do in terms of looking after the patients and you know that's something I think I from Public Health assumed." (Public Health). ".. our re-ablement service, which is one of our key services to keep people out of residential care, GPs either aren't comfortable about what that's to do with or they've even been misinformed to think that it's oversubscribed and therefore there's no point applying to it because they won't be able to get the service." (social Care). "GPs also thought they could manage social care better than the local authority, and they referred for residential care rather than assessment so we need to change our information to them so that they understand the process." (joint post). "...they tend to send inappropriate referrals about .. things like housing and potholes and drop kerbs and they send all that to social care". (social care). "GPs reported that they make referrals to social services and then we don't inform them of the outcome." (joint post). [Quotes p.55-56].	**5. Was the data collected in a way that addressed the research issue?** Can't tell, the researcher has mentioned that semi-structured interviews took place but insufficient detail on form of data collection or data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, there is no mention of consideration of the relationship between researcher and participants. **7. Have ethical issues been taken into consideration?** No, insufficient details of whether the research was explained to participants, informed consent or confidentiality. No information if approval was sought from ethics committee, or why the study might not require ethical approval. **8. Was the data analysis sufficiently rigorous?** Can't tell, there is no information regarding data analysis. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the author has described how the findings will lead to actions. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Serious. **Source of funding**

Study details	Methods and participants	Results	Limitations
			Not reported.
Full citation Mitchell, C., Tazzyman, A., Howard, S. J., Hodgson, D., More that unites us than divides us? A qualitative study of integration of community health and social care services, BMC family practice, 21, 96, 2020 **Ref Id** 1289135 **Country/ies where the study was carried out** UK, England. **Study type** General qualitative inquiry. **Study aims** To explore the barriers and obstacles to integration between community NHS and council services. **Study dates** April 2018 to November 2018.	**Recruitment strategy** Purposive sampling was carried out to recruit participants from community health and social care. Snowball sampling was then used to recruit further participants from the initial interviews. **Setting** NHS community health, and a local authority. **Participant characteristics** Total participants N=24 Strategic level staff – social workers, n=3 Strategic level staff – nursing background, n=3 Social workers, n=9 Health professionals with nursing background, n=9 **Data collection and analysis** Data collection 1 or 2 researchers undertook in person semi-structured interviews lasting approx. 1 hour. Interviews were audio-recorded then transcribed verbatim and anonymised. Field notes were taken during interviews. Data analysis Thematic approach taken for data analysis by 3 of the researchers. Coding framework was created using information from a previous literature review. Transcripts were coded using an iterative process by 2 researchers, and the framework agreed by the whole team.	**Findings (including author's interpretation)** <u>Organisational level integration</u> There were concerns regarding bringing together two organisations, in particular over human resources policies when health and social care professionals have difference grading, pay and responsibilities. Staff were concerned that working together where there was not a parity of grading and responsibilities for example could lead to hostility between team members. "That kind of reflects the situation really, that there are kind of big gaps and uncertainties, and also, probably, a lack of cascading messages down and a lack of kind of information that's...you know, we know the headline that we're leaving and things are happening, but I think a lot of the detail is lost and not fed down always." (operational social care, area 2, social care b) p.5. There were also concerns around data protection and what information could be shared and who it can be shared with, which related to a perceived lack of trust between services.…This lack of coherence about who could access what information was understood to be a potential risk to individuals and a safeguarding issue. "Like I rung the hospital yesterday and asked for a copy of somebody's capacity assessment and the discharge facilitator said to me, she was like, oh, I don't know if I can send you that because of confidentiality. I was like I can't make the decisions that I need to make ..." (operational social care, area 2, interviewee c) p.6. Every interviewee raised inadequate information systems as an issue, specifically the use of different IT systems for human	**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, the author explained that the interview schedule was designed to explore the aim of the study. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author describes how the participants were recruited. **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, there is no mention of the relationship between researcher and participants in the formulation of questions or data collection. **7. Have ethical issues been taken into consideration?**

Study details	Methods and participants	Results	Limitations
		resource and clinical work across professions and organisations. Staff were restricted in what clinical data they had access to, leading to barriers to streamlined working. The lack of a joined up IT system was reported to have a negative impact on data sharing. The majority reported that co-location was a necessary aspect of integration. Many felt co-location would be a way of facilitating integration and fostering trust, relationships and shared working. A possible benefit may also be around greater confidence in data sharing. "…co-locating, sharing the same building together, and in order for me to have district nurses information, or in order for me to have information from the GP if I am in the same place as them, and they know that…yes, this is way forward, part of integration, I think, that would make it very easy." (operational social care, area 3, interviewee c) p.6 <u>Professional workforce integration</u> Social care felt overshadowed by the bigger health sector. Both health and social care staff working in the community felt neglected compared to acute services. Acute care was considered to lack an understanding of what community care entailed. Community staff reported concerns over individuals being discharged without sufficient attention to the handover of care leading to significant issues for community staff to pick up the pieces. ... There was a perception from social care staff that they were dominated by the much bigger NHS. "It's a massive barrier. It really is a big barrier and it's a shame. Because if we all came together, the hospital and us, it'd just make things so much easier, and that ride will	Yes, the study was approved by the Health Research Authority, and participants gave signed consent. **8. Was the data analysis sufficiently rigorous?** Yes, the author describes the process of thematic analysis which involved multiple researchers. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the research provides the views of practitioners, although there are limitations that it is representative of one local area and there are no views from service users. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor. **Source of funding** Not industry funded (funded by National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care Greater Manchester).

Study details	Methods and participants	Results	Limitations
		be so much more bearable.” (operational health, area 2, interviewee C) p.7. Health and social care staff were concerned about being managed by people from different professional backgrounds, and who may not be familiar with their professional codes of practice. Social care staff felt there were fundamental differences to health staff, related to their understanding and implementation of the mental capacity act, and decisions regarding risk. These difference were considered barriers to shared responsibility and trust. Health professionals reported a great responsibility toward those who come under their care, due to their professional standards, and it made them feel as though both social care and acute health services might offload responsibility for certain tasks. “We do have very different kind of ideologies, and really my experience is that the health professionals do tend to be [more] risk-averse.” (operational social care, area 2, interviewee b). “So then, what usually happens, is the district nurses pick it up, because they think, well somebody’s got to do it, and we have a duty of care, and nurses feel, as part of their professional registration, that they have a duty of care….” (operational health, area 3, interviewee a). “Well I think the first thing is that we have statutory responsibilities. So, I think it's a big learning curve for our health colleagues to understand the importance of that, that we are guided by legal requirements, we're not just doing it because somebody thought it was a good idea that somebody should have a care package.” (operational social care, area 2, interviewee a) p.7. Both health and social care interviewees reported that they believed the other	

Study details	Methods and participants	Results	Limitations
		professional group did not fully understand their professional responsibilities, duties and governance. This was highlighted by the ongoing confusion reported by several interviewees around terminology of what to call people using services. This basic terminology issue could act as a barrier to communication. "…it feels like it's so hospital-centric, the whole system, you're either in hospital or out of hospital services. People have short episodes of their lives hopefully in hospitals, then they live in their own homes, in neighbourhoods." (strategic social care, interviewee 2) p.6 Vision and leadership Staff felt that co-location would enable quick and easy discussion regarding what other services could provide. ..interviewees described the potential benefits of joint working, closer collaboration and a deeper understanding of each other's roles..they reported that an understanding of each other's roles from joint working and integration would support seamless care. "…and I would've actually said, I haven't got a clue. I haven't got a clue. I don't deal with that. But now because I've worked with a...and I've been out and I've assessed a patient with a social worker I can say to them, you know, there's different levels of care…... So I can discuss it." (operational health area 2, interviewee health b) p.4	
Full citation Naqvi, D., The general practice perspective on barriers to integration between primary and social care: a London,	**Recruitment strategy** Purposive sampling was used to identify relevant professionals for recruitment. GP surgeries were approached by phone and invited to take part. Information sheets were emailed.	**Findings (including author's interpretation)** Accessing social services - logistical issues Communication between primary care and social care is logistically challenging as	**1. Was there a clear statement of the aims of the research?** Yes. **2. Is a qualitative methodology appropriate?**

Study details	Methods and participants	Results	Limitations
United Kingdom-based qualitative interview study, BMJ Open, 9, 2019 **Ref Id** 1226668 **Country/ies where the study was carried out** England, UK. **Study type** Phenomenological. **Study aims** To explore the perspectives of primary care staff on the barriers faced when working with social care. **Study dates** Not reported.	**Setting** General practices affiliated with Imperial College London. These include a range of practices in many boroughs in London. **Participant characteristics** Total participants N=25 General practitioners, n=18 Practice Managers n=7 **Data collection and analysis** Data collection Semi-structured interviews were held by 2 researchers which lasted between 26 and 52 minutes. Interviews were audio recorded and then transcribed verbatim. Participants chose between face-to-face or over the phone interviews. Face-to-face interviews took place the participants GP surgery in a quiet room without other staff present. Data saturation was reported by the interviewers after 16 interviews with GPs and 6 interviews with PMs. Further recruitment of participants was concluded after this point. Data analysis A thematic framework approach was used for data analysis. Codes were generated by 3 researchers separate to those involved in data collection, and grouped into themes. Two separate researchers reviewed the themes. Overarching findings were discussed with all of the research team. The findings were checked with the participants via a presentation of results. Feedback was allowed to improve validity and accuracy.	doctors are busy with people using services during the day and social care staff are working in the community, making joint conversations about people using services nearly impossible. Participants explained how inefficiency with communication delays care interventions; there is often no standardised method for contacting the other sector and staff may wait weeks for replies to requests. “If you want to speak to social workers urgently, there are barriers because you don’t necessarily have a telephone contact or a hotline or an email address to contact someone from social care.” (GP10). “Sometimes you fax over important things, but you have to wait weeks for a reply.” (PM4). “It would be much more efficient if an allocated social worker comes along. It cuts out all the referrals and things like that. It saves time.” (GP8) p.4 Accessing social services - overworked staff Participants described how local pressures have led to an increase in their workload and time constraints reduce the motivation and efforts to collaborate with social care. Participants also emphasised staff working high workloads are unlikely to accept new responsibilities (such as those working for integration of care) when there is no immediate anticipated reward in return for their work. “You just don’t have the time to sit down and have these meetings.” (GP4). “Everybody is already doing way more work than they can cope with so when there’s no	Yes. **3. Was the research design appropriate to address the aims of the research?** Yes, the author describes how a phenomenological approach will help to answer the research question. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author describes 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 in-depth. There is mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** Can't tell, the interview schedule was first tested with 2 pilot participants but has not critically examined potential bias and influence during data collection. **7. Have ethical issues been taken into consideration?** Yes, ethical approval was received from the NHS Health Research Authority. **8. Was the data analysis sufficiently rigorous?** Yes, there is an in-depth description of data analysis methods. It is clear how themes were emerged. Separate researchers were involved at different stages of the analysis process, as well as results presented back to participants to avoid bias.

Study details	Methods and participants	Results	Limitations
		remuneration for it, nobody wants to do extra work." (PM1) p.3 to 4 <u>Accessing social services - lack of awareness of roles and services</u> Many GPs and PMs mentioned that one of the biggest barriers to service integration is the uncertainty about which roles are carried out by which social service provider and how best to contact these individuals. Often numbers in practice diaries and on websites are out of date, so staff have to ask the person directly what social care they receive and how to contact relevant departments, slowing down both communication and any attempts at collaborative working. Many doctors admitted they were not aware of the roles carried out by each individual member within the social sector, as well as what local services are available and how long each service takes to arrange, which further added to delays in referrals. "CCGs [Clinical Commissioning Groups] have a website of contacts but they are often out of date, you don't know people's names, you don't know who to contact, you don't know how to get hold of them." (GP3). "Sometimes what we find is that there's this amazing service and we knew nothing about it." (GP1) p.3. <u>Interprofessional relationships - poor interprofessional culture</u> All participants perceived the current interprofessional culture as a barrier to service integration and many sensed a lack of mutual respect between social and primary care staff. There is often a siloed working mentality with different teams having different agendas for the person using services and a lack of	**9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the author has discussed the contribution of the study to policy makers, and has suggested future areas for research. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor. **Source of funding** Not reported.

Study details	Methods and participants	Results	Limitations
		motivation for collaborative decision-making. This culture can lead to a diffusion of responsibility and a lack of clarity on who is performing which service for the person, further delaying quality care provision. “Sometimes medical people can be quite dismissive of social people, and I think social people can be quite hostile to medical people.” (GP3). “The approach is ‘this is a social problem and so that’s for the social team’ and ‘we’re the medical team so we deal with medical problems’. So there doesn’t seem to be any integration in that way.” (GP6) p.4. <u>Infrastructure - fewer human resources</u> Participants noted that low levels of staffing and inadequate training of staff were barriers to service integration. They explained that collaborative working requires staff time and resources in primary and social care, but they are unable to keep up with current workloads due to short-staffing and post vacancies. Doctors mentioned that they did not have enough exposure to or understanding of the social sector during medical school, so working with them was a novel task. “Human resources on both sides are an issue. Social workers are just under so much pressure: they have no resources, no time, they're looking after loads of vulnerable people. Same with us, we don’t have enough resources to be able to do more other than run the clinics in the practice.” (GP18). “I know in hospitals, as a medical student, to be honest with you, I don’t actually remember talking to a social worker at all.” (GP9).	

Study details	Methods and participants	Results	Limitations
		"The students I have taught recently have never even seen a social worker or carer, let alone spoken to one. And they have no idea what the social worker does. It is only when the come out into the community, which should happen much earlier…Obviously a lecture on social care would be really boring so being able to see them in their role may help, maybe like shadowing." (GP5). "There isn't any structured teaching on social care in the GP training programme either, we definitely need something there to teach future GPs the intricacies of working with other teams." (GP15) p.5. Interprofessional relationships - lack of regular contact Most GPs and PMs felt that regular contact with social care teams is necessary for effective information transfer and a multidisciplinary approach to care, however they felt the current way of contact through forms and emails and minimal face-to-face contact, was inefficient and a barrier to continuity. Participants felt there was a need for proactive communication rather than the current crisis-led approach (especially for safeguarding issues). Staff felt overwhelmed with unnecessary paperwork. "Communication is often sporadic via email, emergency phone calls or when families raise concerns. There is not really a free-flowing system." (PM4). "In one borough we have really good referral pathways and really good contact with our social workers, in the other one I work in I often have to send generic emails or call the council to get in touch with social services, but	

Study details	Methods and participants	Results	Limitations
		you don't have that direct contact, so it is not as cohesive." (GP6) p.4. Infrastructure - interoperability between information systems A major barrier preventing integration is the lack of shared information sources. GP practices and social care teams use different software with no way user-friendly way of transferring information. This meant communication was limited to emails and phone calls which led to confidentiality issues and delays. GPs and PMs felt information transfer was essential for reducing acute admissions, "We don't share the same computer systems. So social care would have their own system that we don't have access to and they don't have access to our clinical system… Social care needs to be integrated into the medical care more electronically, for them to be here within GP surgeries so they aren't picking up patients as an emergency - so they are ahead of the game so to speak." (PM7) p.5. Infrastructure - insufficient funding Lack of funding underpins many of the barriers such as low staffing, poor interprofessional culture. And since staff are not remunerated for extra work, collaboration is not prioritised. Different funding bodies also reduce the incentive for collaboration, as they create a culture of competing interests between sectors. "Funding: that is probably what everything will be classed under… and requirements of social staff to meet general practice, which they don't have as a contractual requirement in most external services." (PM3) p.5.	

Study details	Methods and participants	Results	Limitations
		<u>Interprofessional relationships - inefficient multidisciplinary team meetings.</u> Participants felt the face-to-face meetings with social care teams were inefficient. PMs mentioned that the social care staff attending those meetings did not look up the people being discussed beforehand, or that did not attend, and so the conversations were not informative. GPs complained of a lack of protected time for these meetings which clashed with their clinics. GPs also noted geographical barriers for community teams who are doing home visits, as the team meetings were held in GP practices. Participants who worked in more than one borough noted a variation between GP practices. “There is no blocked off time… they have these meetings in the middle of surgeries, 10 o’clock in the morning, I can’t just leave the patients for one and a half hours and go somewhere.” (GP8). In one practice I find it very integrated, there is a regular meeting once a month where the social workers, myself, palliative care and anyone else relevant all meets to discuss any relevant patient, any concern with social services and then we follow them up.. the other practice which is in a different borough, you never know if the social worker will turn up and if they don’t you have to wait a good few months to discuss a patient, so I end up calling but that doesn’t work well either.” (GP17) p.4 to 5.	
Full citation Phillipowsky, D. J., The perceptions regarding social workers from within an integrated trust in an age of austerity, Journal	**Recruitment strategy** A convenience sample of professionals from the integrated trust were invited to contribute. Purposive sampling was used to recruit participants using pre-specified criteria that they must be qualified social workers or	**Findings (including author’s interpretation)** <u>Organisational: the structures have been poorly designed and bureaucratic</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?**

Study details	Methods and participants	Results	Limitations
of Integrated Care, 26, 38-53, 2018 **Ref Id** 798439 **Country/ies where the study was carried out** UK, England. **Study type** General qualitative inquiry (interpretive). **Study aims** To explore community professionals' opinions on social worker's roles within a multi-disciplinary team. **Study dates** 2016.	qualified registered community professionals who within their role work closely with social workers. **Setting** An NHS trust with integrated health and social care. **Participant characteristics** N= 41 total respondents Social workers, n=21 n Occupational therapists, n=13 Nurses, n=7 **Data collection and analysis** Data collection Participants completed a questionnaire based online survey. Free-text responses were collected for analysis. Data analysis Data from the survey was used produce the initial codes, which were then used for thematic analysis. The researchers and supervisors discussed the data analysis.	1) The systems and structures in place were significant areas of concerns for all professionals. The narrative that was consistent was an organisation that is too large and rigid in its approach to service delivery. 2) An approach that ignores the key differences in ways of working. “1) It is the integrated organisation that is at the root of most problems.” (social worker). “1) We are not an integrated Trust. We are co-located professionals.” (social worker). “2) […] integration means social workers and nurses in same office which doesn’t work.” (nurse). “2) I have very little faith that our organisation will overcome the challenges.” (OT) p.44. There was a sense that the organisation operates primarily as a health care provider and not a health and social care provider. 'It feels as though the trust sees social care as expensive and alien to them. They do not seem to have an understanding of the statutory responsibilities that they carry out for the Local Authority.” (social worker) p.43. Nurses responded in the affirmative with regards to communication having improved significantly since integration. “it clearly makes sense to be integrated, as the professional boundaries have reduced.” (nurse) p.44. <u>Culture: Social workers operate differentially to health colleagues</u> 1) There was a sense of difficulty and frustration trying to maintain and assert one’s culture when subsumed by a larger force,	Yes. **2. Is a qualitative methodology appropriate?** Yes. **3. Was the research design appropriate to address the aims of the research?** Yes, the authors have described how they will use the responses of the survey to explore the research aims. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author described how the participants were recruited. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection are detailed and justified, although no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** Can't tell, the study specifies that a social worker conducted the study, but does not highlight what impact this may have on bias. The study also specifies that respondents completed the survey at their own discretion. **7. Have ethical issues been taken into consideration?** Yes, ethical approval was gained from the University of Worcester and the local NHS Trust where the study was undertaken. **8. Was the data analysis sufficiently rigorous?**

Study details	Methods and participants	Results	Limitations
		mainly felt by social workers. The answers appeared to be from a position of disempowerment and marginalisation. 2) The clash of cultures was frequently mentioned as a challenge and impediment to true integration. 1) "It is very difficult for a small minority profession to be based in such a large health organisation." (social worker). 2) "Health managers above social workers do not understand social work and often approach challenges in our role from a business or health perspective." (social worker). "I have never been made to feel so worthless in a 17-year career in social work." (social worker) p.43. <u>Political: integration and social work as a political football</u> The narrative throughout responses was that social workers were powerless, a sense of being an issue that needed to be dealt with. "We have no power or control anymore." (social worker). .. Being "subsumed by Health and their agenda." (social worker) p.45. <u>Austerity: cuts have hampered integration</u> 1) Common thread through the responses was the impact of austerity on every aspect of integration. Respondents believe that severe and enduring cuts to the public sector have results in a poorly designed integrated service where the full benefits of social workers have yet to be realised.	Yes, the analysis was described in depth. The author describes strategies they took such as supervision and debriefing with the researchers during the analysis. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the author has used the findings to suggest recommendations for practice. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor. **Source of funding** Not reported.

Study details	Methods and participants	Results	Limitations
		2) There was a perception that the cuts have been disproportionate. Several nurses mentioned budget constraints were impinging on the delivery of services. 3) Some respondents went further, stating that resources are not in place to deliver upon statutory responsibilities/key services. "1) Austerity has torn the social care system to bits." (social worker). "1) Budgets appear to cause issues." (nurse). "2) For health it has benefitted health professionals, but I don't think it has been successful for citizens or for social care, social workers or the care market." (social worker). "3) The Care Act sounds great but the reality it cannot be delivered within the current climate." (social worker) p.43 to 44.	
Full citation Phillipowsky, D. J., Perspectives on social workers from within an integrated setting: a thematic analysis of semi-structured interviews with six UK community practitioners, J Integr Care, 28, 65-76, 2020 **Ref Id** 1289502 **Country/ies where the study was carried out** England, UK.	**Recruitment strategy** See Phillipowsky 2018 **Setting** See Phillipowsky 2018. **Participant characteristics** Total participants N=6 Social workers, n=5 Volunteer nurse, n=1 **Data collection and analysis** Data collection 30 minute long semi-structured interviews took place in a place chosen by the participant, to ensure they felt comfortable.	**Findings (including author's interpretation)** <u>Culture: Social workers operate differentially to health colleagues</u> There was a sense of feeling of abandonment of the social workers. "I think as an integrated Trust we were being eroded anyway but the added stress of the local authority who effectively are abandoning us it's a double whammy for us." (social worker 2) p.69. After five years of integrated working, the knowledge and opinions of social workers appear static, as if there is an ingrained cultural bias; their opinions were predictable and it was very difficult for them to move from that established mindset. The social work	**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, the author described why the study design was appropriate to capture rich data.

Study details	Methods and participants	Results	Limitations
Study type Interpretive - general qualitative inquiry. **Study aims** To explore the opinions of professionals on the social worker's roles within a multi-disciplinary team. **Study dates** 2017.	They were recorded digitally and later transcribed. Data analysis Interview data was analysed using thematic analysis by the author.	respondents were clear that they perceived social work as being under threat and that they feel constantly challenged, with attempts to dilute their status and standing. '"We are seen as low priority and low status compared to health." (social worker 5) p.69. Predominant responses suggested that a health-dominated culture persists within the integrate trust. Participants expressed concerns around the ability of social workers to be fully utilised and to effectively inform the assessment with a social perspective, rather than be underutilised as a tool to complete a specific task. There appears to be a barrier that is preventing understanding from developing, the suggestion is this is due to fundamentally different education and training social work and health services received, leading to the development of cultural silos. Social work participants expressed a sense of being marginalised and not being valued for their unique contribution to the assessment. '"I still think the average community nurse does not understand what a social worker does. It doesn't come with a day shadowing." (nurse 1). "Social work is undervalued, very undervalued, our opinions are undervalued, our professionalism doesn't carry the same weight as other professionals I don't think it does." (social worker 2). "The organisation, the Trust, I think it comes from very high up all the way down. A lot of social workers feel undervalued that it hasn't been integration but a take-over." (social worker 3) p.68. Responses picked up on the element of health culture creeping into the social model of welfare, with social workers increasingly asked to quantify the unquantifiable in order to	**4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author described how the participants were selected. **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 author has acknowledged and described the bias that their role in interviews and data analysis would have, but has not made adjustments. **7. Have ethical issues been taken into consideration?** Yes, approval was gained from the University of Worcester and the NHS trust involved. **8. Was the data analysis sufficiently rigorous?** No, the author has mentioned data was analysed using thematic analysis, but insufficient details provided and only the author was involved in analysis therefore bias was not eliminated. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Some value, but this is limited to the views of social workers as sample was not representative of the whole integrated team (only 1 nurse interviewed).

Study details	Methods and participants	Results	Limitations
		access budgets and services that are ring-fenced to certain criteria. The issue of role clarity and professional identity was discussed....The prevalence and importance of professional supervision by managers with the same professional background was apparent within participants' accounts of integrated working...these responses appeared to be consistent with opinions about the role of supervision in forming a professional identity and its importance in creating a good working environment. "“We definitely haven't maintained a professional identity.” (social worker 4). “My manager was a nurse, she meant well but was clueless about social work practice.” (social worker 2) p.68 to 69. Social workers consistently expressed a lack of understanding of their role within the integrated trust. It could be that these factors have obstructed the full integration of social workers, in addition to undermining the effective collaboration among health and social care professionals. <u>Organisational: the structures have been poorly designed and bureaucratic</u> Participants reported the importance of professional identity...Social workers feel that they do not belong [in the integrated trust]. “Social worker's feel devalued, deskilled and underappreciated. It doesn't matter what level you are on if you are a social worker you feel devalued.” (social worker 1) p.71. There was a feeling of structural inequality. ““it is very much health dominated, management are very much health orientated, not very	**Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate. **Source of funding** Not reported.

Study details	Methods and participants	Results	Limitations
		much social care managers, I feel we have just been side-lined.” (social worker 5) p.71. The tools that are required to facilitate and drive integrated working are not present. The structures and the resources were not present at the time of integration to fully realise the potential of the partnership. This resulted in things remaining distinctively separate as against the envisioned joined up approach. ““the way forward is better technology systems that talk to each other. There is no money, so we can’t have that.” (nurse 1). “It’s just took it back to separating things... services now for health are very much seen separate.” (social worker 1) p.70. The participants favoured co-location where health and social care remained within separate organisations with clear and distinct policies and procedures rather than within one integrated organisation. “5 years ago, we were co-located and it worked really well. If you asked me that same question today, I would say we are further apart.” (social worker 3). “In terms of our integration, we have always co-worked but the difference is when we had the local authority, we had support as they are an external to the integration. A lot of the higher management are health and they don’t look at the social side of it.” (social worker 2). “I think co-location absolutely, that worked really, really well. I don’t think you can be truly integrated, you are both looking at totally different things.” (social worker 3) p.70. Austerity: cuts have hampered integration Respondents’ believe that severe and enduring cuts to the public sector have	

Study details	Methods and participants	Results	Limitations
		resulted in a poorly integrated service where the important contribution of social workers has yet to be realised…. A further complication was the lack of pooled budgets to actually realise a seamless service and deliver the efficiencies that the integrated health and social care promised. ""We have integrated in name and where staff are based only. austerity. . . really impacts on integration." (nurse 1). (Austerity) "Yes, I think it has a huge impact now, I think social care they make it feel like it's your problem. We are questioned how many times do you have to visit." (social worker 3). "Services are, there is hardly anything out there and it is very frustrating, it is very difficult trying to be integrated as nobody knows who should be doing what, whose role is what." (social worker 4). "It is difficult to get any service for anyone these days and it's all heading towards privatisation." (social worker 5) p.69.	
Full citation Round, T., An integrated care programme in London: qualitative evaluation, Journal of Integrated Care, 26, 296-308, 2018 **Ref Id** 1224067 **Country/ies where the study was carried out** England, UK.	**Recruitment strategy** Purposive sampling used to recruit participants. Following the purposive approach, the interviewees were selected based on known engagement with the structures, processes and outcomes of integrated care. **Setting** Two inner-city London boroughs (Southward and Lambeth). **Participant characteristics** N= 31 participants interviewed.	**Findings (including author's interpretation)** <u>Leadership – challenges</u> There was also a lack of communication, "between the leadership and what happened on the ground." There was also a lack of communication, "between the leadership and what happened on the ground." p.302. <u>Shared vision and case for change – challenges</u> There was felt to be a lack of communication between leadership of the programme and operational delivery with, "a disconnect between the Sponsor Board and the level	**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, the author described how the qualitative methods would help explore the aims of the research.

Study details	Methods and participants	Results	Limitations
Study type General qualitative inquiry. **Study aims** To identify what worked, what did not work, and the lessons learnt from the integrated care programme. **Study dates** January to May 2016.	Citizen representatives, n=3 Central management team, n=2 Charity partner/funder, n=2 Local authorities, n=3 Local secondary care providers, n=6 Hospital consultants, n==3 General practitioners, n=5 Community providers, n=3 Commissioners/CCG representatives, n=4 **Data collection and analysis** Data collection Semi-structured interviews were conducted by 4 members of the evaluation team and lasted between 30 to 70 minutes. Focus groups and stakeholder meetings were held. The conversations were digitally recorded with researchers taking field notes during interviews and meetings. Data analysis Data were thematically analysed using a framework approach. Themes were analysed and validated by all members of the interview team to improve consistent and reliability. Themes were discussed and cross-checked during interviews and focus groups to ensure respondent validation.	below", leading to it being, "harder to find the common ground." p.300. <u>Macro-level environment – challenges</u> Many stakeholders focused on the, "slashing of local authority budgets", and "cuts to primary care and mental health budgets", which meant it was, "difficult to deliver social care integration". With the external environment reported as making, "the system dysfunctional," this hampered the ability of organisations to deliver innovation which spanned boundaries within the programme. p.303. <u>Relationships – challenges</u> there was, "initial hostility and suspicion on both sides," with, "primary care worried about a takeover," reacting with, "hostility to what felt like a […] secondary care thing," whilst "the complexities of general practice were not properly understood." <u>Relationships – successes</u> Collaborative working and culture change was perceived as a shared success, as a great strength of the programme. This included shared learning. ""Relationships have been built up." "[…]. (the) main strength to help us build relationships between primary care, secondary care, community services and social services." "co-production between different staff and users." p.302. <u>Intervention – successes</u>	**4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, methods of recruitment were explained. **5. Was the data collected in a way that addressed the research issue?** Yes, methods of data collection were clear but no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, the researcher has not critically examined their own role, potential bias and influence during formulation of the research questions or data collection. **7. Have ethical issues been taken into consideration?** Can't tell, there are insufficient details of how the research was explained to participants, and ethical approval was not sought and no explanation for why it was not required. The researcher did consider consent during data collection. Ethical approval may have been a requirement of funding but it is not reported. **8. Was the data analysis sufficiently rigorous?** Yes, the author has described data analysis methods in detail and has explained the approaches taken to minimise bias during analysis. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?**

Study details	Methods and participants	Results	Limitations
		Improved information technology such as the Local Care Record (an IT solution created to allow read-only access between primary care, secondary care and mental health case records) was also felt to be a tangible success. ""IT changes have helped and have now been rolled out across general practices." p.301. Some interventions were identified as challenges and barriers to the implementation of the programme because they look longer to carry out. Holistic assessments were felt to be, "a very lengthy assessment", and "hugely dependent on the individual doing them," whilst, "some viewed this as tick box exercise." p.301.	Valuable, the authors have used the findings to make recommendations for the future in integrated working. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor. **Source of funding** Not industry funded (funded by the Southwark and Lambeth Integrated Care (SLIC) programme).
Full citation Sheaff, R., Integration and continuity of primary care: polyclinics and alternatives – a patient-centred analysis of how organisation constrains care co-ordination, Health Services and Delivery Research, 3, 2015 **Ref Id** 1270027 **Country/ies where the study was carried out** England, UK. **Study type** General qualitative inquiry.	**Recruitment strategy** Study sites were selected using purposive sampling. A sample of key informants were selected in each site, and snowballing method was used to recruit further participants. **Setting** Data extracted is relevant to a county which is 1 of 5 study sites - pseudonymised 'Tarrow'. **Participant characteristics** Total participants N=11 General practice (GPs, other staff), n=2 Care network co-ordinators, n=3 NHS trust managers and clinicians, n=4 Social care, n=1 Other, n=1 **Data collection and analysis** Data collection Data were collected from informant interview. All interviews were digitally recorded and professionally transcribed, and interviewees	**Findings (including author's interpretation)** <u>Integration and disintegration</u> One of the reasons for the reversal of joint management of primary, acute care and county council social care was that the trust was not culturally integrated. A social care view was that money was spent on social care not to achieve social care goals, but "short-term responses to the tier four emergency issues that [trust name] were having." (social care manager TP09) prompting social care to leave. <u>Community health services with acute care and social services</u> When social workers at another site (Tarrow) began working as part of the mental health trust team, the benefits of organisationally integrating health and social care were immediate [Tarrow had an integrated team under section 75 agreement].	**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, the author has justified the study design. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, it is clear how participants were recruited. **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?**

Study details	Methods and participants	Results	Limitations
Study aims To explore the care-coordination mechanisms that are in use in the NHS. **Study dates** Not reported.	were offered the chance to correct their transcript. Data analysis Data was analysed using a framework. Data was coded against a prior framework. Data was supplemented with ad hoc emails or telephone enquiries where there were gaps.	The subsequent organisational disintegration revealed, with hindsight, how much easier organisational integration had made co-ordinating and maintaining longitudinal continuity of care. "'[D]elayed transfers of care were eradicated within 6 weeks', moving the trust from being 'about the worst in the Strategic Health Authority to the best' and this where there was 'a high performing acute sector and [. . .] an underinvested in community sector.'" (manager TP01). [W]e learnt so much about each other, adult social care and health, because we were together for several years [. . .] We weren't given the 5 years to really make it embed into practice [. . .] it's such a great shame." (Nurse manager TP06) p.68.	No, the researcher has not critically examined their own role or potential bias and influence in the formulation of questions or during data collection. **7. Have ethical issues been taken into consideration?** Yes, ethical approval was obtained from the NHS Research Ethics Committee system. **8. Was the data analysis sufficiently rigorous?** Can't tell, it is clear how the themes were derived but the researcher has not critically examined their own role in potential bias during the analysis. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the author has discussed how the findings could be used in practice and in different populations. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate . **Source of funding** Not industry funded (Health Services and Delivery Research programme of the National Institute for Health Research).
Full citation Sonola, L., Oxleas advanced dementia service: supporting carers and building resilience, 32, 2013	**Recruitment strategy** Not reported. **Setting** London boroughs of Greenwich and Bexley	**Findings (including author's interpretation)** <u>Functional integration</u> Communication between staff was not facilitated by the electronic records system used within the trust. Community and mental	**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.

Study details	Methods and participants	Results	Limitations
Ref Id 1280260 **Country/ies where the study was carried out** England, UK. **Study type** General qualitative inquiry. **Study aims** To understand the strategies used to deliver care co-ordination effectively and to examine barriers and facilitators to successful care co-ordination in a model for dementia care. **Study dates** Not reported.	**Participant characteristics** Total participants N=14 Includes staff from the Greenwich and Bexley dementia teams, managers, local commissioners and a GP. **Data collection and analysis** Data collection Semi-structured interviews and observation of a team meeting. Data analysis Not reported.	health staff had access to a web based electronic care record they cannot access each other's systems without special permissions. They have developed mechanisms to ensure that both records are up to date, meeting face-to-face or telephoning to contact other services, followed by a completed form or faxed letter when needed. These personal interactions build rapport and trust between professionals, and appear to be particularly useful in developing relationships with other care providers. In addition, care co-ordinators attend meetings with local GPs to share information. The service relies on 'low tech' solutions to overcome barriers to sharing data electronically. These methods are more time-consuming; however, they help to maintain strong links with professionals outside the service. "We've got so many different systems that don't talk. Much of this [service] depends on clinicians' respect for each other, relationships and the ability to be flexible." (senior manager) p.17. Team culture There is a clear, shared aim among staff in the service to help people in the latter stages of advanced dementia to live well and die at home, with a focus on bringing together physical and mental health. Staff are strongly rooted in their local communities and feel supported by managers to work in an integrated way. "We [physical and mental health] existed in a slightly parallel universe and there was a yearning for each other's input." (clinician) p.17.	**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, the **Recruitment strategy** was not reported. **5. Was the data collected in a way that addressed the research issue?** Can't tell, the data collection methods are given but insufficient detail provided. **6. Has the relationship between researcher and participants been adequately considered?** Can't tell, there was no detail provided. **7. Have ethical issues been taken into consideration?** Can't tell, there is no detail provided. **8. Was the data analysis sufficiently rigorous?** Can't tell, data analysis methods have not been reported. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the author has mentioned how the findings contribute to current research.

Study details	Methods and participants	Results	Limitations
			Overall methodological limitations (No or minor/Minor/Moderate/Serious) Serious. **Source of funding** Not reported.
Full citation Taylor, A. K., Gilbody, S., Bosanquet, K., Overend, K., Bailey, D., Foster, D., Lewis, H., Chew-Graham, C. A., How should we implement collaborative care for older people with depression? A qualitative study using normalisation process theory within the CASPER plus trial, BMC family practice, 19, 116-, 2018 **Ref Id** 1090825 **Country/ies where the study was carried out** England, UK. **Study type** General qualitative inquiry. **Study aims** To explore the views of people using services and professionals on collaborative care.	**Recruitment strategy** Purposive sampling was used to recruit participants. Invitation letters, information leaflets and consent forms were posted to the trial participants and sent via email to GPs and case managers, **Setting** GP practices in urban and rural areas in the North of England. **Participant characteristics** Total participants N=33 GPs, n=12 Case managers, n=8 Participants, n=13 **Data collection and analysis** Data collection Semi-structured interviews were carried out by 3 researchers, at a time and location that was convenient to the participants (at the practice for GPs, at home for participants, and in the researchers office for case managers). Interviews were digitally recorded and then transcribed verbatim and anonymised. Data analysis Data was analysed used thematic framework analysis by 2 independents researchers who were not involved in data collection. The	**Findings (including author's interpretation)** <u>Liaison between case managers and GPs (collective action)</u> GPs and case managers reported difficulties in being able to communicate reliably with each other, due to CM perceptions about GPs' working hours and the volume of letters and phone calls they already receive, along with GPs' concerns about increasing workload. "'So when I have had contact with the GPs… if they've not been there when I call, then it has been quite difficult, and we tend to keep missing each other, that kind of thing." (CM6). "If someone was to ring me say at three o'clock and say well can you ring me back before five that's going to be pretty impossible because I'm just you know I've just got one patient after another but I could ring them back you know the following morning or that type of thing so that would work. Or email." (GP1). "I would say the only thing with letters is that they'll often sit for a while, while we get through them all really." (GP2) p.6. <u>Evaluating collaborative care (reflexive monitoring)</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, the author describes how the methods used will help to answer the research question. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the author describes how the participants were recruited. **5. Was the data collected in a way that addressed the research issue?** Yes, the methods of data collection are clear, the researchers used a topic guide for the interviews. However, there is no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?**

Study details	Methods and participants	Results	Limitations
Study dates May 2013 to November 2014	framework was developed using normalisation process theory, and then agreed across the wider research team. Researchers with different professional backgrounds were consulted to enhance rigour.	GPs suggested that CMs should be attached to, or embedded in, practices to improve liaison and communication. Similarly, CMs felt that being able to review a person with GPs would enable better care, although they recognised that this added an additional time commitment to both the case manager and the GP. "'I know if somebody came to our practice and said, "I'm the case manager to do this, and these are the sort of people that I want to see," we'd love it. If that was provided, I think that would be a really, really good service. And as I said, the case managers that we've had, when we remember that they're there, they're brilliant. It's really nice when you keep going to see the same person with the same kind of things to just think, "Well, if I can get that person in, they can go and see them, have a really long period of time with them, and actually get a handle on things and sort things out." I think we would just love to do that." (GP8). "I think [a joint review would] be a good idea but it's just time isn't it and like when you're lumped with, because I've worked in practice before when you've got like massive caseloads of people and then you've got like this extra, it sounds really horrible but when you've got this extra, you know like, review to do as well and then that needs, you know it's just… I think that would be good for [the patient] because again it's all about liaising and people know about what's going on with them and make them feel more cared for, I think you know it'd be good for them." (CM4) p.6. <u>Understanding of collaborative care (coherence)</u>	No, the author has not critically examined the roles of the researcher during formulation of questions or data collection in regards to potential bias or influence. **7. Have ethical issues been taken into consideration?** Yes, ethical approval was received from Leeds East Research Ethics Committee, Yorkshire & Humber. **8. Was the data analysis sufficiently rigorous?** Yes, there is an in-depth description of the analysis. It is clear how the themes were derived. The author describes more than one researcher involvement in the analysis, and the results were discussed with researchers of varying professional backgrounds. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Valuable, the author has explained the contribution of this study to existing literature. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor. **Source of funding** Not industry funded (NIHR Health Technology Assessment Programme).

Study details	Methods and participants	Results	Limitations
		GPs were keen to highlight their views on the potential benefit of the case manager intervention. "I would see it as yes we sort of complement each other really and what it does it sort of positively reinforces what we do but also picks up on stuff perhaps that we may have missed because of what I'd mentioned with regards to constraints within general practice at the moment." (GP10) p.5.	
Full citation Vicary, S. A., Oakley, B., J., A deliberative study into the impact of integration on mental health social work in England: merely a dialogue or activism?, The Journal of Mental Health Training, Education, and Practice, 13, 77-89, 2018 **Ref Id** 1290098 **Country/ies where the study was carried out** UK, England. **Study type** Deliberative, general research inquiry. **Study aims**	**Recruitment strategy** Sample of professionals and people who access services was purposefully selected through a mental health trust. Participants were accessed through distribution of a flyer and information sheet explaining the purpose of the study. **Setting** Mental health trust **Participant characteristics** N=40 professionals and people who access services. (n= 4 people who access services, n=36 professionals). Social worker professionals: Social workers: n=5 Student social worker: n=3 Senior/lead social worker: n=3 Other professionals: Manager: n=3 Community psychiatric nurse: n=3 Mental health practitioner: n=2 Community development worker: n=1 Chaplain: n=1	**Findings (including author's interpretation)** <u>Clarity of role</u> Social workers who were employed by one of three local authorities and seconded to the "host" service expressed concerns about being forgotten or ignored by their local authority employers and also about the potential for the loss of their professional identity as a result of this separation. Participants identified that the 'medical model' was the dominant model for the medical and social model of mental health care. Participants felt the service was led by doctors and medical issues took priority over social issues. Some social workers were concerned about the tasks they were allocated describing them as "medical roles", for example checking whether someone had taken their medication. Some social workers who provide social work support to secure units were directly employed. They expressed greater clarity with their role; they are organised as a social work team and managed by a social worker, they have a more clearly defined service user	**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, the authors described how deliberative research would help meet the aims. Phase 1, a literature review is undertaken. Phase 2, the views of participants are sought using the information from phase 1. **4. Was the Recruitment strategy appropriate to the aims of the research?** Yes, the authors described how the participants were recruited. **5. Was the data collected in a way that addressed the research issue?**

Study details	Methods and participants	Results	Limitations
To examine the impact of integrated working on mental health social care. **Study dates** January to June 2015.	Safeguarding specialist practitioner: n=1 Lecturer: n=1 Not specified: n=1 Mental health nurse: n=1 Trainee clinical psychologist: n=1 Employment advisor: n=1 Manager (head of social care): n=1 Student nurse: n=1 E and HR: n=1 Project worker: n=2 Acting head practitioner: n=1 Psychologist: n=1 Co-ordinator: n=1 Local authority manager: n=1 **Data collection and analysis** Data collection Deliberation events took place which were jointly facilitated by the mental health service provider and one of the study's researchers. Participants were provided with a summary of the research found during the research phase. Views of participants on the information was collected by facilitators using a flip chart and note taking. Data analysis The data was analysed by 1 researcher. The research phase identified 4 components for what constitutes effective mental health social work in integrated care, which are: clarity of role, access to professional development, effective operational management and leadership. Data was analysed using the 4 components.	group and range of tasks to perform than their colleagues who are community based. The strongest comment questioning current practice was that social workers could be located in the same offices as other mental health workers, but managed separately. These findings suggest that clarity of role is dependent on the quality and type of support provided by employers, whether health or social care. Access to professional development Some social workers were concerned about having "two managers", one from the "host" service and the other from the local authority. Supervision was raised as an important issue by social workers. Some managers are professionally qualified social workers others have health qualifications, and so there was a concern was expressed by some social workers about not receiving professional supervision from a registered social worker and that this impacted negatively on their professional development. Relevance The service user group stated that they wanted to see "equality" between the professions. Service users were in favour of integrated care and showed no concern about the specific professional training of the person who was working with them as long as the right service was provided when needed. Anger was expressed about the use of authority by some doctors and some social workers. The differentials in power and status that exist between mental health professionals were not seen as benefitting service users... The finding suggests that power differentials between professional in mental health is	Yes, data collection methods were described, but no mention of data saturation. **6. Has the relationship between researcher and participants been adequately considered?** No, there was no mention of the relationship between researcher and participants in the formulation of the questions, or the researchers own bias. **7. Have ethical issues been taken into consideration?** Yes, ethical approval was obtained from the University Research Ethics Committee, the Health Research Ethics Committee and the mental health setting where the research was conducted. **8. Was the data analysis sufficiently rigorous?** No, there is not an in-depth description of the analysis process. The authors have mentioned that the researcher was present for note taking and not part of discussions but has not critically examined their role in potential bias during analysis or selection of data. **9. Is there a clear statement of findings?** Yes. **10. How valuable is the research?** Some value, however the authors note that there are limitations to deliberative research that prevents an iterative discussion. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Moderate.

Study details	Methods and participants	Results	Limitations
		detrimental and that integrated care could provide an opportunity for more equitable sharing of power based on skills, as embodied in mental health social work. p.84. <u>Effective operational management and leadership</u> Social workers complained about having to use two different information technology systems which are not compatible, resulting in a loss of time due to duplication of work, and caused frustration. Health service software is used for their work within the host service, but local authority software for community care assessments.	**Source of funding** Not reported.

AMHP: approved mental health practitioner; CASP: critical appraisal skills programme; CCG: clinical commissioning group; CM: case manager; CMHT: community mental health team; CPN: community psychiatric nurse; HP: health practitioner; IT: information technology; LTNCS: long-term neurological conditions; MHSW: mental health social worker; NRT: neurorehabilitation team; OT: occupational therapist; PIG: policy implementation guide; PM: practice manager; RCT: randomised controlled trial; SW: social worker.

Appendix E Forest plots

Forest plots for review question E1: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

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 E1: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

Community living older adults

Table 10: Evidence profile for comparison between Comprehensive continuum of care and usual care

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Comprehensive continuum of care	Usual Care	Relative (95% CI)	Absolute		
Life satisfaction as a whole (follow-up 3 months)												
1 (Berglund 2015)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness[2]	no serious imprecision[3]	none	60/83 (72.3%)	56/76 (73.7%)	OR 0.93 (0.46 to 1.88)	14 fewer per 1000 (from 174 fewer to 104 more)	LOW	CRITICAL
Life satisfaction as a whole (follow-up 6 months)												
1 (Berglund 2015)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness[2]	very serious[3, 4]	none	49/83 (59%)	50/76 (65.8%)	OR 0.75 (0.39 to 1.43)	67 fewer per 1000 (from 229 fewer to 75 more)	VERY LOW	CRITICAL
Life satisfaction as a whole (follow-up 12 months)												
1 (Berglund 2015)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness[2]	serious[3, 5]	none	65/83 (78.3%)	50/76 (65.8%)	OR 1.88 (0.93 to 3.8)	125 more per 1000 (from 17 fewer to 222 more)	VERY LOW	CRITICAL
Quality of care (follow-up 3 months; assessed with: I am satisfied with the planning that was done for me)												
1 (Berglund 2013)	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness[7]	very serious[8]	none	65	37	-	p=0.001[9]	VERY LOW	CRITICAL

Quality of care (follow-up 6 months; assessed with: I am satisfied with the home help service I receive)												
1 (Berglund 2013)	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness[7]	very serious[8]	none	27	18	-	p=0.303[9]	VERY LOW	CRITICAL
Quality of care (follow-up 6 months; assessed with: I am satisfied with the home nursing care I receive)												
1 (Berglund 2013)	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness[7]	very serious[8]	none	16	8	-	p=0.350[9]	VERY LOW	CRITICAL
Quality of care (follow-up 6 months; assessed with: I am satisfied with the rehabilitation, training, assistive technology and/or home modification I receive)												
1 (Berglund 2013)	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness[7]	very serious[8]	none	32	17	-	p=0.654[9]	VERY LOW	CRITICAL
Quality of care (follow-up 12 months; assessed with: I am satisfied with the home help service I receive)												
1 (Berglund 2013)	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness[7]	very serious[8]	none	22	22	-	p=0.430[9]	VERY LOW	CRITICAL
Quality of care (follow-up 12 months; assessed with: I am satisfied with the home nursing care I receive)												
1 (Berglund 2013)	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness[7]	very serious[8]	none	14	9	-	p=1.00[9]	VERY LOW	CRITICAL
Quality of care (follow-up 12 months; assessed with: I am satisfied with the rehabilitation, training, assistive technology and/or home modification I receive)												
1 (Berglund 2013)	randomised trials	very serious[6]	no serious inconsistency	no serious indirectness[7]	very serious[8]	none	25	19	-	p=0.866[9]	VERY LOW	CRITICAL

CI: confidence interval; OR: odds ratio.

[1] Very serious risk of bias in the evidence contributing to the outcomes as per RoB2 (unclear randomisation and blinding; high attrition rates; data only reported for one outcome from the trial protocol; the authors stated the intervention started prior to baseline measurements and there was a pattern of higher satisfaction in the intervention group at baseline).
[2] Authors state that life satisfaction is closely related to quality of life and subjective well-being. Life satisfaction can be measured to collect data on, for example, emotion-related and social aspects of life where measurement tools for quality of life are weak (Borg et al. 2010). The validated LiSat-11 scale measured satisfaction with work, financial situation, leisure, friends and acquaintances, sexual life, functional capacity, family life, partner relationship, physical health, and psychological health.
[3] 0.8 and 1.25 thresholds for ORs are measures made by the NGA and are not 'GRADE default MIDs'.
[4] 95% CI crosses 2 MIDs (0.8 and 1.25 thresholds for ORs are measures made by the NGA and are not 'GRADE default MIDs').
[5] 95% CI crosses 1 MID (0.8 and 1.25 thresholds for ORs are measures made by the NGA and are not 'GRADE default MIDs').

[6] Very serious risk of bias in the evidence contributing to the outcomes as per RoB2 (unclear randomisation and blinding; data only reported for one outcome reported in the trial protocol; insufficient study power to detect outcomes at 6 and 12 months follow-up).
[7] Pyramid questionnaire (validated and used extensively to measure health and older care patients' perceptions of care quality in Sweden) covers care planning and meetings; older people's participation in and overall satisfaction with the care planning meeting; older people's knowledge of whom to contact with questions about care/service; satisfaction with home help service, home nursing care and rehabilitation, training, assistive technology and/or home modification.
[8] 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 to 399, then the quality was downgraded by 1 level, and if the total n<200, then the quality was downgraded by 2 levels).
[9] For outcomes using data from p-values it was not possible to calculate absolute effect, therefore summary statistics or narrative results are reported.

Table 11: Evidence profile for comparison between Embrace and care as usual

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Embrace	Care as usual	Relative (95% CI)	Absolute		
Quality of life (EQ-5D-3L) - Older adults with complex needs (follow-up 12 months; Better indicated by higher values)												
1 (Spoorenberg 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	187	178	-	MD 0.01 higher (0.02 lower to 0.04 higher)	MODERATE	CRITICAL
Quality of life (EQ-5D-3L) - Frail older adults (follow-up 12 months; Better indicated by higher values)												
1 (Spoorenberg 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	122	115	-	MD 0 higher (0.03 lower to 0.03 higher)	MODERATE	CRITICAL
Quality of life (EQ-VAS) - Older adults with complex needs (follow-up 12 months; Better indicated by higher values)												
1 (Spoorenberg 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	187	178	-	MD 3 higher (0.73 lower to 6.73 higher)	MODERATE	CRITICAL
Quality of life (EQ-VAS) - Frail older adults (follow-up 12 months; Better indicated by higher values)												
1 (Spoorenberg 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	122	115	-	MD 2.8 lower (6.55 lower to 0.95 higher)	MODERATE	CRITICAL

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Embrace**	**Care as usual**	**Relative (95% CI)**	**Absolute**		
Quality of life (RAND-36) - Older adults with complex needs (follow-up 12 months; Better indicated by higher values)												
1 (Spoorenberg 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	187	178	-	MD 0.04 lower (0.2 lower to 0.12 higher)	MODERATE	CRITICAL
Quality of life (RAND-36) - Frail older adults (follow-up 12 months; Better indicated by higher values)												
1 (Spoorenberg 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	122	115	-	MD 0.02 higher (0.17 lower to 0.21 higher)	MODERATE	CRITICAL
Patient assessment of integrated care - Older adults with complex care needs (follow-up 12 months; Better indicated by higher values)												
1 (Uittenbroek 2017)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	187	178	-	MD 0.1 higher (0.39 lower to 0.59 higher)	MODERATE	CRITICAL
Patient assessment of integrated care - Frail older adults (follow-up 12 months; Better indicated by higher values)												
1 (Uittenbroek 2017)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious imprecision[2]	none	122	115	-	MD 1 higher (0.45 to 1.55 higher)	LOW	CRITICAL

CI: confidence interval; EQ-5D: EuroQoL five dimension; MD: mean difference; RAND-36: research and development-36 item health survey

[1] Serious risk of bias in the evidence contributing to the outcomes as per RoB2 (potential bias from randomisation process; lack of blinding; high attrition rates).

[2] 95% CI cross 1 MID (0.5 x control group SD 1.90, for outcome quality of care = 0.95).

Table 12: Evidence profile for comparison between Urban health centres Europe and care as usual

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Urban Centres Europe	Care as usual	Relative (95% CI)	Absolute		
Health-related quality of life (SF-12 PCS) - Greece (follow-up 12 months; Better indicated by higher values)												
1 (Franse 2018)	Non-randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	154	124	-	Adjusted MD 0.4 lower (3.1 lower to 2.3 higher)	MODERATE	CRITICAL
Health-related quality of life (SF-12 PCS) - Spain (follow-up 12 months; Better indicated by higher values)												
1 (Franse 2018)	Non-randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	207	190	-	Adjusted MD 0.4 higher (1.83 lower to 2.63 higher)	MODERATE	CRITICAL
Health-related quality of life (SF-12 MCS) - Greece (follow-up 12 months; Better indicated by higher values)												
1 (Franse 2018)	Non-randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	154	124	-	Adjusted MD 1.7 higher (0.65 lower to 4.05 higher)	MODERATE	CRITICAL
Health-related quality of life (SF-12 MCS) - Spain (follow-up 12 months; Better indicated by higher values)												
1 (Franse 2018)	Non-randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	207	190	-	Adjusted MD 0.4 higher (1.77 lower to 2.57 higher)	MODERATE	CRITICAL
Mental well-being (SF-36) - Greece (follow-up 12 months; Better indicated by higher values)												
1 (Franse 2018)	Non-randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	154	124	-	Adjusted MD 2.2 higher (2.03 lower to 6.43 higher)	MODERATE	CRITICAL
Mental well-being (SF-36) - Spain (follow-up 12 months; Better indicated by higher values)												
1 (Franse 2018)	Non-randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	207	190	-	Adjusted MD 1.1 lower (5.29 lower to 3.09 higher)	MODERATE	CRITICAL

CI: confidence interval; MD: mean difference; SF-MCS: short-form mental component summary; SF-PCS: short-form physical component summary.

[1] Serious risk of bias in the evidence contributing to the outcomes as per ROBINS-I (non-randomised controlled trial with potential selective inclusion; subjective measures used to assess outcomes; lack of blinding).

Table 13: Evidence profile for comparison between Integrated health and social care day unit versus community nursing services

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Integrated health &social care day unit**	**Community nursing services**	**Relative (95% CI)**	**Absolute**		
Health-related quality of life (SF-12 PCS) (follow-up 9 months; Better indicated by higher values)												
1 (Murphy 2017)	Non-randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	25	-	MD 2.50 higher (2.09 lower to 7.09 higher)	LOW	CRITICAL
Health-related quality of life (SF-12 MCS) (follow-up 9 months; Better indicated by higher values)												
1 (Murphy 2017)	Non-randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	24	25	-	MD 3.55 higher (2.86 lower to 9.96 higher)	LOW	CRITICAL

CI: confidence interval; MD: mean difference; SF-MCS: short-form mental component summary; SF-PCS: short-form physical component summary.

[1] Serious risk of bias in the evidence contributing to the outcomes as per ROBINS-I (non-randomised trial; potential confounding and bias in selection of participants; subjective measures used to assess outcomes; lack of blinding).
[2] 95% CI crosses 1 MID (0.5 x control group SD 8.72, for outcome QoL SF-12 PCS = 4.36).
[3] 95% CI crosses 1 MID (0.5 x control group SD 12.88, for outcome QoL SF-12 MCS = 6.44).

Older homeless adults living with mental illness

Table 14: 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	Housing First	Treatment as usual	Relative (95% CI)	Absolute		
Generic quality of life (EQ-5D) (follow-up 12; 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 (0.16 to 11.44 higher)[2]	MODERATE	CRITICAL
Generic quality of life (EQ-5D) (follow-up 24 months; 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 quality of life (QoLI-20) (follow-up 12 months; 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 11.75 higher)[2]	MODERATE	CRITICAL
Condition specific quality of life (QoLI-20) (follow-up 24 months; 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
SF-12 PCS (follow-up 12 months; 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 0.43 lower (2.98 lower to 2.13 higher)[2]	MODERATE	CRITICAL
SF-12 PCS (follow-up 24 months; 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 0.49 higher (2.2 lower to 3.18 higher)[2]	MODERATE	CRITICAL
SF-12 MCS (follow-up 12 months; Better indicated by higher values)												

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Housing First	Treatment as usual	Relative (95% CI)	Absolute		
1 (Chung 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	470	1678	-	Adjusted MD 5.44 higher (2.23 to 8.65 higher)[2]	LOW	CRITICAL
SF-12 MCS (follow-up 24 months; 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 3.82 higher (0.47 to 7.17 higher)[2]	MODERATE	CRITICAL

CI: confidence interval; EQ-5D: EuroQoL five dimensions; MD: mean difference; QoLI: quality of life inventory; SF-MCS: short-form mental component summary; SF-PCS: short-form physical component summary.

[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.
[3] 95% CI crosses 1 MID (0.5 x control group SD 15.88, for outcome SF12 QoL MCS = 7.94).

Older adults living with severe mental illness

Table 15: Evidence profile for comparison between Assertive community treatment and treatment as usual

Quality assessment							No of participants		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Assertive community treatment	Treatment as usual	Relative (95% CI)	Absolute		
First care contact (follow-up 3 months)												
1 (Stobbe 2014)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	Serious[2]	none	31/32 (96.9%)	20/30 (66.7%)	RR 1.45 (1.12 to 1.89)	300 more per 1000 (from 80 more to 593 more)	LOW	IMPORTANT
Hospitalisation rates (follow-up 2 years)												
1 (Stobbe 2014)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	4/32 (12.5%)	4/30 (13.3%)	RR 0.94 (0.26 to 3.42)	8 fewer per 1000 (from 99 fewer to 323 more)	VERY LOW	IMPORTANT
Crisis contacts (follow-up 2 years)												
1 (Stobbe 2014)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	5/32 (15.6%)	4/30 (13.3%)	RR 1.17 (0.35 to 3.96)	23 more per 1000 (from 87 fewer to 395 more)	VERY LOW	IMPORTANT

CI: confidence interval; RR: relative risk.

[1] Serious risk of bias in the evidence contributing to the outcomes as per RoB2 (unclear blinding; high attrition rates and differences between intervention groups).
[2] 95% CI crosses 1 MID.
[3] 95% CI crosses 2 MIDs.

GRADE-CERQual tables for review question E2: Based on the views and experiences of everyone involved, what are the facilitators and barriers to integrated working between registered social workers and other practitioners to support adults with complex needs?

Overarching theme E1 – Barriers to integrated working

Table 16: Evidence summary profile (GRADE-CERQual) for theme E1.1 – Access to shared budgets

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Theme E1.1 – Access to shared budgets						
1 study • Bailey 2012 Ethnographic data with semi-structured interviews and team meeting observations. N=24 practitioners.	Data from 1 study suggested that a lack of pooled budgets was a 'system' barrier that may have practical implications to integration and working in a partnership. 'We've always had integrated staff but we've never had integrated budgets. I've got two budgets that I've got to look at so I can't just look at one budget and think oh we've overspent here, we'll pinch from out of there, I've got to look at 2, one's social care, one's health." (TM 1). [Quote: Bailey 2020 p.1121]	Minor concerns[1]	No or very minor concerns	Moderate concerns[2]	No or very minor concerns	MODERATE

1. Minor concerns about methodological limitations as per CASP qualitative checklist.
2. Studies together offered some rich data.

Table 17: Evidence summary profile (GRADE-CERQual) for theme E1.2 – Complicated bureaucracy

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Theme E1.2 – Complicated bureaucracy						
1 study • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services.	Data from 1 study suggested that bureaucratic referral processes between health and social care was a barrier to integration and created delays to accessing services. No supporting quote.	No or very minor concerns	No or very minor concerns	Serious concerns[1]	No or very minor concerns	MODERATE

1. Studies together did not offer rich data.

Table 18: Evidence summary profile (GRADE-CERQual) for theme E1.3 – Communication difficulties

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Theme E1.3 – Communication difficulties						
3 studies • Naqvi 2019 Phenomenological with semi-structured interviews. N=25 practitioners. • Round 2018 General qualitative inquiry with semi-structured interviews and focus groups. N=31 practitioners. • Taylor 2018 General qualitative inquiry with semi-	Data from 3 studies suggested that issues around communication can create a barrier to successful integrated working. Busy and different schedules between doctors and social workers was suggested to impede communication, as well as a lack of communication between leadership and operational staff. “If you want to speak to social workers urgently, there are barriers because you don’t necessarily have a telephone contact or a hotline or an email address to contact someone from social care.” (GP10). “Sometimes you fax over important things, but you have to wait weeks for a reply.” (PM4).	Minor concerns[1]	No or very minor concerns	Minor concerns[2]	Minor concerns[3]	MODERATE

structured interviews. N=33 practitioners and people who access services.	[Quotes: Naqvi 2019 p.4] "So when I have had contact with the GPs… if they've not been there when I call, then it has been quite difficult, and we tend to keep missing each other, that kind of thing." (CM6). [Quote: Taylor 2018 p.6]					

CM: case manager; PM: practice manager.
1. Minor concerns 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 (Taylor 2018 refers to an integrated team with case managers – these are assumed to be social workers but the paper does not report social worker membership specifically).

Table 19: Evidence summary profile (GRADE-CERQual) for theme E1.4 – Work culture differences

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Sub-theme E1.4.1 – Organisational systems						
5 studies • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services. • Bailey 2012 Ethnographic with data semi-structured interviews and team meeting observations. N=24 practitioners. • Mitchell 2020 General qualitative inquiry with semi-structured interviews. N=24 practitioners. • Phillipowsky 2018	Data from 5 studies suggests that cultural differences between the organisational systems of health and social care, can create barriers towards successful integrated working. Differences in political agendas, financial systems and approaches to care were all reported to hinder integration. There was a view that the social care money was not being spent on social care goals. There were also concerns over the different human resources policies such as those for sickness, grading and pay. The implications of such differences caused tension and were said to lead to feelings of hostility toward team members. "There are issues around pay and conditions, I can be sitting here with a nurse, she gets more annual leave than me, she gets paid more than me, the career options that are available to me as a SW are less than they would be for the nurse." (AMHP 3). [Bailey 2012 p.1125] "So, what I would say is, we are trying to bring the services together, to integrate them, and that will take some teasing out, because they all have different budgets, different management structures,	Minor concerns[1]	Minor concerns[2]	No or very minor concerns	No or very minor concerns	HIGH

General qualitative inquiry (interpretive) with free text questionnaire responses. N=41 practitioners. • Sheaff 2015 General qualitative inquiry with interviews. N=11 practitioners.	different professional bodies. They have different training and development needs, they all have different policies, different procedures." (operational health, area 3, interview a). [Quote: Mitchell 2020 p.5] "It is the integrated organisation that is at the root of most problems." (social worker). [Quote: Phillipowsky 2018 p.44]					
Sub-theme E1.4.2 – Perceived power imbalance						
6 studies • Bailey 2012 Ethnographic with data semi-structured interviews and team meeting observations. N=24 practitioners. • Mitchell 2020 General qualitative inquiry with semi-structured interviews. N=24 practitioners • Naqvi 2019 Phenomenological with semi-structured interviews. N=25 practitioners. • Phillipowsky 2018 General qualitative inquiry (interpretive) with free text questionnaire responses. N=41 practitioners. • Phillipowsky 2020 General qualitative inquiry (interpretive) with semi-structured interviews. N=6 practitioners. • Vicary 2018	Data from 6 studies identified that perceived power imbalances between the health and social sectors hindered successful integrated working. Social workers described the health sector as being more dominant and 'powerful' than social care. As a result, social workers felt abandoned by their local authority, and they experienced a loss of professional identity, as if they and their work were no longer valued or respected. In practice these issues translated into a lack of clarity over who is performing what role, and a subsequent delay to the delivery of quality care. People using services reported that they wanted to see 'equality' between professionals, and differences in power was not beneficial to them. [Quote: Vicary 2018 p.84] "Sometimes medical people can be quite dismissive of social people, and I think social people can be quite hostile to medical people." (GP3). "The approach is 'this is a social problem and so that's for the social team' and 'we're the medical team so we deal with medical problems'. So there doesn't seem to be any integration in that way." (GP6). [Quote: Naqvi 2019 p.4] "It is very difficult for a small minority profession to be based in such a large health organisation." (social worker). [Quote: Phillipowsky 2018 p.43]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

General qualitative inquiry (deliberative) with interactive discussions. N=40 practitioners and people who access services.	""The organisation, the Trust, I think it comes from very high up all the way down. A lot of social workers feel undervalued that it hasn't been integration but a take-over." (social worker 3). [Quote: Phillipowsky 2020 p.68]					
Sub-theme E1.4.3 – Professional identity of team manager						
6 studies • Abendstern 2014 General qualitative inquiry with free text survey responses. N=225 practitioners • Abendstern 2016 General qualitative inquiry with semi-structured interviews. N=21 practitioners. • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services. • Mitchell 2020 General qualitative inquiry with semi-structured interviews. N=24 practitioners • Phillipowsky 2020 General qualitative inquiry (interpretive) with semi-structured interviews. N=6 practitioners. • Vicary 2018 General qualitative inquiry (deliberative) with interactive discussions. N=40	Data from 6 studies suggested that integrated working could be hindered if staff were being managed by someone of a different profession. Health staff and social workers raised concerns that people from different professional backgrounds may not be familiar with their codes of practice and ways of working, and this could lead to role blurring, taking on more work than was appropriate and a loss of professional identity. It was also reported that having multiple managers across an integrated health and social care team created difficulties. "The expectation is that social workers will kind of blur . . . for instance medication, all the kind of mental health professional identities whereas . . . there's a lot of reluctance within the rest of the team to take on the social care roles." (social worker, team A). "'Our manager is from a social work background, so she knows what our limitations are . . . . So . . . you wouldn't necessarily be taking on something that you wouldn't be trained to do." (social worker, team D). [Quotes: Abendstern 2016 p.70-71] "My manager was a nurse, she meant well but was clueless about social work practice." (social worker 2). [Quote: Phillipowsky 2020 p.69]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

practitioners and people who access services.						

AMHP: approved mental health practitioner.
1. Minor concerns about methodological limitations as per CASP qualitative checklist.
2. Some evidence is ambiguous or contradictory without a credible explanation for differences .

Table 20: Evidence summary profile (GRADE-CERQual) for theme E1.5 – Increase in staff workload

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Theme E1.5 – Increase in staff workload						
3 studies • Abendstern 2016 General qualitative inquiry with semi-structured interviews. N=21 practitioners. • Levin 2019 General qualitative inquiry with semi-structured interviews and focus groups. N=25 practitioners. • Naqvi 2019 Phenomenological with semi-structured interviews. N=25 practitioners.	Data from 3 studies suggested that integrated working led to an increase in staff workload. Participants reported that an increase in workload was due to the ready access to social workers, an increase in local pressures and inadequate staffing. The increase in staff workload had a negative impact on integrated working as there was a decrease in motivation to work collaboratively. "No such thing as full up. We don't have a waiting list . . . I think that the new revised caseload weighting tool shows that we were far exceeding the expectations of what we should be doing. . . but . . . We just take it." (social worker, team C). [Quote: Abendstern 2016 p.74] "Everybody is already doing way more work than they can cope with so when there's no remuneration for it, nobody wants to do extra work." (PM1). [Quote: Naqvi 2019 p.4]	Minor concerns[1]	No or very minor concerns	Minor concerns[2]	No or very minor concerns	HIGH

PM: practice manager.
1. Minor concerns about methodological limitations as per CASP qualitative checklist.
2. Studies together offered moderately rich data.

Table 21: Evidence summary profile (GRADE-CERQual) for theme E1.6 Information sharing

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Sub-theme E1.6.1 – Lack of formal information sharing arrangements						
2 studies • Farrington 2015 General qualitative inquiry with interviews. N=24 practitioners. • Naqvi 2019 Phenomenological with semi-structured interviews. N=25 practitioners.	Data from 2 studies reported that a lack of formal information sharing arrangements, such as face-to-face communications, led to ineffective data transfer and a potential loss of information. The lack of formal sharing arrangements was also said to negatively affect care continuity. Ultimately this prevented a multidisciplinary approach to care. “Communication is often sporadic via email, emergency phone calls or when families raise concerns. There is not really a free-flowing system.” (PM4).” “In one borough we have really good referral pathways and really good contact with our social workers, in the other one I work in I often have to send generic emails or call the council to get in touch with social services, but you don’t have that direct contact, so it is not as cohesive.” (GP6). [Quotes: Naqvi 2019 p.4]	Minor concerns[1]	No or very minor concerns	Moderate concerns[2]	No or very minor concerns	LOW
Sub-theme E1.6.2 – Lack of information sharing protocols						
2 studies • Joseph 2019 General qualitative inquiry with focus groups. N=101 practitioners. • Mitchell 2020 General qualitative inquiry with semi-structured interviews. N=24 practitioners.	Data from 2 studies suggests that a lack of information sharing protocols was a barrier to information sharing and integrated working. This could lead to frustrations between healthcare professionals, as well as potential risk to individuals from a safeguarding perspective. “[…] there is a well-established format within the police to pass on information to our partner agencies […] but it doesn’t always flow back to us in a way that we would want it […].” (Police). [Quote: Joseph 2019 p.55] “Like I rung the hospital yesterday and asked for a copy of somebody’s capacity assessment and the discharge facilitator said to me, she was like, oh, I don’t know if I can send you that because of confidentiality. I was like I can’t make the decisions	Moderate concerns[3]	No or very minor concerns	Minor concerns[4]	No or very minor concerns	MODERATE

	that I need to make ...” (operational social care, area 2, interviewee c). [Quote: Mitchell 2020 p.6]					
Sub-theme E1.6.3 – Lack of joined up IT systems						
7 studies • Abendstern 2014 General qualitative inquiry with free text survey responses. N=225 practitioners • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services. • Cornes 2011 General qualitative inquiry (exploratory) with interviews and focus groups. N=77 practitioners, people who access services, and carers of people who access services. • Farrington 2015 General qualitative inquiry with interviews. N=24 practitioners. • Mitchell 2020 General qualitative inquiry with semi-structured interviews. N=24 practitioners. • Naqvi 2019 Phenomenological with semi-structured	Data from 7 studies reported that the lack of joined up IT systems between social care and other professionals acted as a barrier to sharing information. This led to issues around participant confidentiality, delays in care and extra work for social workers inputting data into two systems. Integrated planning did not happen because different aspects of support could not be coordinated. It was felt that effective information transfer was essential to enabling the integrated team to work to reduce acute admissions. “I think it’s really hard because I think the systems don’t help us . . . the fact that you have to anonymise all your emails and stuff . . . [It] can sometimes be confusing, particularly if you’ve got [service users] in the same team with the same initials.” (healthcare practitioner). [Quote: Farrington 2015 p.243] “We don’t share the same computer systems. So social care would have their own system that we don’t have access to and they don’t have access to our clinical system… Social care needs to be integrated into the medical care more electronically, for them to be here within GP surgeries so they aren’t picking up patients as an emergency - so they are ahead of the game so to speak.” (PM7) [Quote: Naqvi 2019 p.5]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

interviews. N=25 practitioners. • Vicary 2018 General qualitative inquiry (deliberative) with interactive discussions. N=40 practitioners and people who access services.						

PM: practice manager.
1. Minor concerns about methodological limitations as per CASP qualitative checklist.
2. Studies together offered some rich data.
3. Moderate concerns about methodological limitations as per CASP qualitative checklist.
4. Studies together offered moderately rich data.

Table 22: Evidence summary profile (GRADE-CERQual) for theme E1.7 Lack of resources

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Theme E1.7 - Lack of resources						
7 studies • Abendstern 2014 General qualitative inquiry with free text survey responses. N=225 practitioners • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services. • Krayer 2018 General qualitative inquiry with interviews and focus groups. N=55 practitioners. • Naqvi 2019	Data from 7 studies reported that a lack of financial resource was a barrier to successful integrated working. Practitioners from health, social care and police services all reported on the implications of a lack of funding, which meant that integrated services were poorly designed and remained fragmented. It was reported that the benefits of the social worker in an integrated team had not been realised, and a reported waste of skills . This had an impact on the delivery of services as resources are not in place to deliver the statutory responsibilities and key services. "The Care Act sounds great but the reality it cannot be delivered within the current climate." (social worker). [Quote: Phillipowsky 2018 p.44] "You know, there's sixteen thousand less officers in the country than there were 4 years ago, so we are saying "no that's your role, you do tha.t" (ASB_I.35,	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Phenomenological with semi-structured interviews. N=25 practitioners. • Phillipowsky 2018 General qualitative inquiry (interpretive) with free text questionnaire responses. N=41 practitioners. • Phillipowsky 2020 General qualitative inquiry (interpretive) with semi-structured interviews. N=6 practitioners. • Round 2018 General qualitative inquiry with semi-structured interviews and focus groups. N=31 practitioners	Police). [Quote: Krayer 2018 p.438] "We have integrated in name and where staff are based only. austerity. . . really impacts on integration." (nurse 1) (Austerity) "Yes, I think it has a huge impact now, I think social care they make it feel like it's your problem. We are questioned how many times do you have to visit." (social worker 3) [Quotes: Phillipowsky 2020 p.69]					

1. Minor concerns about methodological limitations as per CASP qualitative checklist.

Table 23: Evidence summary profile (GRADE-CERQual) for theme E1.8 Lack of shared understanding

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Theme E1.8 - Lack of shared understanding						
9 studies • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services.	Data from 9 studies suggested that a lack of understanding of the roles and responsibilities of different professionals created barriers to successful integrated working. Not understanding the roles of different professionals within integrated teams was reported to create inter-organisational conflict by the perceived 'offloading' of responsibilities. It was also suggested that differences in approaches to care, risk and recovery and a lack of understanding of these across the different professionals, led to a lack of trust and the perception that adults in need	Moderate concerns[1]	Minor concerns[2]	No or very minor concerns	No or very minor concerns	MODERATE

• Beresford 2019 General qualitative inquiry with interviews. N=24 practitioners. • Joseph 2019 General qualitative inquiry with focus groups. N=101 practitioners. • Krayer 2018 Study design with data collection method. N= • Mangan 2014 General qualitative inquiry with semi-structured interviews. N=12 practitioners. • Mitchell 2020 General qualitative inquiry with semi-structured interviews. N=24 practitioners. • Naqvi 2019 Phenomenological with semi-structured interviews. N=25 practitioners. • Phillipowsky 2020 General qualitative inquiry (interpretive) with semi-structured interviews. N=6 practitioners. • Round 2018 General qualitative inquiry with semi-structured interviews and focus groups. N=31 practitioners	of support were being put at risk. “And it’s really hard, I think sometimes, because we sometimes get some very angry people [police] on the phone saying “Well, we can’t do that, you’re asking us to do something that would be a breach of duty for us. You know, I don’t care if they’ve [patient] signed a care plan, it’s not our care plan and we don’t know what to do.” And you are stuck in a really challenging situation then.” (ASB_I.22, Mental Health). [Quote: Krayer 2018 p.438] “Well I think the first thing is that we have statutory responsibilities. So, I think it's a big learning curve for our health colleagues to understand the importance of that, that we are guided by legal requirements, we're not just doing it because somebody thought it was a good idea that somebody should have a care package.” (operational social care, area 2, interviewee a). [Quote: Mitchell 2020 p.7] A lack of shared understanding led to inappropriate referrals and professionals did not understand the roles of services. This led to delays in referrals, and also an underutilisation of available services. “.. our re-ablement service, which is one of our key services to keep people out of residential care, GPs either aren’t comfortable about what that’s to do with or they’ve even been misinformed to think that it’s oversubscribed and therefore there’s no point applying to it because they won’t be able to get the service.” (social care). “...they tend to send inappropriate referrals about .. things like housing and potholes and drop kerbs and they send all that to social care.” (social care). [Quotes: Mangan 2014 p.55-56] “Sometimes what we find is that there's this amazing service and we knew nothing about it.” (GP1). [Quote: Naqvi 2019 p.3]					

1. Moderate concerns about methodological limitations as per CASP qualitative checklist.
2. Some evidence is ambiguous or contradictory without a credible explanation for differences.

Table 24: Evidence summary profile (GRADE-CERQual) for theme E1.9 – Lack of time

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Theme E1.9 – Lack of time						
3 studies • Naqvi 2019 Phenomenological with semi-structured interviews. N=25 practitioners. • Round 2018 General qualitative inquiry with semi-structured interviews and focus groups. N=31 practitioners • Taylor 2018 General qualitative inquiry with semi-structured interviews. N=33 practitioners and people who access services.	Data from 3 studies reported that a lack of time was a barrier to successful integrated working with social workers. It was recognised that whilst taking a holistic approach to care was valued, more time was required to carry out specific interventions such as 'lengthy' holistic assessments. More time was also required to enable participation in integrated meetings. [Quote: Round 2018 p.301] "There is no blocked off time… they have these meetings in the middle of surgeries, 10 o'clock in the morning, I can't just leave the patients for one and a half hours and go somewhere." (GP8). [Quote: Naqvi 2019 p.4]	Minor concerns[1]	No or very minor concerns	Minor concerns[2]	Moderate concerns[3]	LOW

1. Minor concerns about methodological limitations as per CASP qualitative checklist.
2. Studies together offered moderately rich data.
3. Most evidence is from a substantially different context to the review question (Taylor 2018 refers to an integrated team with case managers – these are assumed to be social workers but the paper does not report social worker membership specifically).

Table 25: Evidence summary profile (GRADE-CERQual) for theme E1.10 – Lack of training

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Theme E1.10 – Lack of training						
2 studies • Bailey 2012 Ethnographic with data semi-structured interviews and team meeting observations. N=24 practitioners. • Beresford 2019 General qualitative inquiry with interviews. N=24 practitioners.	Data from 2 studies highlighted that a lack of training in integrated teams was a barrier to successful working. As a result of working within the new, integrated team, participants recognised the need for training to enable them to work in potentially different ways or in different specialisms. "'. . . they do have the basic video on dementia . . . but it's not enough for, we need specific training on reablement with dementia . . . 'cos if you don't understand dementia then you're not gonna know what to do . . . to reable them." [Quote: Beresford 2019 p.98]	Minor concerns[1]	No or very minor concerns	Moderate concerns[2]	No or very minor concerns	MODERATE

1. Minor concerns about methodological limitations as per CASP qualitative checklist
2. Studies together offered some rich data

Overarching theme E2- Facilitators of integrated working

Table 26: Evidence summary profile (GRADE-CERQual) for theme E2.1 – Co-location

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Theme E2.1 – Co-location						
5 studies • Abendstern 2016 General qualitative inquiry with semi-structured interviews. N=21 practitioners. • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services. • Joseph 2019 General qualitative inquiry with focus groups. N=101 practitioners. • Mitchell 2020 General qualitative inquiry with semi-structured interviews. N=24 practitioners • Phillipowsky 2020 General qualitative inquiry (interpretive) with semi-structured interviews. N=6 practitioners.	Data from 5 studies suggested that co-location of practitioners enabled successful integrated working. Co-location was reported to lead to faster referrals and responses from social workers. Being co-located was also reported to improve the relationships and trust between colleagues and organisations. “You are referring to a colleague, which is a lot quicker because you are not sending it out of the office, onto a waiting list” (manager of health staff). “I think the integration for the service user has possibly made it quicker . . . for different disciplines to become involved . . . because we haven’t got an external referral system . . ..You can come back and you can have the discussion . . . so that process has quickened up now because it’s all within the team.” (social worker, team C). [Quotes: Abendstern 2016 p.72] ““…co-locating, sharing the same building together, and in order for me to have district nurses information, or in order for me to have information from the GP if I am in the same place as them, and they know that…yes, this is way forward, part of integration, I think, that would make it very easy.” (operational social care, area 3, interviewee c). [Quote: Mitchell 2020 p.6]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

1. Minor concerns about methodological limitations as per CASP qualitative checklist.

Table 27: Evidence summary profile (GRADE-CERQual) for theme E2.2 – Experiences of integrated working

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Sub-theme E2.2.1 – Shared learning						
6 studies • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services. • Krayer 2018 General qualitative inquiry with interviews and focus groups. N=55 practitioners. • Phillipowsky 2018 General qualitative inquiry (interpretive) with free text questionnaire responses. N=41 practitioners. • Round 2018 General qualitative inquiry with semi-structured interviews and focus groups. N=31 practitioners • Sheaff 2015 General qualitative inquiry with interviews. N=11 practitioners. • Taylor 2018 General qualitative inquiry with semi-structured interviews. N=33 practitioners and	Data from 6 studies reporting on the experiences of integrated working, suggested that sharing knowledge between different professionals within a team, contributed to successful integration and enabled a holistic approach to care. "We learnt so much about each other, adult social care and health, because we were together for several years [. . .]." (nurse manager). [Quote: Sheaff 2015 p.68]	Minor concerns[1]	Minor concerns[2]	Minor concerns[3]	Minor concerns[4]	MODERATE

people who access services.						

1. Minor concerns about methodological limitations as per CASP qualitative checklist.
2. Some evidence is ambiguous or contradictory without a credible explanation for differences.
3. Studies together offered moderately rich data.
4. Some evidence is from a substantially different context to the review question (Taylor 2018 refers to an integrated team with case managers – these are assumed to be social workers but the paper does not report social worker membership specifically).

Table 28: Evidence summary profile (GRADE-CERQual) for theme E2.3 – Information sharing

Study information	**Description of review finding**	**CERQual Quality Assessment**				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Sub-theme E2.3.1 – Joined up IT systems						
3 studies • Bower 2018 General qualitative inquiry with interviews. N=59 practitioners, people who access services, and carers of people who access services. • Levin 2019 General qualitative inquiry with semi-structured interviews and focus groups. N=25 practitioners. • Round 2018 General qualitative inquiry with semi-structured interviews and focus groups. N=31 practitioners	Data from 3 studies reported that IT systems that allowed sharing of information between health and social care was critical to successful integrated working. "IT changes have helped and have now been rolled out across general practices." [Quote: Round 20118 p.301]	Moderate concerns[1]	No or very minor concerns	Minor concerns[2]	No or very minor concerns	MODERATE

Sub-theme E2.3.2 – Formal and informal methods of information sharing						
4 studies • Abendstern 2016 General qualitative inquiry with semi-structured interviews. N=21 practitioners. • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services. • Farrington 2015 General qualitative inquiry with interviews. N=24 practitioners. • Sonola 2013 General qualitative inquiry with semi-structured interviews and team meeting observations. N=14 practitioners.	Data from 4 studies suggested that both formal and informal methods of information sharing between the different professional groups, helped to facilitate integrated working. Formal methods of information sharing such as team meetings were considered useful ways of maintaining links with different professionals. Informal methods such as telephone calls or in-person conversations were also considered helpful. Having a range of methods for information sharing was reported to overcome any barriers created by a lack of integrated IT systems. "[W]e do formally meet and have kind of multidisciplinary discussions about [service users] . . . I think it's really important for the team to have a view of what someone's problem is and how to help them . . . in a formal kind of way, get it in black and white." (healthcare practitioner. "I think people are always open to somebody just walking over and saying can I have a quick word with you about this". Healthcare practitioner). [Quotes: Farrington 2015 p.244]	Moderate concerns[1]	No or very minor concerns	Minor concerns[2]	No or very minor concerns	MODERATE

IT: information technology.
1. Moderate concerns about methodological limitations as per CASP qualitative checklist
2. Studies together offered moderately rich data

Table 29: Evidence summary profile (GRADE-CERQual) for theme E2.4 – Joint training opportunities

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Theme E2.4 – Joint training opportunities						
3 studies • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services. • Joseph 2019 General qualitative inquiry with focus groups. N=101 practitioners. • Levin 2019 General qualitative inquiry with semi-structured interviews and focus groups. N=25 practitioners.	Data from 3 studies reported that joint training was beneficial to integrated working as it promoted a holistic view of care, and enabled the sharing of best practice. "It's very much presenting the whole person back [as] an individual case study, and how the individual elements affect the outcome of what we're doing and the goals that we're working towards and whether they're achieved or not achieved." (NRT9B). [Quote: Aspinal 2014 p.45]	Moderate concerns[1]	Minor concerns[2]	Minor concerns[3]	No or very minor concerns	MODERATE

1. Moderate concerns about methodological limitations as per CASP qualitative checklist.
2. Some evidence is ambiguous or contradictory without a credible explanation for differences.
3. Studies together offered moderately rich data.

Table 30: Evidence summary profile (GRADE-CERQual) for theme E2.5 Retaining the social work identity

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	**Coherence of finding**	**Adequacy**	**Relevance of evidence**	**Overall confidence**
Theme E2.5 – Retaining the social work identity						
5 studies • Abendstern 2016 General qualitative inquiry with semi-structured interviews. N=21 practitioners. • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services. • Bailey 2012 Ethnographic with data semi-structured interviews and team meeting observations. N=24 practitioners. • Mitchell 2020 General qualitative inquiry with semi-structured interviews. N=24 practitioners. • Vicary 2018 General qualitative inquiry (deliberative) with interactive discussions. N=40 practitioners and people who access services.	Data from 5 studies reported that retaining professional identity was important for successful integrated working, as having a social worker's input in the team led to greater awareness of social care resources and locally available services. Studies also reported that maintaining the social worker role brought a "different dimension" to ways of working that supported a person centred approach and enhanced the holistic team perspective. "The profession uses a 'social care model of illness and recovery', focused on 'people's strengths and the strengths of their own community networks' operating from an 'ethic of social justice' and 'widen[ing] the perspective from . . . a medical model." (social worker, team A). [Quotes: Abendstern 2016 p.69] "I think an integrated team is really, really good, working kind of side by side, but I don't think we need to be doing the same job because I think we're losing the kind of individual identity's of each profession." (OT 1). "It's important to get both. I mean yes the medication will stop the mood, but the social model in mental health that means help them to build confidence to go out and meet the people and to live lives to the full. I think it's important to work together both medical and social model." (MHSW 1). [Quotes: Bailey 2012 p.1121-1127]	Minor concerns[1]	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

MHSW: mental health social worker; OT: occupational therapist.
1. Minor concerns about methodological limitations as per CASP qualitative checklist.

Table 31: Evidence summary profile (GRADE-CERQual) for theme E2.6 Shared visions and aims

Study information	Description of review finding	CERQual Quality Assessment				
		Methodological limitations	Coherence of finding	Adequacy	Relevance of evidence	Overall confidence
Theme E2.6 – Shared visions and aims						
2 studies • Aspinal 2014 General qualitative inquiry with semi-structured interviews and focus groups. N=66 practitioners, people who access services and carers of people who access services. • Sonola 2013 General qualitative inquiry with semi-structured interviews and team meeting observations. N=14 practitioners.	Data from 2 studies suggested that having shared visions and aims helped to promote integrated working because it led to an increased understanding between organisations. "We [physical and mental health] existed in a slightly parallel universe and there was a yearning for each other's input." (clinician). [Quote: Sonola 2013 p.17]	Moderate concerns[1]	No or very minor concerns	Moderate concerns[2]	No or very minor concerns	LOW
Sub-theme E2.6.1 – Formal agreements						
3 studies • Bower 2018 General qualitative inquiry with interviews. N=59 practitioners, people who access services, and carers of people who access services. • Krayer 2018 General qualitative inquiry with interviews and focus groups. N=55 practitioners • Levin 2019 General qualitative inquiry with semi-	Data from 3 studies suggested that having formal agreements in place facilitated integrated working. It was reported that formal agreements helped with decision making and to overcome disagreements and challenges because the agreements stated how commissioners and providers would work together. Joint accountability frameworks set out in formal agreements, as well as legal requirements protecting vulnerable people were said to make it hard to neglect responsibilities. "So it's a big deal, you know, you sort of owe the other stakeholders once you've agreed this. Because people will walk away without any of that control, they always have, and will do. So hence there has to be an overbearing focus on governance, it dominates everything." (ID 3 senior CCG manager). [Quote: Bower 2018 p.56]	Moderate concerns[1]	No or very minor concerns	Minor concerns[3]	No or very minor concerns	MODERATE

structured interviews and focus groups. N=25 practitioners.						

CCG: clinical commissioning group.
1. Moderate concerns about methodological limitations as per CASP qualitative checklist.
2. Studies together offered some rich data.
3. Studies together offered moderately rich data.

Appendix G Economic evidence study selection

Study selection for review question E1: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

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 E1: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

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

Appendix I Economic model

Economic model for review question E1: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

No economic analysis was conducted for this review question.

Appendix J Excluded studies

Excluded studies for review question E1: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

Table 32: Excluded studies and reasons for their exclusion

Study	Reason for exclusion
Embrace, integrated primary care for older adults, Nederlands Tijdschrift voor Geneeskunde, 161, 2017	Ineligible study design - conference abstract
Evaluation design of Urban Health Centres Europe (UHCE): preventive integrated health and social care for community-dwelling older persons in five European cities, BMC geriatr, 17, 209, 2017	Ineligible study design - protocol (excluded full text, Franse 2017)
Actrn,, Efficacy and cost-effectiveness of a community based model of care for older patients with complex needs: a study protocol for a multicentre randomized controlled trial using a stepped wedge cluster design, http://www.who.int/trialsearch/Trial2.aspx?TrialID=ACTRN12617000198325, 2017	Ineligible study design - study protocol (no results published)
Alvarez, R., et al., The social work role in reducing 30-day readmissions: the effectiveness of the Bridge Model of transitional care, Journal of gerontological social work, 59, 222-227, 2016	Ineligible country – study conducted in the US
Alvarez-Jimenez, M., Bendall, S., Koval, P., Rice, S., Cagliarini, D., Valentine, L., D'Alfonso, S., Miles, C., Russon, P., Penn, D. L., et al.,, HORYZONS trial: protocol for a randomised controlled trial of a moderated online social therapy to maintain treatment effects from first-episode psychosis services, BMJ Open, 9, e024104, 2019	Ineligible study design - study protocol (no results published)
Anderson, S. E., Hennessy, C., Cornes, M., Manthorpe, J., Developing inter-disciplinary and inter-agency networks: reflections on a ‘community of practice’ approach, Advances in Dual Diagnosis, 6, 132-144, 2013	Ineligible study design - non-systematic review (case study reporting reflections and evaluation of practitioner-led programme aimed at service integration)
Ashcroft, R., et al., Social work's scope of practice in primary mental health care: a scoping review, British Journal of Social Work, 49, 318-334, 2019	Systematic review - references checked but none meet the PICO criteria
Baginsky, M., Social work in hiding? The views of other professionals on social workers and working with social workers, Research, Policy and Planning, 30, 2014	Ineligible population - professionals' perceptions of social workers working in statutory children's services; not integrated working with adults with complex needs
Bailey, D., Mutale, G., Measuring the effectiveness of embedding social workers in integrated primary health care teams working with older adults with complex needs, 69, bjgp19X702821, 2019	Ineligible study design - conference abstract
Beacon, A., Practice-integrated care teams - learning for a better future: Managing	Ineligible study design – non-systematic review (case study)

Study	Reason for exclusion
Community Care, Journal of Integrated Care, 23, 74-87, 2015	
Beresford, B., Mann, R., Parker, G., Kanaan, M., Faria, R., Rabiee, P., Weatherly, H., Clarke, S., Mayhew, E., Duarte, A., Laver-Fawcett, A., Aspinal, F., Health Services and Delivery Research, 2019	Ineligible study design - cohort study, when observational designs were not considered due to sufficient experimental studies
Bhattacharyya, O., Shaw, J., Sinha, S., Gordon, D., Shahid, S., Wodchis, W. P., Anderson, G., Innovative Integrated Health and Social Care Programs in Eleven High-Income Countries, Health affairs (Project Hope), 39, 689-696, 2020	Ineligible study design – survey data
Boongird, C., Thamakaison, S., Krairit, O., Impact of a geriatric assessment clinic on organizational interventions in primary health-care facilities at a university hospital, Geriatrics and Gerontology International, 11, 204-210, 2011	Ineligible country – study conducted in Thailand
Bower, P., et al., Improving care for older people with long-term conditions and social care needs in Salford: the CLASSIC mixed-methods study, including RCT, Health Services and Delivery Research, 6, 2018	Ineligible study design - cohort design, when observational designs were not considered due to sufficient experimental studies
Brugha, T. S., Taub, N., Smith, J., Morgan, Z., Hill, T., Meltzer, H., Wright, C., Burns, T., Priebe, S., Evans, J., Fryers, T., Predicting outcome of assertive outreach across England, Social psychiatry and psychiatric epidemiology, 47, 313-322, 2012	Ineligible study design - observational study, when observational designs were not considered due to sufficient experimental studies
Bywaters, P., McLeod, E., Fisher, J., Cooke, M., Swann, G., Good intentions, increased inequities: Developing social care services in Emergency Departments in the UK, Health and Social Care in the Community, 19, 460-467, 2011	Ineligible study design - audit (to identify number of social care interventions located or co-located in emergency departments across the UK)
Cameron, A., Lart, R., Bostock, L., Coomber, C., Factors that promote and hinder joint and integrated working between health and social care services: a review of research literature, Health & social care in the community, 22, 225-233, 2014	Systematic review - references checked but none meet the PICO criteria
Care Quality Commission, Oxfordshire: local system review report, 2018	Ineligible study design - non-systematic review (Care Quality Commission report)
Carpenter, J., Luce, A., Wooff, D., Predictors of outcomes of assertive outreach teams: a 3-year follow-up study in North East England, Social psychiatry and psychiatric epidemiology, 46, 463-471, 2011	Ineligible study design - observational study, when observational designs were not considered due to sufficient experimental studies
Cassarino, M., Robinson, K., O'Shaughnessy, I., Smalle, E., White, S., Devlin, C., Quinn, R., Trepel, D., Boland, F., Ward, M. E., et al.,, A randomised controlled trial exploring the impact of a dedicated health and social care professionals team in the emergency department on the quality, safety, clinical and cost-effectiveness of care for older adults: a study protocol, Trials, 20, 2019	Ineligible study design - study protocol (no results published)

Study	Reason for exclusion
Cassarino, M., et al., Impact of early assessment and intervention by teams involving health and social care professionals in the emergency department: a systematic review, PLoS ONE, 14, e0220709, 2019	Systematic review - references checked but none meet the PICO criteria
Challis, D., Abendstern, M., Clarkson, P., Hughes, J., Sutcliffe, C., Comprehensive assessment of older people with complex care needs: the multi-disciplinarity of the Single Assessment Process in England, Ageing & Society, 30, 1115-1134, 2010	Ineligible study design – survey data assessing staff mix involved in multi-disciplinary needs assessment
Cheetham, M., Van der Graaf, P., Khazaeli, B., Gibson, E., Wiseman, A., Rushmer, R., "It was the whole picture" a mixed methods study of successful components in an integrated wellness service in North East England, BMC health services research, 18, 200, 2018	Ineligible study design - Community level health and wellbeing programme (local authority departments and NHS Trusts - not clear on social worker involvement)
Clarkson, P., Brand, C., Hughes, J., Challis, D., Integrating assessments of older people: examining evidence and impact from a randomised controlled trial, Age and ageing, 40, 388, 2011	Ineligible study design - research letter assessing a randomised controlled trial conducted pre-2010
Craig, S., et al., Self-reported patient psychosocial needs in integrated primary health care: a role for social work in interdisciplinary teams, Social work in health care, 55, 41-60, 2016	Ineligible study design - non-comparative study (survey)
Cronqvist, A., Sundh, K., On collaboration between nurses and social workers in the service of older people living at home. A critical literature review, International Practice Development Journal, 3, 2013	Systematic review - references checked but none meet the PICO criteria
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 intervention – not a social work approach to integrated working (two-person team involving a nurse case manager and primary care physician)
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 systematic review - references checked but none meet the PICO criteria
Dore-Gauthier, V., Miron, J. P., Jutras-Aswad, D., Ouellet-Plamondon, C., Abdel-Baki, A., Specialized assertive community treatment intervention for homeless youth with first episode psychosis and substance use disorder: A 2-year follow-up study, Early Intervention in Psychiatry, 14, 203-210, 2020	Ineligible study design - observational study, when observational designs were not considered due to sufficient experimental studies
Ede, V., Okafor, M., Kinuthia, R., Belay, Z., Tewolde, T., Alema-Mensah, E., Satcher, D., An Examination of Perceptions in Integrated Care Practice, Community mental health journal, 51, 949-961, 2015	Ineligible country – study condeucted in the US

Study	Reason for exclusion
Eklund, K., Wilhelmson, K., Gustafsson, H., Landahl, S., Dahlin-Ivanoff, S., One-year outcome of frailty indicators and activities of daily living following the randomised controlled trial: "Continuum of care for frail older people", BMC geriatrics, 13, 76, 2013	Ineligible outcomes - reports level of frailty, activities of daily living, mini mental state and self-rated health
Erker, R., Alefan, Q., Goodridge, D., Crawley, A., Rabbitskin, N., Bighead, S., Blackburn, D., Evaluation of a medication safety and adherence program within a First Nations community in Saskatchewan, Canada, Journal of the American Pharmacists Association., 2020	Ineligible population – focused on pharmacist and medical team
Farris, G., Sircar, M., Bortinger, J., Moore, A., Krupp, J. E., Marshall, J., Abrams, A., Lipsitz, L., Mattison, M., Extension for Community Healthcare Outcomes--Care Transitions: Enhancing Geriatric Care Transitions Through a Multidisciplinary Videoconference, Journal of the American Geriatrics Society, 65, 598-602, 2017	Ineligible country – study conducetd in Mexico
Fouche, C., Butler, R., Shaw, J., Atypical alliances: the potential for social work and pharmacy collaborations in primary health care delivery, Social Work in Health Care, 52, 789-807, 2013	Ineligible study design - non-systematic review references checked but none meet the PICO criteria
Franse, C. B., Voorham, A. J. J., van Staveren, R., Koppelaar, E., Martijn, R., Valia-Cotanda, E., Alhambra-Borras, T., Rentoumis, T., Bilajac, L., Marchesi, V. V., Rukavina, T., Verma, A., Williams, G., Clough, G., Garces-Ferrer, J., Mattace Raso, F., Raat, H., Evaluation design of Urban Health Centres Europe (UHCE): preventive integrated health and social care for community-dwelling older persons in five European cities, BMC geriatrics, 17, 209, 2017	Ineligible study design - protocol
Fraser, M. W., Elephant in the room: inter-professional barriers to integration between health and social care staff, Journal of Integrated CareJ Integr Care, 27, 64-72, 2019	Ineligible study - survey data (addressing barriers to integrated working and joint assessments)
Goeman, D., Howard, J., Ogrin, R., Implementation and refinement of a community health nurse model of support for people experiencing homelessness in Australia: A collaborative approach, BMJ Open, 9, 2019	Ineligible intervention - not a social work approach to integrated working (community health nurse)
Goodwin, N., et al., Co-ordinated care for people with complex chronic conditions: key lessons and markers for success, 33, 2013	Ineligible study design - non-systematic review (selected case studies)
Harcourt, D., McDonald, C., Cartlidge-Gann, L., Burke, J., Working Together to Connect Care: a metropolitan tertiary emergency department and community care program, Australian health review : a publication of the Australian Hospital Association, 42, 189-195, 2018	Ineligible study design - non-systematic review (also, description of non-social worker integrated working)
Hayes, S. L., Mann, M. K., Morgan, F. M., Kelly, M. J., Weightman, A. L., Collaboration between local health and local government agencies for health improvement, Cochrane Database of Systematic Reviews, 2012	Cochrane systematic review - references checked but none meet the PICO criteria

Study	Reason for exclusion
Henderson, L., Bain, H., Allan, E., Kennedy, C., Integrated health and social care in the community: A critical integrative review of the experiences and well-being needs of service users and their families, Health & social care in the community., 15, 2020	Ineligible study design - Integrative review.
Holwerda, A., Fokkens, A. S., Engbers, C., Brouwer, S., Collaboration between mental health and employment services to support employment of individuals with mental disorders, Disability & Rehabilitation, 38, 1250-6, 2016	Ineligible intervention - not a social work approach to integrated working
Howard, W., Tabard forensic service: an independent report of an integrated model of community forensic mental health provision, 2017	Ineligible study design – Non-systematic review (narrative discussion paper)
Hu, M., The impact of an integrated care service on service users: the service users' perspective, Journal of Health Organization and Management, 28, 495-510, 2014	Ineligible study design - qualitative and non-comparative survey data
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 study design - retrospective before-and-after study when observational designs were not considered due to sufficient experimental studies
Hwang, S. W., Stergiopoulos, V., O'Campo, P., Gozdzik, A., Ending homelessness among people with mental illness: The at Home/Chez Soi randomized trial of a Housing First intervention in Toronto, BMC Public Health, 12, 2012	Ineligible study - description and baseline characteristics
Isrctn,, Evaluation of a person-centred multidimensional interdisciplinary rehabilitation program for community dwelling older people with dementia and their informal primary caregivers, http://www.who.int/trialsearch/Trial2.aspx?TrialID=ISRCTN59155421, 2015	Ineligible study design - study protocol (no results published)
Isrctn,, Engager: evaluation of a collaborative care intervention for offenders, http://www.who.int/trialsearch/Trial2.aspx?TrialID=ISRCTN11707331, 2016	Ineligible study design - study protocol (no results published)
Isrctn,, Community navigators study, http://www.who.int/trialsearch/Trial2.aspx?TrialID=ISRCTN10771821, 2017	Ineligible study design - study protocol (no results published)
Isrctn,, PARTNERS2: a cluster randomised control trial of a model of collaborative care for people with a diagnosis of bipolar, schizophrenia or other psychoses, http://www.who.int/trialsearch/Trial2.aspx?TrialID=ISRCTN95702682, 2017	Ineligible study design - clinical trial (no effectiveness results published)
Isrctn,, Assertive outreach treatment for alcohol related admissions, http://www.who.int/trialsearch/Trial2.aspx?TrialID=ISRCTN67000214, 2016	Ineligible study design - study protocol (no results published)

Study	Reason for exclusion
Janse, B., Huijsman, R., Looman, W. M., Fabbricotti, I. N., Formal and informal care for community-dwelling frail elderly people over time: A comparison of integrated and usual care in the Netherlands, Health Soc Care Community, 26, e280-e290, 2018	Ineligible study design– before-and-after study when observational designs were not considered due to sufficient experimental studies
Jarrett, M., Thornicroft, G., Forrester, A., Harty, M., Senior, J., King, C., Huckle, S., Parrott, J., Dunn, G., Shaw, J., Continuity of care for recently released prisoners with mental illness: a pilot randomised controlled trial testing the feasibility of a Critical Time Intervention, Epidemiology and psychiatric sciences, 21, 187-193, 2012	Ineligible intervention – not a social work approach to integrated working (psychiatric nurse managing critical time intervention to link prisoners with community support on release from prison)
Kidd, S. A., Vitopoulos, N., Frederick, T., Leon, S., Wang, W., Mushquash, C., McKenzie, K., Trialing the Feasibility of a Critical Time Intervention for Youth Transitioning Out of Homelessness, American Journal of Orthopsychiatry, 2020	Ineligible intervention – not a social work approach to integrated working (Housing Outreach Program-Collaboration intervention involved peer support workers, 2 transitional case managers; unclear whether adults with complex needs)
Lee, S., De Castella, A., 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, Australian and New Zealand Journal of Psychiatry, 44, 505-512, 2010	Ineligible study design - evaluation of an integrated homeless mental health initiative
Lennox, C., Kirkpatrick, T., Taylor, R. S., Todd, R., Greenwood, C., Haddad, M., Stevenson, C., Stewart, A., Shenton, D., Carroll, L., et al.,, Pilot randomised controlled trial of the ENGAGER collaborative care intervention for prisoners with common mental health problems, near to and after release, Pilot and feasibility studies, 4, 2018	Ineligible intervention - not a social work approach to integrated working (ENGAGER supervisor and practitioner meeting with individuals being released from prison and liaising with other organisations and agencies)
Lin, M. P., Blanchfield, B. B., Kakoza, R. M., Vaidya, V., Price, C., Goldner, J. S., Higgins, M., Lessenich, E., Laskowski, K., Schuur, J. D., ED-based care coordination reduces costs for frequent ED users, American Journal of Managed Care, 23, 762-766, 2017	Ineligible country – study conducted in US
Macadam, M., Progress toward integrating care for seniors in Canada: "We have to skate toward where the puck is going to be, not to where it has been.",Int J Integr Care, 11 Spec Ed, e016, 2011	Ineligible study design - non-systematic review, references checked but none meet the PICO criteria
Malik, B., Wells, J., Hughes, J., Clarkson, P., Keady, J., Young, A., Challis, D., Complex care needs and devolution in Greater Manchester: a pilot study to explore social care innovation in newly integrated service arrangements for older people, Australian health review : a publication of the Australian Hospital Association., 13, 2020	Ineligible study design – non-systematic review (case studies reporting the level of integration between different health and social care teams)
Mann, J., Quigley, R., Harvey, D., Tait, M., Williams, G., Strivens, E., OPEN ARCH: Integrated care at the primary-secondary interface for the community-dwelling older	Ineligible intervention - not a social work approach to integrated working (allied health or nursing professional and a geriatrician); case reports

Study	Reason for exclusion
person with complex needs, Australian Journal of Primary Health, 26, 104-108, 2020	
Marcusson, J., Nord, M., Johansson, M. M., Alwin, J., Levin, LÅ, Dannapfel, P., Thomas, K., Poksinska, B., Sverker, A., Olaison, A., et al.,, Proactive healthcare for frail elderly persons: study protocol for a prospective controlled primary care intervention in Sweden, BMJ Open, 9, e027847, 2019	Ineligible study design - study protocol (no results published)
Maslin-Prothero, S. E., Bennion, A. E., Integrated team working: a literature review, International Journal of Integrated Care [Electronic Resource], 10, e043, 2010	Systematic review - references checked but none meet the PICO criteria
Mason, A., Goddard, M., Weatherly, H., Chalkley, M., Integrating funds for health and social care: An evidence review, Journal of Health Services Research and Policy, 20, 177-188, 2015	Systematic review - references checked but none meet the PICO criteria
McAiney, C. A., Hillier, L. M., Paul, J., McKinnon Wilson, J., Tersigni Phelan, A., Wagner, F., O'Connor, S., Improving the seniors' transition from hospital to the community: a case for intensive geriatric service workers, International psychogeriatrics, 29, 149-163, 2017	Ineligible study design - observational study with no comparator, when observational designs were not considered due to sufficient experimental studies
McGregor, J., Mercer, S. W., Harris, F. M., Health benefits of primary care social work for adults with complex health and social needs: a systematic review, Health & Social Care in the Community, 26, 1-13, 2018	Systematic review - references checked but none meet the PICO criteria
Miller, E., Cameron, K., Challenges and benefits in implementing shared inter-agency assessment across the UK: A literature review, Journal of interprofessional care, 25, 39-45, 2011	Ineligible study design - non-systematic review checked but none meet the PICO criteria
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 observational study, Substance abuse treatment, prevention, and policy, 12, 26, 2017	Ineligible study design - observational study, when observational designs were not considered due to sufficient experimental studies
Mueller-Stierlin, A. S., Helmbrecht, M. J., Herder, K., Prinz, S., Rosenfeld, N., Walendzik, J., Holzmann, M., Dinc, U., Schutzwohl, M., Becker, T., et al.,, Does one size really fit all? The effectiveness of a non-diagnosis-specific integrated mental health care program in Germany in a prospective, parallel-group controlled multi-centre trial, BMC Psychiatry, 17, 283, 2017	Ineligible intervention - unclear whether social worker involvement (integrated mental health services in collaboration with health service providers; community-based multi-professional teams, psychiatric case management, crisis intervention via home treatment or beds in non-hospital Settings, family-oriented psychoeducation)
Nct,, The Whole Health Study: collaborative Care for OUD and Mental Health Conditions, https://clinicaltrials.gov/show/NCT04245423, 2020	Ineligible study design - study protocol (no results published)
Nct,, Implementation of Community-based Collaborative Management of Complex Chronic Patients,	Ineligible study design - study protocol (no results published)

Study	Reason for exclusion
https://clinicaltrials.gov/show/NCT02956395, 2016	
Nct,, Integrated Care Including Assertive Community Treatment in Early Psychosis, Https://clinicaltrials.gov/show/nct02037581, 2014	Ineligible study design - study protocol (no results published)
Nct,, Community-based Mental Health Care for People with Severe and Enduring Mental Ill Health (RECOVER-E), https://clinicaltrials.gov/show/NCT03892473, 2019	Ineligible study design - study protocol (no results published)
Nct,, Building Infrastructure for Community Capacity in Accelerating Integrated Care, https://clinicaltrials.gov/show/NCT04092777, 2019	Ineligible study design - study protocol (no results published)
Nct,, Community-based Mental Health Care for People with Severe and Enduring Mental Ill Health, https://clinicaltrials.gov/show/NCT03922425, 2019	Ineligible study design - study protocol (no results published)
Nct,, Integrated Care in Psychotic Disorders with Severe Mental Illness, https://clinicaltrials.gov/show/NCT01888627, 2013	Ineligible study design - study protocol (no results published)
Nct,, Feasibility Trial of an Acceptance and Commitment Therapy Intervention for Individuals Experiencing Homelessness, https://clinicaltrials.gov/show/NCT04243018, 2020	Ineligible study design - study protocol (no results published)
Nct,, Integrated Care & Patient Navigators for Latinos With Serious Mental Illness, https://clinicaltrials.gov/show/NCT02469714, 2015	Ineligible country – study conducted in the US
Nct,, Enhanced Primary Care for Elderly, https://clinicaltrials.gov/show/NCT03180606, 2017	Ineligible study design - study protocol (no results published)
Nct,, Community-based Mental Health Care for People with Severe and Enduring Mental Ill Health, https://clinicaltrials.gov/show/NCT03837340, 2019	Ineligible study design - study protocol (no results published)
Ntr,, Fit for Work' evaluation study: the effects of a multidisciplinary re-employment programme for persons with mental health problems, http://www.who.int/trialsearch/Trial2.aspx?TrialID=NTR3920, 2013	Ineligible study design - study protocol (no results posted)
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 - study protocol (publication excluded - Spoorenberg 2013)
Ntr,, Treatment effectiveness in multiproblem young adults, http://www.who.int/trialsearch/Trial2.aspx?TrialID=NTR5163, 2015	Ineligible study design - study protocol (publication Luijks 2017)
O'Neill, E. A., Ratliff, D., Collaborative care for individuals with bipolar disorder or schizophrenia	Systematic review - references checked checked but none meet the PICO criteria

Study	Reason for exclusion
and co-occurring physical health conditions: A systematic review, Social Work in Mental Health, 15, 705-729, 2017	
O'Donovan, J., Russell, K., Kuipers, P., Siskind, D., Elphinston, R. A., A Place to Call Home: Hearing the Perspectives of People Living with Homelessness and Mental Illness Through Service Evaluation, Community mental health journal, 55, 1218-1225, 2019	Ineligible study - survey data (on a transitional housing programme delivered by occupational therapists and rehabilitation therapy aides in collaboration with local social housing providers)
Osborne, S., et al., Cohort study of a specialist social worker intervention on hospital use for patients at risk of long stay, BMJ Open, 8, 2018	Ineligible study design - cohort study with historical controls, when observational designs were not considered due to sufficient experimental studies
Ostovari, M., Yu, D., Impact of care provider network characteristics on patient outcomes: Usage of social network analysis and a multi-scale community detection, PloS one, 14, 2019	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 shelter system, Prof Case Manag, 21, 34-42, 2016	Ineligible study design - non-comparative study
Powers, M., Schmitz, C., Moritz, M. B., Preparing social workers for ecosocial work practice and community building, Journal of Community Practice, 27, 446-459, 2019	Ineligible country – study conducted in the US
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 study design– before-and-after cohort study when observational designs were not considered due to sufficient experimental studies
Reeves, S., Pelone, F., Harrison, R., Goldman, J., Zwarenstein, M., Interprofessional collaboration to improve professional practice and healthcare outcomes, Cochrane Database of Systematic Reviews, 2017	Cochrane systematic review - references checked but none meet the PICO criteria
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 systematic review - references checked but none meet the PICO
Reilly, S., Planner, C., Gask, L., Hann, M., Knowles, S., Druss, B., Lester, H., Collaborative care approaches for people with severe mental illness, Cochrane Database of Systematic Reviews, 2013	Cochrane systematic review - references checked but none meet the PICO
Richards, D. A., Bower, P., Chew-Graham, C., Gask, L., Lovell, K., Cape, J., Pilling, S., Araya, R., Kessler, D., Barkham, M., Bland, J. M., Gilbody, S., Green, C., Lewis, G., Manning, C., Kontopantelis, E., Hill, J. J., Hughes-Morley, A., Russell, A., Clinical effectiveness and cost-effectiveness of collaborative care for	Ineligible intervention - not a social work approach to integrated working (clinical focus in people living with depression)

Study	Reason for exclusion
depression in UK primary care (CADET): A cluster randomised controlled trial, Health technology assessment, 20, 1-192, 2016	
Ritchie, C., Andersen, R., Eng, J., Garrigues, S. K., Intinarelli, G., Kao, H., Kawahara, S., Patel, K., Sapiro, L., Thibault, A., Tunick, E., Barnes, D. E., Implementation of an Interdisciplinary, Team-Based Complex Care Support Health Care Model at an Academic Medical Center: Impact on Health Care Utilization and Quality of Life, 11, e0148096, 2016	Ineligible country – study conducted in the US
Rowan, J., Wilberforce, M., Verbeek, H., Challis, D. J., Multi-agency working and implications for care managers: Managing Community Care, J Integr Care, 24, 56-66, 2016	Ineligible study design - questionnaires and diaries comparing single versus multi-agency work and job satisfaction outcomes
Roxby, S., Partnership in action: forging a new approach, Housing, Care and Support, 21, 99-107, 2018	Ineligible study design – non-systematic review (description of partnership programme with a focus on housing)
Rutman, D., Hubberstey, C., Poole, N., Schmidt, R. A., Van Bibber, M., Multi-service prevention programs for pregnant and parenting women with substance use and multiple vulnerabilities: Program structure and clients' perspectives on wraparound programming, BMC Pregnancy and Childbirth, 20, 2020	Ineligible study design - non-systematic review (discussion paper evaluating 8 different programmes for pregnant women at risk)
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 study design - pre-post intervention cohort study, when observational designs were not considered due to sufficient experimental studies
Sempe, L., Billings, J., Lloyd-Sherlock, P., Multidisciplinary interventions for reducing the avoidable displacement from home of frail older people: a systematic review, BMJ Open, 9, e030687, 2019	Systematic review - references checked but none meet the PICO criteria
Singer, S., Roick, J., Meixensberger, J., Schiefke, F., Briest, S., Dietz, A., Papsdorf, K., Mössner, J., Berg, T., Stolzenburg, J. U., et al.,, The effects of multi-disciplinary psycho-social care on socio-economic problems in cancer patients: a cluster-randomized trial, Supportive care in cancer, 26, 1851-1859, 2018	Ineligible intervention - not a social work approach to integrated working (stepped care provided by doctors, with referral to social workers where required); ineligible outcomes (finance and employment status)
Smith, L., Collaborative practice to support adults with complex needs: ESSS Outline, 43, 2018	Ineligible study design - non-systematic review
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 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	Ineligible outcomes - outcomes reported do not meet protocol eligibility criteria (prevalence and severity of individual health-related problems)
Spoorenberg, S. L., Uittenbroek, R. J., Middel, B., Kremer, B. P., Reijneveld, S. A., Wynia, K., Embrace, a model for integrated elderly care:	Ineligible study design - protocol

Study	Reason for exclusion
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	
Sserunkuma, J., Sin, J., Joined up thinking, Professional Social Work, 12-13, 2010	Ineligible study design - non-systematic review (discussion paper)
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 integrated working (focus on clinician led intervention)
Stokes, J., Kristensen, S. R., Checkland, K., Bower, P., Effectiveness of multidisciplinary team case management: difference-in-differences analysis, BMJ open, 6, e010468, 2016	Ineligible study design - observational study, when observational designs were not considered due to sufficient experimental studies
Strating, M. M. H., Broer, T., Van Rooijen, S., Bal, R. A., Nieboer, A. P., Quality improvement in long-term mental health: Results from four collaboratives, Journal of Psychiatric and Mental Health Nursing, 19, 379-388, 2012	Ineligible intervention - case studies; unclear whether social worker involvement
Strupp, J., Dose, C., Kuhn, U., Galushko, M., Duesterdiek, A., Ernstmann, N., Pfaff, H., Ostgathe, C., Voltz, R., Golla, H., Analysing the impact of a case management model on the specialised palliative care multi-professional team, Supportive care in cancer, 26, 673-679, 2018	Ineligible study design - observational before-and-after study when observational designs were not considered due to sufficient experimental studies
Svensson, B., Hansson, L., Lexen, A., Outcomes of clients in need of intensive team care in Flexible Assertive Community Treatment in Sweden, Nordic Journal of Psychiatry, 72, 226-231, 2018	Ineligible study design – before-and-after cohort study, when observational designs were not considered due to sufficient experimental studies
Tormey, S., Binions, L., Dunne, A., Soh, J., O'Connor, M., Kennelly, S., 211 A Novel Integrated Care Approach: Supporting Older Persons to Remain at Home, Age and ageing, 48, 2019	Ineligible study design - conference abstract
Tuggey, E. M., Lewin, W. H., A multidisciplinary approach in providing transitional care for patients with advanced cancer, 3, 139-43, 2014	Ineligible study design - non-systematic review (narrative discussion and case report)
Turner-Stokes, L., Pick, A., Nair, A., Disler, P. B., Wade, D. T., Multi-disciplinary rehabilitation for acquired brain injury in adults of working age, Cochrane Database of Systematic Reviews, 2015	Cochrane systematic review - references checked but none meet the PICO criteria
Uittenbroek, R. J., Spoorenberg, S. L., Brans, R., Middel, B., Kremer, B. P., Reijneveld, S. A., Wynia, K., Embrace, a model for integrated elderly care]. [Dutch, Tijdschrift voor gerontologie en geriatrie, 45, 92-104, 2014	Ineligible study design - conference abstract

Study	Reason for exclusion
Van der Marck, M. A., Bloem, B. R., Borm, G. F., Overeem, S., Munneke, M., Guttman, M., Effectiveness of multidisciplinary care for Parkinson's disease: A randomized, controlled trial, Movement Disorders, 28, 605-611, 2013	Ineligible study - not a social work approach to integrated working (movement disorders neurologist led)
van Orden, M. L., Deen, M. L., Spinhoven, P., Haffmans, J., Hoencamp, E., Five-Year Mental Health Care Use by Patients Referred to Collaborative Care or to Specialized Care, Psychiatric services (Washington, D.C.), 66, 840-844, 2015	Ineligible intervention - not a social work approach to integrated working (collaboration between GP and mental health professional)
Vasyushkina, M. A., The multidisciplinary case management team as an effective model for providing modern psychiatric care under compulsory treatment conditions, International Journal of Culture and Mental Health, 11, 120-121, 2018	Ineligible country – study conducted in Russia
Vestjens, L., Cramm, J. M., Birnie, E., Nieboer, A. P., Evaluating an integrated primary care approach to improve well-being among frail community-living older people: A theory-guided study protocol, BMC geriatrics, 18, 173, 2018	Ineligible study design - study protocol (no results published)
Viswanathan, U., Desai, S., Ramaiah, S., Improving health outcomes for black and minority ethnic communities through shared leadership, Ethnicity and Inequalities in Health and Social Care, 3, 44-48, 2010	Ineligible study design - non-systematic review (discussion paper describing improved leadership programme)
Vungkhanching, M., Tonsing, K. N., Social Workers' Perceived Role Clarity as Members of an Interdisciplinary Team in Brain Injury **Setting**s, Journal of social work in disability & rehabilitation, 15, 370-384, 2016	Ineligible country – study conducted in the US
Wahlbeck, K., Cresswell-Smith, J., Haaramo, P., Parkkonen, J., Interventions to mitigate the effects of poverty and inequality on mental health, Soc Psychiatry Psychiatr Epidemiol, 52, 505-514, 2017	Ineligible study design - non-systematic review
Webb, L., Witham, G., Ford, T., The provision of a mental health practitioner within a young people's substance misuse clinical team, Mental Health and Substance Use: Dual Diagnosis, 5, 254-267, 2012	Ineligible study design - qualitative
Weinstein, L. C., Lanoue, M. D., Plumb, J. D., King, H., Stein, B., Tsemberis, S., A primary care-public health partnership addressing homelessness, serious mental illness, and health disparities, Journal of the American Board of Family Medicine: JABFM, 26, 279-87, 2013	Ineligible country –study conducted in the US
Welch, N., Fernandes, A., Mental health and housing: developing a care and support pathway, Housing Care and Support, 13, 16-22, 2010	Ineligible study design - non-systematic review (description of support pathway project development)
Wernher, I., Bjerregaard, F., Tinsel, I., Bleich, C., Boczor, S., Kloppe, T., Scherer, M., Härter, M., Niebling, W., König, H. H., et al.,, Collaborative treatment of late-life depression in primary care (GermanIMPACT): study protocol	Ineligible study design - study protocol (no results published)

Study	Reason for exclusion
of a cluster-randomized controlled trial, Trials, 15, 351, 2014	
Wilberforce, M., Tucker, S., Abendstern, M., Brand, C., Giebel, C. M., Challis, D., Membership and management: structures of inter-professional working in community mental health teams for older people in England, International psychogeriatrics, 25, 1485-92, 2013	Ineligible outcomes - multi-disciplinary team composition and management arrangements
Wilberforce, M., Tucker, S., Brand, C., Abendstern, M., Jasper, R., Challis, D., Is integrated care associated with service costs and admission rates to institutional **Setting**s? An observational study of community mental health teams for older people in England, International journal of geriatric psychiatry, 31, 1208-1216, 2016	Ineligible study design - observational before-and-after study, when observational designs were not considered due to sufficient experimental studies
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
Williams, K. D., Dobney, T., Geller, J., **Setting** the eating disorder aside: an alternative model of care, European eating disorders review, 18, 90-6, 2010	Ineligible intervention - not a social work approach to integrated working
Wong, A. K. C., Wong, F. K. Y., Ngai, J. S. C., Hung, S. Y. K., Li, W. C., Effectiveness of a health-social partnership program for discharged non-frail older adults: a pilot study, BMC geriatrics, 20, 339, 2020	Ineligible country – study conducted in Hong Kong
Wood, L., Wood, N. J. R., Vallesi, S., Stafford, A., Davies, A., Cumming, C., Hospital collaboration with a Housing First program to improve health outcomes for people experiencing homelessness, Housing, Care and Support, 22, 27-39, 2019	Ineligible study design - use of administrative data sets and case reports
Wright, E., Zarnegar, R., Hermansen, I., McGavin, D., A clinical evaluation of a community-based rehabilitation and social intervention programme for patients with chronic pain with associated multi-morbidity, Journal of Pain Management, 10, 149-159, 2017	Ineligible intervention - not a social work approach to integrated working (clinical focus on pain management)
Young, M. Scott, Barrett, Blake, Engelhardt, Mark A., Moore, Kathleen A., Six-Month Outcomes of an Integrated Assertive Community Treatment Team Serving Adults with Complex Behavioral Health and Housing Needs, Community mental health journal, 50, 474-9, 2014	Ineligible country – study conduced in the US
Zatzick, D., Rivara, F., Jurkovich, G., Russo, J., Trusz, S. G., Wang, J., Wagner, A., Stephens, K., Dunn, C., Uehara, E., et al.,, Enhancing the population impact of collaborative care interventions: mixed method development and	Ineligible country – study conducted in the US

Study	Reason for exclusion
implementation of stepped care targeting posttraumatic stress disorder and related comorbidities after acute trauma, General Hospital Psychiatry, 33, 123-134, 2011	

Excluded studies for review question E2: Based on the views and experiences of everyone involved, what are the facilitators and barriers to integrated working between registered social workers and other practitioners to support adults with complex needs?

Table 33: Excluded studies and reasons for their exclusion

Study	Reason for Exclusion
What outcomes are important to people with long-term neurological conditions using integrated health and social care?, Health and Social Care in the Community, 23, 559-568, 2015	Ineligible phenomenon of interest - not relevant to integrated working
Abendstern, M., Jasper, R., Loynes, N., Hughes, J., Sutcliffe, C., Challis, D., 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 relevant to integrated working
Abrams, R., The need for flexibility when negotiating professional boundaries in the context of home care, dementia and end of life, Ageing and Society, 39, 1976-1995, 2019	Ineligible phenomenon of interest – not a social work approach to integrated working
Agyapong, V. I. O, Jabbar, F., Conway, C., Shared care between specialised psychiatric services and primary care: The experiences and expectations of general practitioners in Ireland, International Journal of Psychiatry in Clinical Practice, 16, 293-299, 2012	Ineligible phenomenon of interest - not a social work approach to integrated working
Ahmad, M., van den Broeke, J., Saharso, S., Tonkens, E., Persons With a Migration Background Caring for a Family Member With Dementia: Challenges to Shared Care, The Gerontologist, 60, 340-349, 2020	Ineligible phenomenon of interest - not relevant to integrated working
Ai, A. L., Rollman, B. L., Berger, C. S., Comorbid mental health symptoms and heart diseases: can health care and mental health care professionals collaboratively improve the assessment and management?, Health and Social Work, 35, 27-38, 2010	Ineligible country - study conducted in the US
Alexander, G. L., Pasupathy, K. S., Steege, L. M., Strecker, E. B., Carley, K. M., Multi-disciplinary communication networks for skin risk assessment in nursing homes with high IT sophistication, International Journal of Medical Informatics, 83, 581-91, 2014	Ineligible country - study conducted in the US
Alissa, D., Our support, our lives: joining up the public services used by disabled people, 2015	Ineligible phenomenon of interest - not a social work approach to integrated working
Almqvist, A.-L., Lassinantti, K., Young people with complex needs meet complex organizations: an interview study with Swedish professionals about sustainable work practices,	Ineligible country - study conducted in Sweden

Study	Reason for Exclusion
Community Work and Family, 21, 620-635, 2018	
Amador, S., Evaluation of an organisational intervention to promote integrated working between health services and care homes in the delivery of end-of-life care for people with dementia: understanding the change process using a social identity approach, International Journal of Integrated Care, 16, 2016	Ineligible phenomenon of interest - not a social work approach to integrated working
Anastas, T., Waddell, E. N., Howk, S., Remiker, M., Horton-Dunbar, G., Fagnan, L. J., Building Behavioral Health Homes: Clinician and Staff Perspectives on Creating Integrated Care Teams, The journal of behavioral health services & research, 46, 475-486, 2019	Ineligible country - study conducted in the US
Anastas, T., E. Needham, W., Howk, S., Remiker, M., Horton-Dunbar, G., Fagnan, L. J., Building Behavioral Health Homes: Clinician and Staff Perspectives on Creating Integrated Care Teams, The Journal of Behavioral Health Services & Research, 46, 475-486, 2019	Ineligible country - study conducted in the US
Anderson, S. E., Hennessy, C., Cornes, M., Manthorpe, J., Developing inter-disciplinary and inter-agency networks: reflections on a "community of practice" approach, Advances in Dual Diagnosis, 6, 132-144, 2013	Ineligible phenomenon of interest - not a social work approach to integrated working
Anderson-Butcher, D., Lawson, H. A., Iachini, A., Flaspohler, P., Bean, J., Wade-Mdivanian, R., Emergent Evidence in Support of a Community Collaboration Model for School Improvement, Children & Schools, 32, 160-171, 2010	Ineligible country - study conducted in the US
Angell, B., Matthews, E., Barrenger, S., Watson, A. C., Draine, J., Engagement processes in model programs for community reentry from prison for people with serious mental illness, International Journal of Law and Psychiatry, 37, 490-500, 2014	Ineligible country - study conducted in the US
Asad, S., Chreim, S., Peer support providers' role experiences on interprofessional mental health care teams: a qualitative study, Community Ment Health J, 52, 767-774, 2016	Ineligible country - study conducted in Canada
Asad, S., Chreim, S., Peer Support Providers' Role Experiences on Interprofessional Mental Health Care Teams: A Qualitative Study, Community Ment Health J, 52, 767-774, 2016	Ineligible country - study conducted in Canada
Baxter, L., Fancourt, D., What are the barriers to, and enablers of, working with people with lived experience of mental illness amongst community and voluntary sector organisations? A qualitative study, PloS one, 15, 2020	Ineligible phenomenon of interest - not a social work approach to integrated working (focused on working with people with lived experience)
Best, S., Facilitating integrated delivery of services across organisational boundaries: essential enablers to integration, British Journal of Occupational Therapy, 80, 302-309, 2017	Ineligible phenomenon of interest - not a social work approach to integrated working

Study	Reason for Exclusion
Blake, M., Bowes, A., Gill, V., Husain, F., Mir, G., A collaborative exploration of the reasons for lower satisfaction with services among Bangladeshi and Pakistani social care users, Health & social care in the community, 25, 1090-1099, 2017	Ineligible phenomenon of interest - not relevant to integrated working
Boehmer, K. R., Holland, D. E., Vanderboom, C. E., Identifying and addressing gaps in the implementation of a community care team for care of Patients with multiple chronic conditions, BMC Health Serv Res, 19, 2019	Ineligible country - study conducted in the US
Bookey-Bassett, S., Markle-Reid, M., McKey, C., Akhtar-Danesh, N., A review of instruments to measure interprofessional collaboration for chronic disease management for community-living older adults, Journal of Interprofessional CareJ Interprof Care, 30, 201-210, 2016	Ineligible study design - not qualitative research methods
Brannelly, T., An ordinary life: people with dementia living in a residential **Setting**, Dementia: The International Journal of Social Research and Practice, 18, 757-768, 2019	Ineligible phenomenon of interest - not a social work approach to integrated working
Brown, H., Howlett, F., A critical evaluation of the ’short stay project, service users’ perspectives, Housing Care and Support, 20, 71-84, 2017	Ineligible phenomenon of interest - not relevant to integrated working
Bulinski, L., Social reintegration of TBI patients: A solution to provide long-term support, Medical Science Monitor, 16, 2010	Ineligible country - study conducted in Poland
Busch-Armendariz, N., Nsonwu, M. B., Heffron, L. C., A kaleidoscope: The role of the social work practitioner and the strength of social work theories and practice in meeting the complex needs of people trafficked and the professionals that work with them, International Social Work, 57, 7-18, 2014	Ineligible country - study conducted in the US
Cameron, A., Bostock, L., Lart, R., Service user and carers perspectives of joint and integrated working between health and social care, Journal of Integrated Care, 22, 62-70, 2014	Ineligible study design – non-systematic review (literature review)
Castro, R., Senecat, J., de Chalendar, M., Vajda, I., Dan, D., Boncz, B., Bridging the gap between health and social care for rare diseases: Key issues and innovative solutions, Advances in Experimental Medicine and Biology, 1031, 605-627, 2017	Ineligible study design - not qualitative research methods
Cheetham, M., Van der Graaf, P., Khazaeli, B., Gibson, E., Wiseman, A., Rushmer, R., "It was the whole picture" a mixed methods study of successful components in an integrated wellness service in North East England, BMC health services research, 18, 200, 2018	Ineligible phenomenon of interest - not relevant to integration with social worker
Chen, F., Developing community support for homeless people with mental illness in transition, Community Mental Health Journal, 50, 520-530, 2014	Ineligible country - study conducted in the US

Study	Reason for Exclusion
Clarke, A., Wydall, S., 'Making Safe': a coordinated community response to empowering victims and tackling perpetrators of domestic violence, Social Policy and Society, 12, 393-406, 2013	Ineligible phenomenon of interest - not relevant to integrated working
Clarke, S., Multi-agency transition services: greater collaboration needed to meet the priorities of young disabled people with complex needs as they move into adulthood, J Integr Care, 19, 30-40, 2011	Ineligible phenomenon of interest - not relevant to integrated working
Close, H., Hancock, H., Mason, J. M., Murphy, J. J., Fuat, A., de Belder, M., Hungin, A. P., "It's Somebody else's responsibility" - perceptions of general practitioners, heart failure nurses, care home staff, and residents towards heart failure diagnosis and management for older people in long-term care: a qualitative interview study, BMC Geriatrics, 13, 69, 2013	Ineligible phenomenon of interest - not relevant to integration with social worker
Coates, D., Working with families with parental mental health and/or drug and alcohol issues where there are child protection concerns: Inter-agency collaboration, Child & Family Social Work, 22, 1-10, 2017	Ineligible country - study conducted in Australia
College Of Social Work, Royal College Of General Practitioners, GPs and social workers: partners for better care: delivering health and social care integration together, 2014	Ineligible study design - not qualitative research methods
Dalziel, R., Willis, M., Capacity building with older people through local authority and third-sector partnerships, Ageing and Society, 35, 428-449, 2015	Ineligible study design - not qualitative research methods
Davidson, L., Beyond co-occurring disorders to behavioral health integration, Advances in Dual Diagnosis, 7, 185-193, 2014	Ineligible country - study conducted in the US
Dearnaley, P., Competitive advantage in the new social care marketplace: a new theoretical perspective, Housing Care and Support, 17, 5-15, 2014	Ineligible study design - not qualitative research methods
Dearnaley, P., Competitive advantage in the new contrived social care marketplace: do we need a new theoretical framework?, Housing Care and Support, 16, 126-135, 2013	Ineligible study design - not qualitative research methods
Dearnaley, P., Competitive advantage in the new contrived social care marketplace: how did we get here?, Housing Care and Support, 16, 76-84, 2013	Ineligible study design - not qualitative research methods
DiLauro, M. D., Examination of an integrative health care model for social work practice, Health and Social Work, 43, 261 to 268, 2018	Ineligible study design - not qualitative research methods
Dobbins, M. I., Thomas, S. A., Melton, S. L., Lee, S., Integrated Care and the Evolution of the Multidisciplinary Team, Primary Care; Clinics in Office Practice, 43, 177-90, 2016	Ineligible study design - not qualitative research methods
Drennan, V., Care of people with multiple comorbidities in general practice, Primary Health Care, 25, 15-15, 2015	Ineligible study design - not qualitative research methods

Study	Reason for Exclusion
D'Sa, A., Rigby, M., The effectiveness of the service user consultant role in specialist personality disorder services, Mental Health Review Journal, 16, 185-196, 2011	Ineligible phenomenon of interest - not relevant to integrated working
Edmunds, C., Kilbride, K., Collaboration: "easy to say, difficult to do", J Integr Care, 23, 232-249, 2015	Ineligible phenomenon of interest - not a social work approach to integrated working
El-Faragy, N., Partnership working across sectors: a multi-professional perspective, J Integr Care, 27, 328-345, 2019	Ineligible phenomenon of interest - not a social work approach to integrated working
Ellins, J., Glasby, J,, Together we are better? Strategic needs assessment as a tool to improve joint working in England, J Integr Care, 19, 34-41, 2011	Ineligible phenomenon of interest - not a social work approach to integrated working
Ellis, W. R., Dietz, W. H., A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience Model, Academic Pediatrics, 17, S86-S93, 2017	Ineligible country - study conducted in the US
Emilsson, U. M., The role of social work in cross-professional teamwork: examples from an older people's team in England, British Journal of Social Work, 43, 116-134, 2013	Ineligible phenomenon of interest - not relevant to integrated working
Erens, B., Early findings from the evaluation of the Integrated Care and Support Pioneers in England, J Integr Care, 25, 137-149, 2017	Ineligible phenomenon of interest - not a social work approach to integrated working
Erens, B., Can health and social care integration make long-term progress? Findings from key informant surveys of the integration pioneers in England, J Integr Care, 28, 14-26, 2020	Ineligible study design - not qualitative research methods (survey)
Everington, S., Jointly funded care package, Disability, 6-7, 2010	Ineligible study design - not qualitative research methods
Fisher, J., 'Neither a professional nor a friend': the liminal spaces of parents and volunteers in family support, Families, 2018	Ineligible phenomenon of interest - not relevant to integrated working (views of parents of children aged 5 or under)
Fletcher-Smith, J. C., Walker, M. F., Cobley, C. S., Steultjens, E. M. J., Sackley, C. M., Occupational therapy for care home residents with stroke, Cochrane Database of Systematic Reviews, 2013	Ineligible phenomenon of interest - not a social work approach to integrated working (studies on occupational therapy interventions only)
Fraser, M. W., Elephant in the room: inter-professional barriers to integration between health and social care staff, J Integr Care, 27, 64-72, 2019	Ineligible study design – not qualitative research methods (survey)
Frawley, H. C., Kuan-Yin, L., Granger, C. L., Higgins, R., Butler, M., Denehy, L., An allied health rehabilitation program for patients following surgery for abdomino-pelvic cancer: a feasibility and pilot clinical study, Supportive Care in Cancer, 28, 1335-1350, 2020	Ineligible study design - not qualitative research methods (effectiveness data, not considered for E1 as multidisciplinary team does not involved a social worker)
Fylan, B., Tranmer, M., Armitage, G., Blenkinsopp, A., Cardiology patients' medicines management networks after hospital discharge: A mixed methods analysis of a complex	Ineligible phenomenon of interest - not a social work approach to integrated working

Study	Reason for Exclusion
adaptive system, Res Social Adm Pharm, 15, 505-513, 2019	
Gage, H., Dickinson, A., Victor, C., Williams, P., Cheynel, J., Davies, S. L., Iliffe, S., Froggatt, K., Martin, W., Goodman, C., Integrated working between residential care homes and primary care: a survey of care homes in England, BMC geriatrics, 12, 71, 2012	Ineligible phenomenon of interest - not a social work approach to integrated working
Galavan, E., Repper, J., The collaborative assessment and management of suicide (CAMS): a recovery-oriented approach to working with suicidal people, Mental Health and Social Inclusion, 22, 86-90, 2017	Ineligible study design - not qualitative research methods
Gallacher, K., Morrison, D., Jani, B., Macdonald, S., May, C. R., Montori, V. M., Erwin, P. J., Batty, G. D., Eton, D. T., Langhorne, P., Mair, F. S., Uncovering Treatment Burden as a Key Concept for Stroke Care: A Systematic Review of Qualitative Research, PLoS Medicine, 10, 2013	Systematic review - references checked but none meet the PICO criteria
Gill, A., Kuluski, K., Jaakkimainen, L., Naganathan, G., Upshur, R., Wodchis, W. P., "Where do we go from here?" Health system frustrations expressed by patients with multimorbidity, their caregivers and family physicians, Healthcare Policy, 9, 73-89, 2014	Ineligible country – study conducted in Canada
Gleave, R., What is 'more integration' between health and social care? Results of a survey of primary care trusts and directors of adult social care in England, J Integr Care, 18, 29-44, 2010	Ineligible study design - not qualitative research methods
Glendinning, C., Moran, N., Challis, D., Fernández, J-L., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Netten, A., Stevens, M., Wilberforce, M., Personalisation and Partnership: Competing Objectives in English Adult Social Care? The Individual Budget Pilot Projects and the NHS, Social Policy and Society, 10, 151-162, 2011	Ineligible phenomenon of interest - not relevant to integrated working
Grace, A., Mahony, C., O'Donoghue, J., Heffernan, T., Molony, D., Carroll, T., A Vision for Enhancing Multimorbid Care using Clinical Decision Support Systems...MEDINFO 2013, Stud Health Technol Inform, 192, 1117-1117, 2013	Ineligible phenomenon of interest - not relevant to integrated working
Gudnadottir, M., Bjornsdottir, K., Jonsdottir, S., Perception of integrated practice in home care services, Journal of Integrated CareJ Integr Care, 27, 73-82, 2019	Ineligible country - study conducted in Iceland
Hainsworth, E. G., Shahmanesh, M., Stevenson, F., Exploring the views and experiences of HIV positive patients treated for cancer: a systematic review of the literature, AIDS CareAIDS Care, 30, 535-543, 2018	Systematic review - references checked but none meet the PICO criteria
Hannah, G., Developing performance-based contracts between agencies and service providers: results from a Getting To Outcomes	Ineligible country - study conducted in the US

Study	Reason for Exclusion
support system with social service agencies, Children and Youth Services Review, 32, 1430-1436, 2010	
Hansen, J. O., Bjerge, B., What role does employment play in dual recovery? A qualitative meta-synthesis of cross-cutting studies treating substance use treatment, psychiatry and unemployment services, Advances in Dual Diagnosis, 10, 105-1, 2017	Ineligible study design - references checked but none meet the PICO criteria
Harlock, J., Challenges in integrating health and social care: the Better Care Fund in England, Journal of Health Services Research and Policy, early cite September 4 2019, 2019	Ineligible phenomenon of interest - not relevant to integrated working with social workers
Hayes, S. L., Mann, M. K., Morgan, F. M., Kelly, M. J., Weightman, A. L., Collaboration between local health and local government agencies for health improvement, Cochrane Database of Systematic Reviews, 2012	Ineligible study design - not qualitative research methods (effectiveness methods, considered for E1)
Hendry, A., Taylor, A., Mercer, S., Knight, P., Improving Outcomes through Transformational Health and Social Care Integration -- The Scottish Experience, Healthcare Quarterly, 19, 73-79, 2016	Ineligible study design - not qualitative research methods
Hill, D. J., Laredo, E., First and last and always: streetwork as a methodology for radical community social work practice, Critical and Radical Social Work, 7, 25-39, 2019	Ineligible study design - not relevant to integrated working
Ho, A., Hau Yan, Luk, J. K., Chan, F. H., Ng, W. C., Kwok, C. K., Yuen, J. H., Tam, M. Y., Kan, W. W., Chan, C. L., Dignified palliative long-term care: An interpretive systemic framework of end-of-life integrated care pathway for terminally ill Chinese older adults, Am J Hosp Palliat Care, 33, 439-447, 2016	Ineligible country - study conducted in Hong Kong
Hood, R., How professionals talk about complex cases: a critical discourse analysis, Child & Family Social Work, 21, 125-135, 2016	Ineligible population - under 18 years old
Ismail, S., Fox, G., Cracknell, A., Burns, E., 61 INTERFACE GERIATRICS AND NEW WAYS OF WORKING: AVOIDING ADMISSIONS BY IMPLEMENTING EARLY SPECIALIST ASSESSMENT BY INTERFACE GERIATRICIANS IN THE EMERGENCY DEPARTMENT (ED), Age & Ageing, 43, i14-i14, 2014	Ineligible study design - abstract
Jones, S. H., Barrowclough, C., Allott, R., Day, C., Earnshaw, P., Wilson, I., Integrated Motivational Interviewing and Cognitive-Behavioural Therapy for Bipolar Disorder with Comorbid Substance Use, Clinical Psychology & Psychotherapy, 18, 426-437, 2011	Ineligible phenomenon of interest - not a social work approach to integrated working
Jose de Sao. J., Older persons' experiences and perspectives of receiving social care: a systematic review of the qualitative literature, Health and Social Care in the Community, 24, 1-11, 2016	Ineligible phenomenon of interest - not relevant to integrated working

Study	Reason for Exclusion
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 country - study conducted in Canada
Kennedy, N., Armstrong, C., Woodward, O., Cullen, W., Primary care team working in Ireland: a qualitative exploration of team members' experiences in a new primary care service, Health Soc Care Community, 23, 362-370, 2015	Ineligible country - study conducted in Ireland; non-UK
Kidd, S. A., Vitopoulos, N., Frederick, T., Leon, S., Karabanow, J., McKenzie, K., More Than Four Walls and a Roof Needed: A Complex Tertiary Prevention Approach for Recently Homeless Youth, American Journal of Orthopsychiatry, 89, 248-257, 2019	Ineligible country - study conducted in Canada
Klinga, C., Understanding the dynamics of sustainable change: a 20-year case study of integrated health and social care, BMC Health Serv Res, 18, 2018	Ineligible country - study conducted in Sweden
Knowles, S., Hidden caring, hidden carers? exploring the experience of carers for people with long-term conditions, Health and Social Care in the Community, 24, 203-213, 2016	Ineligible phenomenon of interest - not relevant to integrated working
Koenig, T. L., Multidisciplinary teams' practice strategies with older adult clients who hoard, Social Work in Mental Health, 12, 81-97, 2014	Ineligible country - study conducted in the US
Kupeli, N., Leavey, G., Harrington, J., Lord, K., King, M., Nazareth, I., Moore, K., Sampson, E. L., Jones, L., What are the barriers to care integration for those at the advanced stages of dementia living in care homes in the UK? Health care professional perspective, Dementia (London, England), 17, 164-179, 2018	Ineligible phenomenon of interest - not a social work approach to integrated working
Laird, E. A., McGurk, P., Reid, B., Ryan, A., "Making the best of what we have": The lived experiences of community psychiatric nurses, day centre managers and social workers supporting clients with dementia attending a generic day care service, International Journal of Older People Nursing, 12, 2017	Ineligible phenomenon of interest - not relevant to integrated working
Larkin, M., Developing the knowledge base about carers and personalisation: contributions made by an exploration of carers' perspectives on personal budgets and the carer-service user relationship, Health and Social Care in the Community, 23, 33-41, 2015	Ineligible phenomenon of interest - not a social work approach to integrated working
Lawrence-Jones, J., Dual diagnosis (drug/alcohol and mental health): service user experiences, Practice (09503153), 22, 115-131, 2010	Ineligible phenomenon of interest - not a social work approach to integrated working
Lennox, C., Stevenson, C., Edge, D., Hopkins, G., Thornicroft, G., Susser, E., Conover, S.,	Ineligible outcomes - themes not relevant to barriers and facilitators of integrated working

Study	Reason for Exclusion
Herman, D., Senior, J., Shaw, J., Critical Time Intervention: a qualitative study of the perspectives of prisoners and staff, Journal of Forensic Psychiatry and Psychology, 31, 76-89, 2020	
Lisa de Saxe, Z., Lombardi, B. M., Guan, T., Integrated Behavioral Health and Social Work: a Global Perspective, Global Social Welfare, 6, 49-56, 2019	Ineligible study design - not qualitative research methods
MacIntyre, G., Stewart, A., For the record: the lived experience of parents with a learning disability - a pilot study examining the Scottish perspective, British Journal of Learning Disabilities, 2012	Ineligible population - children under 18 years old
Mackenzie, C. R., Keuskamp, D., Ziersch, A. M., Baum, F. E., Popay, J., A qualitative study of the interactions among the psychosocial work environment and family, community and services for workers with low mental health, BMC Public HealthBMC Public Health, 13, 796, 2013	Ineligible country - study conducted in Australia)
Maddock, A., Consensus or contention: an exploration of multidisciplinary team functioning in an Irish mental health context, European Journal of Social Work, 18, 246-261, 2015	Ineligible country - study conducted in Ireland
Mager, D. R., Lange, J. W., Greiner, P. A., Saracino, K. H., Using simulation pedagogy to enhance teamwork and communication in the care of older adults: The ELDER Project, The Journal of Continuing Education in Nursing, 43, 363-369, 2012	Ineligible country - study conducted in the US
Manthorpe, J., Samsi, K., Improving practice in communication with older people and support networks living in housing with care schemes: aspirations and ambitions, British Journal of Social Work, 42, 1495-1512, 2012	Ineligible study design - not qualitative research methods
Maramaldi, P., Interdisciplinary medical social work: a working taxonomy, Social work in health care, 53, 532-551, 2014	Ineligible country - study conducted in the US
Martin, G. P., Ward, V., Hendy, J., Rowley, E., Nancarrow, S., Heaton, J., Britten, N., Fielden, S., Ariss, S., The challenges of evaluating large-scale, multi-partner programmes: the case of NIHR CLAHRCs, Evidence & Policy, 7, 489-509, 2011	Ineligible phenomenon of interest - not a social work approach to integrated working
Matthews, A., Stansfield, J., Supporting Communication for Parents with Intellectual Impairments: Communication Facilitation in Social Work Led Parenting Meetings, BRITISH JOURNAL OF LEARNING DISABILITIES, 42, 244-250, 2014	Ineligible phenomenon of interest - not a social work approach to integrated working
McCabe, K. E., Wallace, A., Crosland, A., A model for collaborative working to facilitate knowledge mobilisation in public health, Evidence & Policy, 11, 559-576, 2015	Ineligible study design - not qualitative research methods

Study	Reason for Exclusion
McCabe, L., Robertson, J., Kelly, F., Scaffolding and working together: A qualitative exploration of strategies for everyday life with dementia, Age and Ageing, 47, 303-310, 2018	Ineligible phenomenon of interest - not relevant to integrated working
Mcdonagh, T., Tackling homelessness and exclusion: understanding complex lives, 2011	Ineligible study design - not qualitative research methods. One study referenced - Cornes 2011 - has been considered for inclusion
McGregor, J., Mercer, S. W., Harris, F. M., Health benefits of primary care social work for adults with complex health and social needs: a systematic review, Health & Social Care in the Community, 26, 1-13, 2018	Systematic review - criteria for inclusion does not meet the criteria set out in the protocol
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 country - study conducted in Australia
Meddings, S., Gordon, I., Owen, D., Family and systemic work, 163-185, 2010	Ineligible study design - not qualitative research methods
Meyer-Kalos, P., Lee, M., Studer, L., Line, T., Fisher, C., Opportunities for Integrating Physical Health Within Assertive Community Treatment Teams: Results from Practitioner Focus Groups, Community Ment Health J, 53, 306-315, 2017	Ineligible country - study conducted in the US
Miles, H., 'A new horizon?': evaluation of an integrated Substance Use Treatment Programme (SUTP) for mentally disordered offenders, Advances in Dual Diagnosis, 8, 90-101, 2015	Ineligible study design - not qualitative research methods (effectiveness study, not considered for E1 as integrated team does not include a social worker)
Moore, M., Whiteside, L. K., Dotolo, D., Wang, J., Ho, L., Conley, B., Forrester, M., Fouts, S. O., Vavilala, M. S., Zatzick, D. F., The role of social work in providing mental health services and care coordination in an urban trauma center emergency department, Psychiatric Services, 67, 1348-1354, 2016	Ineligible country - study conducted in the US
Morley, K., Baillie, A., Leung, S., Sannibale, C., Teesson, M., Haber, P., Is specialized integrated treatment for comorbid anxiety, depression and alcohol dependence better than treatment as usual in a public hospital **Setting**?, Alcohol and Alcoholism, 51, 402-409, 2016	Ineligible study design - not qualitative research methods (effectiveness study, not considered for E1 as integrated team does not include a social worker)
Mulvale, G., Codesigning health and other public services with vulnerable and disadvantaged populations: insights from an international collaboration, Health Expect, 22, 284-297, 2019	Ineligible phenomenon of interest - not a social work approach to integrated working
Munn, J. C., Telling the Story: Perceptions of Hospice in Long-Term Care, American Journal of Hospice and Palliative Medicine, 29, 201-209, 2012	Ineligible country - study conducted in the US
Munoz, S-A., Co-producing care services in rural areas, J Integr Care, 21, 276-287, 2013	Ineligible phenomenon of interest - not relevant to integrated working with social workers

Study	Reason for Exclusion
Murray, G. F., Rodriguez, H. P., Lewis, V. A., Upstream With A Small Paddle: How ACOs Are Working Against The Current To Meet Patients' Social Needs, Health affairs (Project Hope), 39, 199-206, 2020	Ineligible country - study conducted in the US
Nandan, M., Scott, P. A., Interprofessional Practice and Education: Holistic Approaches to Complex Health Care Challenges, Journal of Allied Health, 43, 150-156, 2014	Ineligible study design - not qualitative research methods
Nash, M., Mental health and long-term conditions 2: managing depression, Nursing Times, 21-23, 2011	Ineligible study design - not qualitative research methods
National Institute For Health Research School for Social Care Research, An exploration of service user and practitioner experiences of community treatment orders, 4, 2014	Ineligible phenomenon of interest - not a social work approach to integrated working
Nct,, Health Care Hotspotting: a Randomized Controlled Trial, https://clinicaltrials.gov/show/NCT02090426, 2014	Ineligible country - study conducted in the US
Ness, O., Borg, M., Semb, R., Topor, A., ’Negotiating partnerships:’ parents’ experiences of collaboration in community mental health and substance use services, Advances in Dual Diagnosis, 9, 130-138, 2016	Ineligible phenomenon of interest - not relevant to integrated working (parents experiences of collaborating with mental health professionals)
Ni, S. H. E. Eidin, Clarifying the mechanisms and resources that enable the reciprocal involvement of seldom heard groups in health and social care research: a collaborative rapid realist review process, Health Expectations, 2019	Ineligible phenomenon of interest - not a social work approach to integrated working
Nover, C. H., Mental Health in Primary Care: Perceptions of Augmented Care for Individuals With Serious Mental Illness, Social Work in Health Care, 52, 656-668, 2013	Ineligible country - study conducted in the US
Ørtenblad, Lisbeth, Meillier, Lucette, Jønsson, Alexandra R., Multi-morbidity: A patient perspective on navigating the health care system and everyday life, Chronic Illness, 14, 271-282, 2018	Ineligible country - study conducted in Denmark
Ottosdottir, G., Evans, R., Ethics of Care in Supporting Disabled Forced Migrants: Interactions with Professionals and Ethical Dilemmas in Health and Social Care in the South-East of England, British Journal of Social Work, 44, 2014	Ineligible phenomenon of interest - not a social work approach to integrated working
Parker, W. M., Ferreira, K., Vernon, L., Cardone, K. E., The delicate balance of keeping it all together: Using social capital to manage multiple medications for patients on dialysis, Res Social Adm Pharm, 13, 738-745, 2017	Ineligible country - study conducted in the US
Parris, A., Implementing interventions for an individual with complex needs through a co-ordinated approach, Advances in Mental	Ineligible study design - not qualitative research methods

Study	Reason for Exclusion
Health and Intellectual Disabilities, 4, 33-37, 2010	
Pearson, M., Brand, S. L., Quinn, C., Shaw, J., Maguire, M., Michie, S., Briscoe, S., Lennox, C., Stirzaker, A., Kirkpatrick, T., Byng, R., Using realist review to inform intervention development: methodological illustration and conceptual platform for collaborative care in offender mental health, Implementation ScienceImplement Sci, 10, 134, 2015	Ineligible phenomenon of interest - not a social work approach to integrated working
Phillips, J. E., Dobbs, C., Burholt, V., Marston, H., Extracare: Does it promote resident satisfaction compared to residential and home care?, British Journal of Social Work, 45, 949-967, 2015	Ineligible phenomenon of interest - not a social work approach to integrated working
Phongtankuel, V., Meador, L., Adelman, R. D., Roberts, J., Henderson, C. R., Jr., Mehta, S. S., del Carmen, T., Reid, M., Multicomponent palliative care interventions in advanced chronic diseases: A systematic review, Am J Hosp Palliat Care, 35, 173-183, 2018	Ineligible phenomenon of interest - not a social work approach to integrated working
Piercy, H., 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 phenomenon of interest - not a social work approach to integrated working
Pipon-Young, F. E., I'm not all gone, I can still speak: the experiences of younger people with dementia. An action research study, Dementia: The International Journal of Social Research and Practice, 11, 597-616, 2012	Ineligible phenomenon of interest - not a social work approach to integrated working
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 country - study conducted in Canada
Probst, B., Not quite colleagues: Issues of power and purview between social work and psychiatry, Social Work in Mental Health, 10, 367-383, 2012	Ineligible country - study conducted in the US
Redfern, H., Burton, J., Lonne, B., Seiffert, H., Social Work and Complex Care Systems: The Case of People Hospitalised with a Disability, Australian Social Work, 69, 27-38, 2016	Ineligible country - study conducted in Australia
Reeves, S., Pelone, F., Harrison, R., Goldman, J., Zwarenstein, M., Interprofessional collaboration to improve professional practice and healthcare outcomes, Cochrane Database of Systematic Reviews, 2017	Ineligible study design - not qualitative research methods (effectiveness systematic review, considered for E1)
Reilly, S., Planner, C., Gask, L., Hann, M., Knowles, S., Druss, B., Lester, H., Collaborative care approaches for people with severe mental illness, Cochrane Database of Systematic Reviews, 2013	Ineligible study design - not qualitative research methods (effectiveness systematic review, considered for E1

Study	Reason for Exclusion
Rimmer, C. J., Gill, K. A., Greenfield, S., Dowswell, G., The design and initial patient evaluation of an integrated care pathway for faecal incontinence: a qualitative study, BMC Health Serv Res, 15, 444, 2015	Ineligible phenomenon of interest - not a social work approach to integrated working
Riste, L. K., Enacting person-centredness in integrated care: a qualitative study of practice and perspectives within multidisciplinary groups in the care of older people, Health ExpectationsHealth Expect, 21, 1066-1074, 2018	Ineligible phenomenon of interest - not relevant to integrated working
Rodgers, M., Dalton, J., Harden, M., Street, A., Parker, G., Eastwood, A., Integrated care to address the physical health needs of people with severe mental illness: a rapid review, Health Services and Delivery Research, 4, i-xxvi, 1-129, 2016	Ineligible study design - not qualitative research methods
Ross, L. E., Vigod, S., Wishart, J., Waese, M., Spence, J. D., Oliver, J., Chambers, J., Anderson, S., Shields, R., Barriers and facilitators to primary care for people with mental health and/or substance use issues: a qualitative study, BMC family practice, 16, 135, 2015	Ineligible country - study conducted in Canada
Ruggiano, N., Shtompel, N., Edvardsson, D., Engaging in Coordination of Health and Disability Services as Described by Older Adults: Processes and Influential Factors, The Gerontologist, 55, 1015-1025, 2015	Ineligible country - study conducted in the US
Salina, Doreen D., et, al, Addressing unmet needs in incarcerated women with co-occurring disorders, Journal of Social Service Research, 37, 365-378, 2011	Ineligible country - study conducted in the US
Shand, J., Turner, S., System wide collaboration? Health and social care leaders' perspectives on working across boundaries, J Integr Care, 27, 83-94, 2019	Ineligible phenomenon of interest - not a social work approach to integrated working
Sheridan, J., Barnard, M., Webster, S., Influences on the provision of drug services in England: the experiences and views of front line treatment workers, Health & social care in the community, 19, 403-11, 2011	Ineligible country - study conducted in New Zealand
Smith, R., Longitudinal studies and housing with care in England: a review, Housing, Care & Support, 18, 1-11, 2015	Ineligible study design - not qualitative research methods
Spiers, G., Aspinal, F., Bernard, S., Parker, G., What outcomes are important to people with long-term neurological conditions using integrated health and social care?, Health & Social Care in the CommunityHealth Soc Care Community, 23, 559-568, 2015	Ineligible phenomenon of interest - not relevant to integrated working
Spoorenberg, S. L., Wynia, K., Fokkens, A. S., Slotman, K., Kremer, H. P., Reijneveld, S. A., Experiences of Community-Living Older Adults Receiving Integrated Care Based on the Chronic Care Model: A Qualitative Study, PLoS	Ineligible country - study conducted in Netherlands

Study	Reason for Exclusion
ONE [Electronic Resource]PLoS ONE, 10, e0137803, 2015	
Stanhope, V., Matejkowski, J., Understanding the role of individual consumer-provider relationships within assertive community treatment, Community Mental Health Journal, 46, 309-318, 2010	Ineligible country - study conducted in the US
Stanhope, V., The ties that bind: Using ethnographic methods to understand service engagement, Qualitative Social Work: Research and Practice, 11, 412-430, 2012	Ineligible country - study conducted in the US
Stanhope, V., Henwood, B. F., Activating people to address their health care needs: learning from people with lived experience of chronic illness, Community Ment Health J, 50, 656-663, 2014	Ineligible country - study conducted in the US
Steiner, B., Zippel-Schultz, B., Popa, A., Hellrung, N., Szczesny, S., Möller, C., Schultz, C., Haux, R., CASEPLUS-SimPat: An Intersectoral Web-Based Case Management System for Multimorbid Dementia Patients, Journal of Medical Systems, 44, 1-8, 2020	Ineligible country - study conducted in Germany
Stokes, J., Riste, L., Cheraghi-Sohi, S., Targeting the 'right' patients for integrated care: stakeholder perspectives from a qualitative study, Journal of Health Services Research and Policy, 2018	Ineligible phenomenon of interest - not relevant to integrated working
Storm, M., Lunde Husebø, A. M., Thomas, E. C., Elwyn, G., Zisman-Ilani, Y., Coordinating Mental Health Services for People with Serious Mental Illness: A Scoping Review of Transitions from Psychiatric Hospital to Community, Administration and Policy in Mental Health and Mental Health Services Research, 46, 352-367, 2019	Ineligible study design – non-systematic review (scoping review, references checked but none meet the PICO criteria)
Swarbrick, M. A., Wellness-oriented peer approaches: A key ingredient for integrated care, Psychiatric Services, 64, 723-726, 2013	Ineligible study design - not qualitative research methods
Taylor, J., Morrissey, C., Integrating treatment for offenders with an intellectual disability and personality disorder, British Journal of Forensic Practice, 14, 302-315, 2012	Ineligible study design - not qualitative research methods
Tee, H., Priebe, S., Santos, C., Xanthopoulou, P., Webber, M., Giacco, D., Helping people with psychosis to expand their social networks: The stakeholders' views, BMC Psychiatry, 20, 2020	Ineligible phenomenon of interest - not relevant to integrated working
Tsantefski, M., Inclusivity in interagency responses to domestic violence and child protection, Australian Social Work, 71, 202-214, 2018	Ineligible country - study conducted in Australia
Tucker, H., Burgis, M., Patients set the agenda on integrating community services in Norfolk, J Integr Care, 20, 231-240, 2012	Ineligible phenomenon of interest - not relevant to integrated working
Turner-Stokes, L., Pick, A., Nair, A., Disler, P. B., Wade, D. T., Multi-disciplinary	Systematic review of effectiveness research - considered for E1

Study	Reason for Exclusion
rehabilitation for acquired brain injury in adults of working age, Cochrane Database of Systematic Reviews, 2015	
Turnpenny, A., Beadle-Brown, J., Use of quality information in decision-making about health and social care services--a systematic review, Health & social care in the community, 23, 349-61, 2015	Ineligible phenomenon of interest – not a social work approach to integrated working
Uittenbroek, R. J., van der Mei, S. F., Slotman, K., Reijneveld, S. A., Wynia, K., 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, e0207109, 2018	Ineligible country - study conducted in Netherlands
Vassilev, I., Band, R., Kennedy, A., James, E., Rogers, A., The role of collective efficacy in long-term condition management: A metasynthesis, Health Soc Care Community, 27, e588-e603, 2019	Ineligible phenomenon of interest – not a social work approach to integrated working
Ward, R. L., Nichols, A. D., Freedman, R. I., Uncovering health care inequalities among adults with intellectual and developmental disabilities, Health and Social Work, 35, 280-290, 2010	Ineligible country - study conducted in the US
Waring, S., Laurence, A., Shortland, N., Humann, M., The role of information sharing on decision delay during multiteam disaster response, Cognition, Technology & Work, 1-17, 2019	Ineligible population - not focused on integrated working for adults with complex needs
Watkins, K. E., Ober, A. J., Lamp, K., Lind, M., Diamant, A., Osilla, K. C., Heinzerling, K., Hunter, S. B., Pincus, H. A., Implementing the Chronic Care Model for Opioid and Alcohol Use Disorders in Primary Care, Progress in community health partnerships : research, education, and action, 11, 397-407, 2017	Ineligible country - study conducted in the US
Whiteford, H., McKeon, G., Harris, M., Diminic, S., Siskind, D., Scheurer, R., System-level intersectoral linkages between the mental health and non-clinical support sectors: A qualitative systematic review, Australian and New Zealand Journal of Psychiatry, 48, 895-906, 2014	Systematic review - references checked but none meet the PICO criteria
Wilberforce, M., An electronic referral system supporting integrated hospital discharge, Journal of Integrated CareJ Integr Care, 25, 99-109, 2017	Ineligible phenomenon of interest - not relevant to integrated working
Willis, R., Satisfaction with social care services among South Asian and White British older people: the need to understand the system, Ageing and Society, 36, 1364-1387, 2016	Ineligible phenomenon of interest - not a social work approach to integrated working

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 E1: What is the effectiveness of integrated working among registered social workers and other practitioners to support adults with complex needs?

No research recommendations were made for this review question.

Research recommendations for review question E2: Based on the views and experiences of everyone involved, what are the facilitators and barriers to integrated working between registered social workers and other practitioners to support adults with complex needs?

No research recommendations were made for this review question.