Evidence Check

Best practice approaches and service elements for addressing key health system issues experienced by people with disability and their carers

An Evidence Check rapid review brokered by the Sax Institute
for the NSW Ministry of Health—March 2026

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This report was prepared by: Reidar P. Lystad, Vaishnavi Calisa, Bronwyn Newman, Robyn Clay-Williams, Reema Harrison, and Rebecca Mitchell. Australian Institute of Health Innovation, Macquarie University.

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Enquiries regarding this report may be directed to the:

Director
Evidence Connect
Sax Institute
www.saxinstitute.org.au
evidence.connect@saxinstitute.org.au

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Executive summary

Background

People with disability and their carers face complex and persistent challenges within the health system. In response, the Health and Social Policy Branch (HSPB) of the New South Wales (NSW) Ministry of Health is developing an NSW Health Disability Health Strategy aimed at driving meaningful health system reform. To inform the strategy's development including community consultations, the HSPB commissioned the Sax Institute to broker a rapid evidence review, which was undertaken by a team of researchers at the Australian Institute of Health Innovation at Macquarie.

Purpose and review questions

This review aimed to address the following specific questions:

Question 1: What best practice approaches have been shown to be highly effective in addressing the key issues experienced by people with disability and their carers in the health system?*

Question 2: What elements of services have been shown to be highly effective in addressing the key issues experienced by people with disability and their carers in the health system?*

Methods

The search strategy was developed in consultation with the Sax Institute and the NSW Ministry of Health policy team. It involved a systematic search of five electronic databases (i.e. MEDLINE, EMBASE, PsycINFO, AMED, and CINAHL) to identify recent peer-reviewed scientific literature and a complementary targeted search of grey literature. This review included interventional studies examining the effectiveness of health service delivery models and best practice approaches to improve health outcomes for people with disability and their carers in Australia or other high-income countries with healthcare systems and burden of disease similar to Australia. Eligible studies had to report on one or more of six specific outcomes of interest (i.e. 1) Improvements in co-ordination of care, continuity of care, and communication by health service staff for people with a disability and

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* The key issues were the following six outcomes of interest: (1) Improvements in co-ordination of care, continuity of care, and communication by health service staff for people with a disability and their carers; (2) Improvements in access to preventive health care for people with a disability and their carers; (3) Improvements in health literacy and health practices of people with a disability and their carers; (4) Improvements in experience and satisfaction with health services for people with a disability and their carers; (5) Improvements in attitudes, knowledge, and skills of health service staff providing care for people with a disability and their carers; (6) System-level improvements that lead to better health outcomes for people with a disability, their cares, and the system (e.g. cost efficiencies, process or service efficiencies).

their carers; 2) Improvements in access to preventive health care for people with a disability and their carers; 3) Improvements in health literacy and health practices of people with a disability and their carers; 4) Improvements in experience and satisfaction with health services for people with a disability and their carers; 5) Improvements in attitudes, knowledge, and skills of health service staff providing care for people with a disability and their carers; and 6) System-level improvements that lead to better health outcomes for people with a disability, their carers, and the system). Only full-text articles in English published in peer-reviewed scientific journals from 1 January 2015 to 31 July 2025 were eligible for inclusion. The study selection process was performed by two independent reviewers. Data were extracted from the included studies, tabulated, and narratively synthesised by category of outcome of interest. The level of evidence was determined according to the National Health and Medical Research Council (NHMRC) evidence hierarchy for intervention studies.

Results

A total of 29 peer-reviewed journal articles reporting on 24 unique studies were included in this review. More than half (54%) of the included studies originated from the United Kingdom (UK) or the United States of America (US). Only 2 (8%) of the included studies originated from Australia. In regard to outcomes of interest, 10 (42%) studies reported on system-level improvements that lead to better health outcomes, 8 (33%) studies reported on outcomes for improvements in health literacy or health practices, 4 (17%) studies reported on outcomes for improvements in experience or satisfaction with health services, 4 (17%) studies reported on outcomes for improvements in attitudes, knowledge, and skills of health service staff, and 3 (13%) studies reported on outcomes for improvements in co-ordination of care, continuity of care, and communication by health service staff. None of the included studies reported on outcomes for improvements in access to preventive health care.

Key findings

Health service staff training appeared to be an effective intervention to improve outpatient care across cohorts with a range of different disabilities, although the effectiveness of training interventions was significantly moderated by implementation challenges.

Community-based collaborative care model interventions appeared to be useful in improving healthcare delivery for individuals with mental illness, while technology-based interventions were seemingly more effective in promoting self-management for people with a physical disability.

Major gaps in the evidence base included:

- Evidence for effective patient/carer training interventions, health policy interventions, hospital-based care model interventions, and paediatric-to-adult transition service model interventions.
- Evidence for effective interventions, other than technology-based interventions, to improve outcomes of interest for individuals with a physical or sensory disability.
- Evidence for effective interventions to improve access to preventive health care for individuals with disability.

Strengths and limitations

This rapid review employed a well-developed systematic search strategy and robust study selection process; however, the expedited nature necessitated several limitations (e.g. inclusion of recent evidence only, and no risk of bias assessment or quality appraisal was conducted). Thus, the conclusions of this rapid review should be interpreted with caution.

Conclusions

This rapid review identified recent evidence for health service delivery models and best practice approaches demonstrating improved health outcomes for people with disability and their carers. It highlighted the potential for health service staff training to improve the quality of outpatient care for people with a range of disabilities, community-based collaborative care models to facilitate continuity of care for people with a mental illness, and technology-based interventions to promote self-management for people with a physical disability. It also highlighted major gaps in the contemporary evidence base for healthcare service models and care approaches demonstrated to improve health outcomes for people with disability.

Background

Background and context

People with disability and their carers face complex and persistent challenges within the health system. Key issues include fragmented and poorly coordinated care, inadequate access to preventive health care and health promotion services, and gaps in health workforce capabilities, particularly concerning staff skills, communication, and attitudes. Additionally, people with disability often experience limited opportunities to partner with health professionals in care planning and encounter health information that is frequently inaccessible or difficult to understand. System-wide challenges further exacerbate these issues, notably health administrative data systems lack disability identifiers, health policies are often developed without adequately incorporating the perspectives of people with disability, and there are insufficient adaptive supports or innovative service delivery models, such as integrated “one-stop shop” clinics available.

In response to ongoing concerns regarding the quality, accessibility, and appropriateness of health care, the Health and Social Policy Branch (HSPB) of the New South Wales (NSW) Ministry of Health is developing an NSW Health Disability Health Strategy aimed at driving meaningful health system reform. As a critical part of this strategy development, HSPB will consult directly with people with disability and their carers, along with obtaining evidence from a review of the scientific and grey literature, ensuring the strategy accurately reflects lived experiences and incorporates evidence-based best practices. To effectively inform these consultations and avoid duplication of existing efforts, HSPB commissioned the Sax Institute to broker a rapid evidence review, which was conducted by a team of researchers at the Australian Institute of Health Innovation at Macquarie University.

Purpose and review questions

The purpose of this review was to identify and synthesise current evidence on effective health service delivery models and best practice approaches that have demonstrated improved health outcomes for people with disability and their carers.

The review was designed to answer the following two questions:

Question 1: What best practice approaches have been shown to be highly effective in addressing the key issues experienced by people with disability and their carers in the health system?

Question 2: What elements of services have been shown to be highly effective in addressing the key issues experienced by people with disability and their carers in the health system?

Methods

Review of peer-reviewed scientific literature

Search strategy

The search strategy for this rapid review was developed by the review team in consultation with the Sax Institute and the NSW Ministry of Health policy team. It comprised a systematic search of recent peer-reviewed scientific literature and a complementary targeted search of grey literature (see below).

The search for recent peer-reviewed scientific literature was executed on 31 July 2025 using five electronic databases: MEDLINE, EMBASE, PsycINFO, and AMED via the Ovid portal, and CINAHL via the EBSCOhost portal. The search string employed in the five electronic databases featured three key concepts: people with disability, health services, and eligible study designs. Sets of keywords and phrases were developed for each key concept. For each key concept, the set of key words and phrases was combined with relevant controlled vocabulary (i.e. indexing terms) specific to each database. The electronic database searches were limited to articles published in English language from 1 January 2015 to 31 July 2025. The electronic database searches were also limited to studies conducted in Australia or other high-income countries with healthcare systems and burden of disease similar to Australia.[*] The search strings and results for each database are provided in Appendix 1.

The electronic database searches were complemented by backward citation tracking, which involved manually screening the reference lists of included studies, relevant review articles identified during the screening process and retrieved relevant grey literature documents to identify potentially eligible studies that were not captured by the electronic database searches.

Eligibility criteria

This review included interventional studies examining the effectiveness of health service delivery models and best practice approaches to improve health outcomes for people with disability and their carers in Australia or other high-income countries with healthcare systems and burden of disease similar to Australia.[*] For the purposes of this review, people with disability is defined broadly as people with impairments of body function or structure, activity limitations, or participation restrictions, which can be related to genetic disorders, congenital anomalies, illnesses, injuries, ageing, or a combination of these factors.[†] Eligible studies had to report on one or more of six specific outcomes

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[***] The World Bank considers the following countries within the Organisation for Economic Co-operation and Development (OECD) to be comparable to Australia in social and economic characteristics and likely to have similar burden of disease: Canada, New Zealand, United Kingdom, United States of America, and Nordic countries (e.g. Denmark, Finland, Iceland, Norway, and Sweden).

[†] The World Bank considers the following countries within the Organisation for Economic Co-operation and Development (OECD) to be comparable to Australia in social and economic characteristics and likely to have similar burden of disease: Canada, New Zealand, United Kingdom, United States of America, and Nordic countries

of interest (Table 1). Only full-text articles in English language published in peer-reviewed scientific journals from 1 January 2015 to 31 July 2025 were eligible for inclusion.

Table 1 – Eligibility criteria

Included	Excluded
Study design	
Randomised and non-randomised controlled trials, quasi-experimental studies, comparative effectiveness studies	Non-interventional studies, non-original research (e.g. reviews, editorials, commentaries, opinion/perspective articles)
Outcomes of interest	
(1) Improvements in co-ordination of care, continuity of care, and communication by health service staff for people with a disability and their carers (2) Improvements in access to preventive health care for people with a disability and their carers (3) Improvements in health literacy and health practices of people with a disability and their carers (4) Improvements in experience and satisfaction with health services for people with a disability and their carers (5) Improvements in attitudes, knowledge, and skills of health service staff providing care for people with a disability and their carers (6) System-level improvements that lead to better health outcomes for people with a disability, their cares, and the system (e.g. cost efficiencies, process or service efficiencies)	
Study language	
English	Non-English
Study country	

Organisation for Economic Co-operation and Development (OECD) countries comparable to Australia in social and economic characteristics and burden of disease, i.e.: • Canada • Denmark • Finland • Iceland • New Zealand • Norway • Sweden • United Kingdom (UK) • United States of America (US)	Non-OECD countries and OECD countries not comparable to Australia in social and economic characteristics and burden of disease
Study publication date	
1 January 2015 to 31 July 2025	Before 1 January 2015
Study population	
Studies focused on people with disability, their carers, or both	
Study setting	
Any setting (e.g. primary, secondary, tertiary community, allied, aged, social care), public/private, staff type/combination, service elements/combination, mode of delivery (e.g. in-person, virtual), duration/frequency, cost	
Interventions of interest	
Interventions, best practice approaches, or service delivery models explicitly designed to address the key issues faced by people with disability and their carers, and the elements of those effective interventions, approaches, models	Interventions without clearly defined outcome measures related to the key issues or those not implemented in a health system context
Other relevant category for inclusion/exclusion	

Full-text article available	Full-text article not available (e.g. conference abstracts)

Study selection process

Records retrieved from the electronic database searches were imported into the web-based screening and data extraction tool Covidence (Covidence, Melbourne, Australia). Duplicate records were identified and removed using the in-built automatic duplicate detection functionality in Covidence. Additional duplicates that were not detected and removed automatically were identified through clerical review and removed manually. Unique records were subjected to a two-step screening process. Firstly, titles and abstracts were screened by two independent reviewers (RL, VC) to identify potentially eligible articles, with obviously irrelevant and ineligible articles being discarded. Second, full-text versions of potentially eligible articles were retrieved and carefully assessed against the eligibility criteria by two independent reviewers (RL, VC). Ineligible articles were excluded and the reason for exclusion was recorded. Any disagreements between the two independent reviewers were discussed and resolved by mutual consensus.

Data extraction

The review team developed a purpose-made data extraction tool in Excel (Microsoft, Redmond, Washington). The following data were extracted: study characteristics (i.e. name of first author, year of publication, study design, study country, study period, and study population), study objectives, intervention characteristics (i.e. type of intervention, intervention duration, and intervention setting), study outcomes, and key findings. Data were initially extracted by one reviewer (VC) and subsequently verified by a second reviewer (RL). Any discrepancies were discussed and resolved by mutual consensus.

Data synthesis

The extracted data were tabulated and narratively synthesised by category of outcome of interest (as defined in the eligibility criteria), type of intervention (i.e. community-based care model, hospital-based care model, paediatric to adult transition service model, health service staff training, patient/carer training, technology-based intervention, or health policy), and type of disability (i.e. psychosocial disability, neurodevelopmental disability, neurological disability, physical disability, sensory disability, and dementia).[*] Given the expedited nature of rapid reviews and the expected heterogeneity in measures of effect across the included studies, quantitative synthesis (i.e. meta-analysis) and quantitative approaches for evaluating certainty of evidence were not feasible. For the purposes of this rapid review, consistency of evidence was evaluated for each category combination of type of disability, type of intervention, and outcome of interest based on similarity of estimates of effect across studies (i.e. direction of effect and statistical significance). Consistency of evidence was

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[*] The types of disability was based on the categories and descriptions provided by the National Disability Services (https://nds.org.au/disability-types-and-description), whereby the categories are not mutually exclusive.

categorised as: consistent evidence of improvement with the intervention, consistent evidence of no improvement with the intervention, mixed evidence of improvement and no improvement with the intervention, or absence of evidence. Consistency of evidence was initially evaluated by one reviewer (VC) and subsequently verified by a second reviewer (RL). Any discrepancies were discussed and resolved by mutual consensus.

Assessment of level of evidence

The level of evidence of included articles was determined according to the National Health and Medical Research Council (NHMRC) evidence hierarchy for intervention studies (Appendix 2).

Review of grey literature

In addition to searching electronic databases for recent peer-reviewed scientific literature, selected grey literature sources were searched to identify grey literature such as reports and policy documents published by government agencies or not-for-profit organisations. In consultation with the Sax Institute and the NSW Ministry of Health policy team, the websites of the following government departments and agencies and not-for-profit organisations were targeted for the grey literature searches:

- Australian Government Department of Health, Disability and Ageing
- Australian Capital Territory Health and Community Services Directorate
- New South Wales Government Department of Health
- Northern Territory Government Department of Health
- Queensland Government Department of Health
- South Australia Government Department of Health
- Tasmanian Government Department of Health
- Victorian Department of Health
- Western Australia Government Department of Health
- Australian Institute of Health and Welfare
- Australian Commission on Safety and Quality in Health Care
- Centre of Research Excellence in Disability and Health
- National Centre of Excellence in Intellectual Disability Health
- National Centre for Disability Advocacy
- People with Disability Australia
- United Kingdom Department of Health & Social Care

- Health Canada

Grey literature sources were searched using their in-built search functionality, which consisted of simple free-text search bars with or without filtering capabilities (e.g. by document type, publication range). The search results were manually screened by two reviewers to identify and retrieve relevant grey literature documents.

The relevant grey literature documents were subjected to a two-step process:

(1) Firstly, the reference lists of all retrieved grey literature documents were manually screened by one reviewer to identify potentially eligible articles that had not been identified by the electronic database searches. These potentially eligible articles were incorporated into the systematic review of recent peer-reviewed scientific literature by retrieving full-text versions and carefully assessing them against the eligibility criteria (as outlined above). The full-text screening of these potentially eligible articles was performed by two independent reviewers. Any disagreements between the two independent reviewers were discussed and resolved by mutual consensus.
(2) Secondly, grey literature documents were reviewed by one reviewer to determine if they contained full reports on original research that had not been published in the peer-reviewed scientific literature. If a grey literature document contained a full report on original research that had not been published in the peer-reviewed scientific literature, then it was carefully assessed against the eligibility criteria (as outlined above) by two independent reviewers. Any disagreements between the two independent reviewers were discussed and resolved by mutual consensus. Relevant data were extracted from eligible grey literature documents by one reviewer and subsequently verified by a second reviewer. Any discrepancies were discussed and resolved by mutual consensus.

Findings from eligible grey literature documents were planned to be reported separately to findings from peer-reviewed scientific literature.

Results

Review of peer-reviewed scientific literature

Search results

The electronic database searches returned 3,614 records, including 523 duplicates. After screening 3,091 unique records, full-text versions of 68 potentially eligible articles were retrieved and evaluated against the eligibility criteria, of which 18 articles were included. Citation searching identified a further 24 potentially eligible articles, of which 11 articles were included. The 29 included articles reported on a total of 24 unique studies.[1-29] In regard to the 63 excluded articles,[30-92] the reasons for exclusion were: wrong outcome (n = 35; 56%), wrong study design (n = 20; 32%), and wrong study population (n = 8; 13%). Appendix 3 contains a list of excluded studies and their primary reason for exclusion. Figure 1 provides a PRISMA flow diagram illustrating the study selection process.

Characteristics of included studies

Table 2 provides an overview of the characteristics of the included studies. Of the 24 included unique studies, 7 (29%) were randomised control trials (RCTs), 6 (25%) were cluster RCTs, 6 (25%) were quasi-experimental studies with historical controls, 3 (13%) were quasi-experimental studies with concurrent controls, and 2 (8%) were quasi-experimental studies with both concurrent and historical controls. Using the NHMRC levels of evidence hierarchy, 7 (29%) of the included studies were Level II, 6 (25%) were Level III-1, 5 (21%) were Level III-2, and 6 (25%) were Level III-3.

The included studies were conducted in 8 different countries, including 7 (29%) from the UK, 6 (25%) from the US, 5 (21%) from Nordic countries, 3 (13%) from Australia, 2 (8%) from Canada, and 1 (4%) from New Zealand. Fifteen (63%) studies targeted adults with disability, 5 (21%) studies targeted older adults with disability, and 4 (17%) studies targeted children with disability. Twenty-one (88%) studies were conducted in outpatient care settings, and 3 (13%) studies were conducted in inpatient care settings. Seven (29%) studies involved health service staff training, 5 (21%) studies were of technology-based interventions, 4 (17%) studies examined community-based care models, 2 (8%) studies were of hospital-based care models, 2 (8%) studies involved paediatric-to-adult transitional care models, 2 (8%) studies involved patient and/or carer training, and 2 (8%) studies examined health policies. Appendix 4 contains detailed descriptions of the interventions used across the included studies.

Ten of the included (42%) studies reported on system-level improvements that lead to better health outcomes (Outcome 6), 8 (33%) studies reported on improvements in health literacy or practices (Outcome 4), 4 (17%) studies reported on improvements in experience or satisfaction with health services (Outcome 4), 4 (17%) studies reported on improvements in attitudes, knowledge, and skills of health service staff (Outcome 5), and 3 (13%) studies reported on improvements in co-ordination of care, continuity of care, or communication by health service staff (Outcome 1). None of included studies reported on improvements in access to preventive health care (Outcome 2).

Figure 1 – PRISMA flow diagram of the study selection process

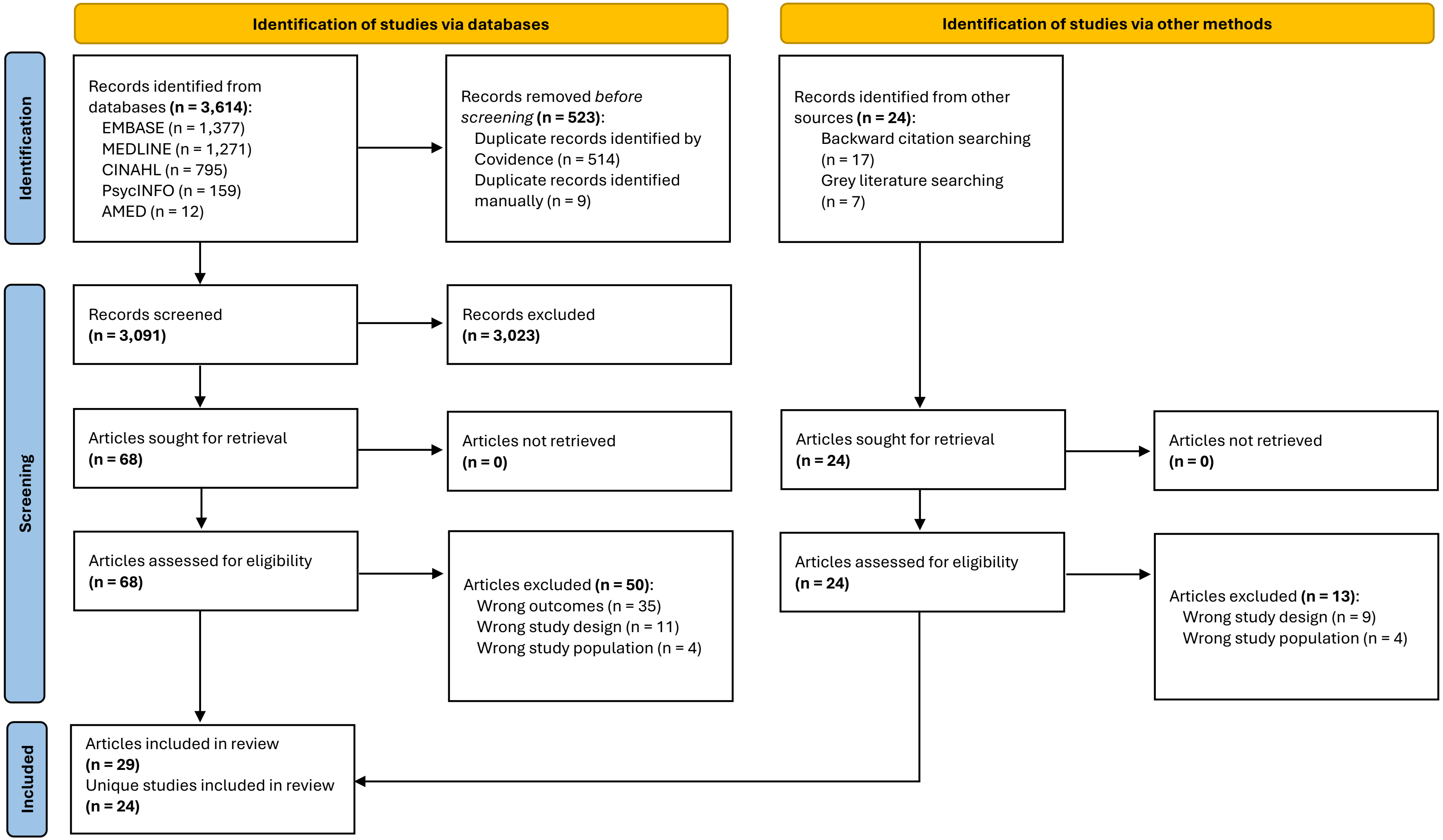

Table 2 – Characteristics of included studies

Study	Study design	Level of evidence	Country	Disability population	Care setting	Type of intervention	Outcome of interest
Killaspy 2015[1]	Cluster randomised controlled trial	III-1	UK	Adults with severe mental illness	Inpatient	Health service staff training	6
Blumberg 2015[2]	Quasi-experimental (historical control)	III-3	US	Adults with glaucoma	Outpatient	Health policy intervention	3
Coventry 2015[3]	Cluster randomised controlled trial	III-1	UK	Adults with diabetes mellitus and/or coronary artery disease with depressive symptoms	Outpatient – primary care	Community-based care model	3, 4
Chan 2015[4]	Randomised controlled trial	II	New Zealand	Children with asthma	Outpatient	Technology-based intervention	3
Luxford 2015 [5]	Quasi-experimental (historical and concurrent control)	III-2	Australia	Older adults with dementia*	Inpatient	Hospital-based care model	4, 5, 6
Lindsay 2016[6,7]	Quasi-experimental (historical control)	III-3	Canada	Children with spina bifida	Outpatient - hospital	Paediatric-to-adult transition service model	1

Study	Study design	Level of evidence	Country	Disability population	Care setting	Type of intervention	Outcome of interest
Singh 2016[8]	Quasi-experimental (historical control)	III-3	Finland	Adults with developmental disability	Outpatient – residential care	Health service staff training	6
Caller 2016[9]	Randomised controlled trial	II	US	Adults with epilepsy and cognitive impairment	Outpatient – hospital	Patient/carer training	3
Brooker 2016[10]	Quasi-experimental (historical control)	III-3	UK	Older adults with dementia	Outpatient – residential care	Health service staff training	5, 6
Szczepura 2016[11]	Quasi-experimental (historical control)	III-3	UK	Older adults with dementia	Outpatient – residential care	Health policy intervention	6
Valimaki 2017[12,13]	Randomised controlled trial	II	Finland	Adults with mental illness requiring antipsychotic medication	Outpatient	Technology-based intervention	3
Gustafsson 2017[14]	Randomised controlled trial	II	Sweden	Older adults with dementia or cognitive decline	Inpatient	Hospital-based care model	6
Hassiotis 2018[15,16]	Cluster randomised controlled trial	III-1	UK	Adults with intellectual disability	Outpatient – community service	Health service staff training	6

Study	Study design	Level of evidence	Country	Disability population	Care setting	Type of intervention	Outcome of interest
Wu 2018[17,20]	Quasi-experimental (concurrent control)	III-2	US	Adults with type II diabetes with depressive symptoms	Outpatient – primary care	Technology-based intervention	4,6
Bjorkelund 2018[18]	Cluster randomised controlled trial	III-1	Sweden	Adults with depression	Outpatient – primary care	Community-based care model	4
Worobey 2018[19]	Randomised controlled trial	II	US	Adults who were wheelchair-dependent	Outpatient	Technology-based intervention	3
Ring 2018[21,22]	Cluster randomised controlled trial	III-1	UK	Adults with epilepsy and intellectual disability	Outpatient – community service	Health service staff training	5, 6
Westbury 2018 [3]	Quasi-experimental (historical control)	III-3	Australia	Older adults with dementia	Outpatient – residential care	Health service staff training	6
Thoegersen 2019[24]	Quasi-experimental (concurrent control)	III-2	Denmark	Adults with serious mental illness	Outpatient – community service	Community-based care model	1, 4
Qian 2019[25]	Cluster randomised controlled trial	III-1	US	Adults with intellectual or developmental disability	Outpatient – residential care	Health service staff training	5

Study	Study design	Level of evidence	Country	Disability population	Care setting	Type of intervention	Outcome of interest
Gerrard 2019[26]	Quasi-experimental (concurrent control)	III-2	UK	Adults with learning disability	Outpatient	Community-based care model	6
Johnson 2020[27]	Randomised controlled trial	II	Australia	Children with cerebral palsy or other neurodevelopmental disability	Outpatient – home	Technology-based intervention	3
Kingsnorth 2021[28]	Quasi-experimental (historical and concurrent control)	III-2	Canada	Children with acquired brain injury and cerebral palsy	Outpatient – hospital	Paediatric-to-adult transition service model	1
Streltzov 2022[29]	Randomised controlled trial	II	US	Adults with epilepsy and cognitive impairment	Outpatient – home	Patient/carer training	3

** The age of the disability population (i.e. patients with dementia) was not explicitly stated, but it was assumed to be adults aged ≥65 years.*

Summary of findings

Table 3 contains a summary matrix of findings by type of disability (in rows), type of intervention (in columns), outcome of interest (represented by numbered icons within each cell), and availability and consistency of evidence of effectiveness (indicated by the colour of the numbered icons).

Outcome 1: Improvements in co-ordination of care, continuity of care, and communication by health service staff

Table 4 provides a tabular overview of the findings for improvements in co-ordination of care, continuity of care, and communication by health service staff. A total of three studies[6,7,24,28] reported on this outcome of interest category, all of which only addressed continuity of care outcomes.

Two studies[6,7,28] focused on paediatric-to-adult transition service models, involving introduction of a multidisciplinary transitional service to provide support to young people with childhood onset disabilities, as they transitioned from paediatric to adult services. Of these, one study[28] reported improvement in continuity of care in the intervention group during the transition period compared with the concurrent control group provided with usual care, and the other study[6,7] highlighted key challenges to implementation of a transitional service, including lack of clarity on the roles of clinicians in the service, difficulties balancing emerging autonomy of the young person with continued involvement of their parents, and insufficient duration of transitional support.

The remaining study focused on maintenance of continuity of care from inpatient to outpatient settings for adult patients with serious mental illness (i.e. schizophrenia, persistent delusional disorders, schizoaffective disorders, and bipolar affective disorders).[24] It evaluated the Assertive Community Treatment model of care, which involved several modifications to a standard community mental health service, including extended hours of operation, lower case load for staff, and increased attempts to engage patients in long-term care.[24] This study showed higher maintenance of care in the intervention group, compared to standard community mental health treatment.[24]

Outcome 2: Improvements in access to preventive health care

None of the included studies reported on outcomes for improvements in access to preventive health care.

Outcome 3: Improvements in health literacy or health practices

Table 5 provides a tabular overview of the findings for improvements in health literacy or practices. A total of 8 studies[2-4,9,12,13,19,27,29] reported on this outcome.

Five studies[2,4,12,13,19,27] evaluated interventions aimed to improve adherence to prescribed treatment, with one study[2] examining medication adherence in glaucoma using a government medication cost subsidy, two studies[4,12,13] examining medication adherence in childhood asthma and mental illness, respectively, using a technology-based prompt, and two studies[19,27] examining adherence to non-pharmacological management in physical disability, using a technology-based instruction tool. There was a decrease in medication non-adherence behaviours due to high cost of medication following implementation of a government medication cost subsidy,[2] as well as increased adherence to treatment where technology-based tools were used to aid management of physical disabilities.[4,19,27] Conversely, a personalised text message-based tool intended to improve antipsychotic medication adherence in community-dwelling adults with mental illness did not show evidence of decreased hospital re-admission for psychiatric care.[12,13]

Three studies[3,9,29] evaluated two distinct interventions to promote self-management of disability caused by multiple chronic health conditions, one intervention involved a collaborative care model,[3] and the other intervention involved patient education.[9,29] Only the collaborative care model was shown to increase self-management behaviours in community-dwelling adults with diabetes mellitus or coronary artery disease and depressive symptoms compared to usual care,[3] while the patient education intervention for management of epilepsy with cognitive impairment showed improved cognitive function without increased engagement in self-management behaviours compared to usual care.[9,29]

Outcome 4: Improvements in experience or satisfaction with health services

Table 6 provides a tabular overview of the findings for improvements in experiences or satisfaction with health services. A total of five studies[3,5,17,18,24] reported on this outcome.

Four studies[3,17,18,24] measured patient satisfaction in an outpatient care setting, while one study[5] measured carer satisfaction in an inpatient care setting. In the outpatient care settings, interventions using a collaborative care approach – that is, coordination of care between multiple healthcare practitioners to optimise management of a complex chronic condition (e.g. mental illness or multiple chronic conditions) – was shown to improve patient satisfaction with the service, compared to usual care.[3,17,18,24] Of the two interventions aiming to improve communication between the healthcare team and patients or carers, the addition of an automated telephone-based assessment tool to a collaborative care approach showed no evidence of increased patient satisfaction, compared to a collaborative care approach alone,[17] while an in-person tool to promote involvement of carers in dementia care in an inpatient setting was shown to improve carer satisfaction with the service, compared to previous experiences with the service prior to the intervention.[5]

Outcome 5: Improvements in attitudes, knowledge, and skills of health service staff

Table 7 provides a tabular overview of the findings for improvements in attitudes, knowledge, and skills of health service staff. A total of four studies[5,10,21,22,25] reported on this outcome, all of which evaluated interventions involving staff education and training.

Two studies[21,22,25] evaluated changes in the nature of care provided for adults with intellectual and/or developmental disability in an outpatient setting. Of these, one study[21,22] showed qualitative differences in the type of care delivered, with a modest reduction in the number of episodes of care required by nursing staff as a result of their training under a new care framework, compared to usual care. In contrast, one study[25] found no evidence that providing active support training to group home carers changed the level of assistance provided by the carers at 12-month follow up, compared to assistance provided by carers who did not undergo the additional training.

Two studies[5,10] evaluated changes in the knowledge and attitudes of staff providing care for older adults with dementia. Clinician training in TOP 5, a clinician-carer communication tool, was shown to increase their confidence in caring for inpatients with dementia, as well as increasing the likelihood of their collaboration with carers in the provision of care, compared to their confidence and attitudes, pre-intervention.[5] Training of nursing home staff in psychosocial care strategies also led to improvement in knowledge of evidence-based dementia care, as well as increasing person-centred and hope-focused attitudes to care, compared to pre-training, although caution should be exercised in the interpretation of these results as the reporting lacked numerical values for effect sizes and evidence of statistical significance.[10]

Outcome 6: System-level improvements that lead to better health outcomes

Table 8 provides a tabular overview of findings for system-level improvements that lead to better health outcomes. A total of 11 studies[1,5,8,10,11,14-16,20-23,26] reported on this outcome.

Six studies[5,10,11,14,23,26] evaluated interventions facilitating appropriate prescribing of medication for older adults with dementia[5,10,11,14,23] or adults with a learning disability and/or autism[26], with five studies[5,10,11,23,26] focusing exclusively on psychotropic prescribing. In the inpatient setting for patients with dementia, use of a clinician-carer communication tool resulted in a reduction in antipsychotic medication costs, compared to the pre-implementation period,[5] while a pharmacist-led medication review intervention reduced drug-related re-admissions over a 30-day follow-up period, compared to usual care.[14] In the outpatient setting, interventions involving staff training in psychosocial care approaches to support psychotropic de-prescribing resulted in decreased prevalence of psychotropic prescribing, compared to concurrent and historical controls,[10,23] and an increased likelihood of maintained dose reduction and deprescribing when a psychotropic medication challenge was attempted, compared to a concurrent control.[26] In contrast, a health policy intervention in the UK addressing multiple facets of dementia care, including awareness-raising, early diagnosis, and improved dementia care, showed no evidence of effect on country-wide antipsychotic prescribing, compared to the pre-intervention period.[11]

Three studies[8,15,16,21,22] evaluated staff-training interventions aiming to improve the care of adults with an intellectual or developmental disability in an outpatient setting. These interventions aimed to decrease the use of restrictive practices and/or improve health outcomes, without the goal of facilitating appropriate psychotropic prescribing practices.[8,15,16,21,22] Of these, Mindfulness-Based Positive Behaviour Supports Training, resulted in a reduction in the frequency of adverse outcomes, including the rate of injuries and staff turnover due to workplace stressors, compared to the pre-intervention period,[8] while the other two interventions, Positive Behaviour Support Training[15,16] and a novel Learning Disability Epilepsy Nurse Competency Framework,[21,22] reduced the cost of care without significantly impacting health outcomes, when compared to usual care.[15,16,21,22]

Of the remaining two studies, one study[1] evaluated service quality improvement and cost-effectiveness of a staff training intervention intended to increase patient engagement in inpatient mental health rehabilitation. The other study[20] evaluated the cost-effectiveness of a technology-facilitated care model, compared to a multidisciplinary healthcare team approach, for patients with Type II diabetes and depressive symptoms in a primary care setting. Neither of the two studies[1,20] demonstrated evidence of improved care or improved cost-effectiveness, compared to usual care.

Table 3 – Summary of findings matrix by type of disability, type of intervention, outcome of interest, and effectiveness[*†]

	Community-based care model	Hospital-based care model	Health service staff training	Patient/carer training	Paediatric-to-adult transition service model	Technology-based intervention	Health policy intervention
Psychosocial disability [‡]	🟢1 2 🟢3 🟢4 5 6	1 2 3 4 5 6	1 2 3 4 5 🔴6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 🔴3 🟡4 5 🟡6	1 2 3 4 5 6
Neurodevelopmental disability [§]	1 2 3 4 5 🟢6	1 2 3 4 5 6	1 2 3 4 🟡5 🟡6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 🟡3 4 5 6	1 2 3 4 5 6
Neurological disability [‖]	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 🟢5 🟡6	1 2 🟡3 4 5 6	🟢1 2 3 4 5 6	1 2 🟡3 4 5 6	1 2 3 4 5 6
Physical disability [¶]	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	🟢1 2 3 4 5 6	1 2 🟢3 4 5 6	1 2 3 4 5 6
Sensory disability [**]	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 🟢3 4 5 6
Dementia [††]	1 2 3 4 5 6	1 2 3 🟢4 🟢5 🟢6	1 2 3 4 🟢5 🟢6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 🔴6

* Green indicates consistent evidence of improvement with the intervention across studies; red indicates consistent evidence of no improvement with the intervention across studies; yellow indicates mixed evidence of improvement and no improvement with the intervention across studies; grey indicates absence of evidence.

† The six outcomes of interest were: (1) improvements in co-ordination of care, continuity of care, and communication by health service staff for people with a disability and their carers; (2) improvements in access to preventive health care for people with a disability and their carers; (3) improvements in health literacy and health practices of people with a disability and their carers; (4) improvements in experience and satisfaction with health services for people with a disability and their carers; (5) improvements in attitudes, knowledge, and skills of health service staff providing care for people with a disability and their carers; and (6) system-level improvements that lead to better health outcomes for people with a disability, their carers, and the system (e.g. cost efficiencies, process or service efficiencies).

‡ Studies contributing to consistency of evidence assessment for community-based care model for improvements in co-ordination of care, continuity of care, and communication by health service staff for people with a disability and their carers (Outcome 1): Thoegersen 2019[24]; studies contributing to consistency of evidence assessment for community-based care model for improvements in health literacy and health practices of people with a disability and their carers (Outcome 3): Coventry 2015[3]; studies contributing to consistency of evidence assessment for community-based care model for improvements in experience and satisfaction with health services for people with a disability and their carers (Outcome 4): Coventry 2015[3], Bjorklund 2018[18] and Thoergersen 2019[24]; studies contributing to consistency of evidence assessment for health service staff training for system-level improvements that lead to better health outcomes for people with a disability, their cares, and the system (Outcome 6): Killaspy 2015[1]; studies contributing to consistency of evidence assessment for technology-based intervention for improvements in health literacy and health practices of people with a disability and their carers (Outcome 3): Valimaki 2017[12,13]; studies contributing to consistency of evidence assessment for technology-based intervention for improvements in experience and satisfaction with health services for people with a disability and their carers (Outcome 4): Wu 2018[17,20]; and studies contributing to consistency of evidence assessment for technology-based intervention for system-level improvements that lead to better health outcomes for people with a disability, their cares, and the system (Outcome 6): Wu 2018[17,20].

§ Studies contributing to consistency of evidence assessment for community-based care model for system-level improvements that lead to better health outcomes for people with a disability, their cares, and the system (Outcome 6): Gerrard 2019[26]; studies contributing to consistency of evidence assessment for health service staff training for improvements in attitudes, knowledge, and skills of health service staff providing care for people with a disability and their carers (Outcome 5): Ring 2018[21,22], Qian 2019[25]; studies contributing to consistency of evidence assessment for health service staff training for system-level improvements that lead to better health outcomes for people with a disability, their cares, and the system (Outcome 6): Singh 2016[8], Hassiotis 2018[15,16], Ring 2018[21,22]; and studies contributing to consistency of evidence assessment for technology-based intervention for improvements in health literacy and health practices of people with a disability and their carers (Outcome 3): Johnson 2020[27].

‖ Studies contributing to consistency of evidence assessment for health service staff training for improvements in attitudes, knowledge, and skills of health service staff providing care for people with a disability and their carers (Outcome 5): Ring 2018[21,22]; studies contributing to consistency of evidence assessment for health service staff training for system-level improvements that lead to better health outcomes for people with a disability, their cares, and the system (Outcome 6): Ring 2018[21,22]; studies contributing to consistency of evidence assessment for patient/carer training for improvements in health literacy and health practices of people with a disability and their carers (Outcome 3): Caller 2016[9], Streltzov 2022[29]; studies contributing to consistency of evidence assessment for paediatric-to-adult transition service model for improvements in co-ordination of care, continuity of care, and communication by health service staff for people with a disability and their carers (Outcome 1): Lindsay 2016[6,7], Kingsnorth 2021[28]; and *studies contributing to consistency of evidence assessment for technology-based intervention for improvements in health literacy and health practices of people with a disability and their carers (Outcome 3): Johnson 2020 [27].*

¶ Studies contributing to consistency of evidence assessment for paediatric-to-adult transition service mode for improvements in co-ordination of care, continuity of care, and communication by health service staff for people with a disability and their carers (Outcome 1): Kingsnorth 2021 [28]; and studies contributing to consistency of evidence assessment for technology-based intervention for improvements in health literacy and health practices of people with a disability and their carers (Outcome 3): Chan 2015 [4], Worobey 2018 [19].

*** Studies contributing to consistency of evidence assessment for health policy intervention for improvements in health literacy and health practices of people with a disability and their carers (Outcome 3): Blumberg 2015 [2].*

†† Studies contributing to consistency of evidence assessment for hospital-based care model for improvements in experience and satisfaction with health services for people with a disability and their carers (Outcome 4): Luxford 2015 [5]; studies contributing to consistency of evidence assessment for hospital-based care model for improvements in attitudes, knowledge, and skills of health service staff providing care for people with a disability and their carers (Outcome 5): Luxford 2015 [5]; studies contributing to consistency of evidence assessment for hospital-based care model for system-level improvements that lead to better health outcomes for people with a disability, their cares, and the system (Outcome 6): Luxford 2015 [5], Gustafsson 2017 [14]; studies contributing to consistency of evidence assessment for health service staff training for improvements in attitudes, knowledge, and skills of health service staff providing care for people with a disability and their carers (Outcome 5): Brooker 2016 [10]; studies contributing to consistency of evidence assessment for health service staff training for system-level improvements that lead to better health outcomes for people with a disability, their cares, and the system (Outcome 6): Brooker 2016 [10], Westbury 2018 [23]; and studies contributing to consistency of evidence assessment for health policy intervention for system-level improvements that lead to better health outcomes for people with a disability, their cares, and the system (Outcome 6): Szezepura 2016 [11].

Table 4 – Summary of findings for Outcome 1: improvements in co-ordination of care, continuity of care, and communication by health service staff

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
Lindsay 2016[6,7]	**Inter-agency transition model** – transition support healthcare service for young people with spina bifida (aged 14 to 25 years), to aid transition from paediatric to adult community health services for ongoing disability management. **Comparator:** no formal transition of care support.	**Outcome measure(s):** experiences of transition from paediatric to adult health services, under the new transition model, and for those without access to formal transition support, collected through semi-structured interviews with youth with spina bifida, their parents and clinicians. **Key findings:** qualitative evidence: Challenges during transition, for those without formal transition support: • Lack of adult services close to where they lived. • Local primary care providers lacking specific knowledge of spina bifida. • Long waiting times to see adult providers, disrupting continuity of care. • Less integration in adult services compared to paediatric services (i.e. no multidisciplinary appointments in adult care). • Lack of confidence and lack of skills and knowledge to self-manage their condition. • Feeling of overwhelm in trying to navigate adult services without parental support.	Facilitators and barriers relevant to implementation of the new transition model, were described within the following themes: *Structural factors:* • Facilitators: commitment from senior leadership in supporting the new model and advocating for funding and inter-agency partnerships • Barriers: insufficient engagement of frontline clinicians in planning and implementation of the new model *Availability and continuity of care:* • Facilitators: nurse practitioner acted as a helpful bridge connecting young people to adult services • Barriers: young people living outside the catchment area for the adult community health

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
		Challenges during transition, under the new model: • Lack of clarity about the functioning of the transition service and roles of different team members. • Overprotective parenting, hindering development of independence and self-management skills. Benefits of receiving transition support, under the new model: • Nurse practitioner on the transition team assisted in building trust with adult providers, decreasing anxiety around navigating adult services. Key recommendations for transition support, from youth and parents: • Better access to transition services outside of urban areas. • Shared transition clinics between paediatric and adult providers to build relationships with new providers before leaving old ones. • Ongoing transition support after the age of 25, including support accessing primary care and specialist services as an adult, as well as	centre could not access primary care providers there, gaps in adult services (e.g. less rehabilitation physician and neurogenic bowel care providers within adult services). *Organisation of care:* • <u>Barriers</u>: confusion over structure and goals of the transition clinic contributed to lack of understanding and acceptance of the transition team nurse practitioner scope of practice. *Relational factors:* • <u>Facilitators</u>: regular steering committee meetings to enhance inter-agency partnerships • <u>Barriers</u>: front-line clinicians lacked understanding of the transition service and were sometimes resistant to their involvement; the nurse practitioner and life skills coach were not fully integrated into existing clinical teams and were

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
		life skills support relating to school, employment, housing and finances. - Begin the process of transferring responsibility from parents to youth at a younger age. - Increased flexibility in accommodating diversity in abilities and support needs among individuals with the same disability type.	not provided a consistent workspace and basic resources; part-time staffing, extended leave and turnover of staff *Personal factors:* - Barriers: parental reluctance to transfer disability management responsibilities to their children
Thoegersen 2019[24]	**Assertive Community Treatment –** community-based care model for adults with serious mental illness to maintain engagement with patients following discharge from inpatient mental health care. **Comparator:** community mental health treatment.	**Outcome measure(s):** disengagement from mental health services (defined as having no contact with the mental health team or local mental health services for a continuous period of ≥6 months within the 2-year follow-up period). **Key finding:** evidence of improvement in continuity of care: - Significantly lower disengagement from mental health services in intervention group (n=16, 8%) compared to control group (n=22, 14%).	*Fidelity:* - Higher treatment fidelity (91%) in Assertive Community Treatment group, compared to the standard community mental health treatment group (40%), which may have inflated the relative benefits of Assertive Community Treatment.
Kingsnorth 2021[28]	**LIFEspan Model of Transitional Care –** 2-year period of multidisciplinary team-	**Outcome measure(s):** maintenance of "continuous care" (defined by the participant having at least one	Implementation issues not specifically explored.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
	supported preparation for healthcare transition to improve continuity of care for young people with childhood-onset disabilities, transitioning from outpatient paediatric to adult rehabilitation services. The intervention group consisted of young people with acquired brain injury or cerebral palsy. **Comparator:** concurrent control group of 16-year-old participants with spina bifida receiving usual care, but no formal transition support.	visit to an adult provider within one year post-discharge from the paediatric rehabilitation service) **Key finding:** evidence of improvement in continuity of care: • Significantly higher maintenance of care in intervention group (n=35, 45%) compared to concurrent control group (n=3, 14%).	

Table 5 – Summary of findings for Outcome 3: improvements in health literacy or practices

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
Blumberg 2015[2]	**US Medicare Part D prescription drug benefit** – Medicare Modernization Act Part D, implemented in 2006, to allow adults covered by Medicare to purchase insurance for prescription drugs, with the aim to increase the availability of prescription medication to Medicare beneficiaries and decrease cost-related non-adherence to prescription medication in the Medicare beneficiary population. This study focused on Medicare beneficiaries with glaucoma. **Comparator:** pre-Medicare Part D implementation (i.e. 2004 and 2005).	**Outcome measure(s):** prevalence of cost-related medication non-adherence, and prevalence of cost-saving behaviours. **Key finding:** evidence of improvement in health practices: • Significant decrease in skipping doses (8.2% to 2.8%) and taking smaller doses (9.4% to 2.7%) from pre-implementation period to post-implementation period. • Significant decrease in purchasing prescriptions outside US (6.9% to 1.3%), asking for prescription samples from physicians (52.9% to 44.1%), shopping for the best prices (26.2% to 15.2%) and restricting spending on basic needs to be able to afford medications (8.0% to 3.5%) from pre-implementation period to post-implementation period.	Implementation issues not specifically explored.
Coventry 2015[3]	**Integrated collaborative care model** – for management of depression in adults with comorbid type II diabetes and/or coronary heart disease with	**Outcome measure(s):** self-management behaviours at four months post-intervention compared to baseline (measured through Health Education Impact Questionnaire).	Implementation issues not specifically explored.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
	depressive symptoms, in a primary care setting. **Control:** usual care from general practitioner, including referrals for psychological therapy and/or prescription for antidepressant medication prescription, as indicated.	**Key finding:** evidence of improvement in health practices: • Significant increase in reported self-management behaviours in the following domains: skill acquisition, constructive attitudes, self-monitoring, health service navigation, emotional wellbeing.	
Chan 2015 [4]	**Electronic monitoring device** – audiovisual reminders to aid adherence to preventive asthma treatment in children with asthma. **Control:** use of an identical preventive inhaler delivering corticosteroid therapy, with attached electronic monitoring device, but with audiovisual reminder function disabled.	**Outcome measure(s):** adherence to preventive inhaled corticosteroids (defined as proportion of prescribed preventer doses taken during 6-month follow-up period). **Key finding:** evidence of improvement in health practices: • Significant increased adherence in the intervention group (median adherence: 84%, 10th – 90th percentile: 54% – 96%) compared to control group (median adherence: 30%, 10th – 90th percentile: 8% – 68%).	Implementation issues not specifically explored.
Caller 2016[9]	**HOBSCOTCH –** training and education in self-management of	**Outcome measure(s):** objective cognitive function (measured using Repeatable Battery for the Assessment of Neuropsychological Status, with higher score indicating better cognitive function),	Barriers to implementation: difficulties reaching participants via telephone, participants had difficulty remembering

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
	cognitive impairment for adults with epilepsy. **Control:** no formal training in addition to usual epilepsy care.	which was used as a proxy measure for health literacy and practices. **Key finding:** mixed evidence of improvement in health practices: - Significantly greater improvement, post-intervention, in overall cognitive function score (+4.9 versus -2.3) and in the attention domain (+2.9 versus -8.9) in the intervention group, compared to the control group. - No evidence of greater improvement in the domains of immediate memory, visuospatial/constructional, language, or delayed memory.	appointments, transportation barriers for in-person visits. Author suggested modifications: fully virtual delivery, increased time interval between visits, greater flexibility with appointment scheduling
Valimaki 2017[12,13]	**Mobile.Net** – tailored and automated text message-based tool to encourage medication adherence in adults with mental illness taking antipsychotic medications. **Control:** no additional reminder tool	**Outcome measure(s):** proportion of patients re-admitted to hospital during the 12-month follow-up period, which was used as a proxy measure for health literacy and practices. **Key findings:** no evidence of improvement in health practices: - No significant difference in proportion of participants re-admitted in the intervention	Usability: 98% reported that Mobile.Net was easy to use, with 87% reporting they did not cause harm. 72% were satisfied with the content of the SMS messages and 61% found it useful. 64% stated they would continue to use the SMS system in future. Groups in which higher usefulness was reported, were divorced people and those seeking employment.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
		group (n=242, 43.0%) compared to the control group (n=216, 38.8%).	Perceived harm: Women were more likely to perceive the intervention as harmful than men; the most common examples of harm were being woken up by the messages, or disturbance at work.
Worobey 2018[19]	**Web-Based Transfer Training –** outpatient training program to improve independent wheelchair transfer technique in adult manual and power wheelchair users who can transfer independently. **Control:** no additional transfer training provided.	**Outcome measure(s):** wheelchair transfer technique (measured using Transfer Assessment Instrument). **Key findings:** evidence of improvement in health practices: • Significant improvement in transfer technique scores at one day post-training in both in-person and web-based transfer training groups compared to control, with improvements maintained at two days post-training.[*]	Facilitators of implementation: viewing videos of both correct and incorrect transfer technique was considered particularly helpful; participants were motivated to implement transfer training to decrease unpleasant physical symptoms (e.g. numbness or tingling due to carpal tunnel syndrome). Barriers to implementation: participants noted their existing preferences for transferring contradicted some teaching in transfer training, with some noting physical limitations (e.g. upper extremity and trunk weakness) limiting their ability to modify their transfer technique.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
Johnson 2020[27]	**Physitrack –** online exercise prescription tool to deliver home exercise programs for children with cerebral palsy or other neurodevelopmental disability. **Control:** home exercise program with paper-based delivery	**Outcome measure(s):** adherence to exercise program (measured through self-completed exercise log: (1) proportion of exercised attempted of total exercises prescribed and (2) proportion of exercise repetitions attempted of total prescribed (3) numerical rating of adherence from 0-10); performance of prescribed exercises (measured through Correctness of Exercise Performance scale completed by physiotherapists based on videos of participants performing exercises). **Key findings:** mixed evidence of improvement in health practices: • Significantly higher self-reported adherence to prescribed number of repetitions for each exercise in the intervention (median rating: 10.0, 95% CI: 9.0 – 10.0) compared to control group (median rating: 9.0, 95% CI: 6.0 – 10.0). • No evidence of improved adherence using other measures, or improved performance of exercises in the intervention compared to the control group.	<u>Usability</u>: high usability scores reported by participants, moderate usability scores reported by therapists.
Streltzov 2022[29]	**HOBSCOTCH** – training and education in self-management of cognitive impairment for adults with	**Outcome measure(s):** frequency of engagement in self-management behaviours (measured through	<u>Satisfaction with intervention</u>: 95% of participants in the intervention groups stated that HOBSCOTCH provided

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
	epilepsy. In this study, there were two intervention groups, one offering entirely virtual delivery “distance delivery”, and the other with some face-to-face delivery “in-person delivery”. **Control:** no formal training in addition to usual epilepsy care.	Epilepsy Self-Management Scale, higher score indicates better self-management). **Key findings:** no evidence of improvement in health practices: - No evidence of increased engagement in self-management at six months in either intervention group (distance delivery mean difference (SD): +10.2 (3.2) versus in-person delivery mean difference (SD): +7.9 (2.9) versus control group mean difference (SD): +4.1 (1.7)).	tools useful in daily life, with an average rating of 73/100 in perceived benefit. Participant feedback included: making the program longer and offering a self-directed, electronic program.

** Results are provided in a box-whisker plot, with numerical results not presented.*

Table 6 – Summary of findings for Outcome 4: improvements in experiences or satisfaction with health services

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
Coventry 2015[3]	**Integrated collaborative care model:** case manager involvement for care coordination and treatment of depression in adults with comorbid type II diabetes and/or coronary heart disease, in a primary care setting. **Control:** usual care from general practitioner, including referrals for psychological therapy and/or prescription for antidepressant medication prescription, as indicated.	**Outcome measure(s):** patient assessment of quality of care (measured through Patient Assessment of Chronic Illness Care scale), and patient satisfaction with care (measured through Client Satisfaction Questionnaire). **Key findings:** evidence of improvement in patient satisfaction with health services: • Significantly superior overall quality of care and care within the following domains, patient activation, delivery design/decision support, goal setting, and problem solving/contextual counselling, in the intervention group compared to the control group. • Significantly higher overall satisfaction with care as well as satisfaction with the quality of service, with the appropriateness of service, that the services helped, and that the patient would come back to the service, in the intervention group compared to the control group.	Implementation issues not specifically explored.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
Luxford 2015[5]	**TOP 5:** clinician-carer communication tool to aid inpatient care for patients with dementia. **Comparator:** pre-TOP 5 implementation.	**Outcome measure(s):** carer satisfaction with intervention and hospital-based care (both rated on a 5-point Likert scale). **Key findings:** evidence of improvement in carer satisfaction with health services: - >80% of carer respondents reported high satisfaction with the intervention in terms of the following domains: information provided regarding intervention, clinician personalisation of care, benefit provided to patient, patient calmness, carer engagement in patient care. - Significant increase in agreement with the following statements post-implementation, compared to pre-implementation: 'staff making the carer feel comfortable to provide information about the patient', 'staff listening to and taking notice of information provided by the carer'.	Facilitators: acceptability to staff, an existing culture of engagement with carers, focused training for clinicians in how to effectively write the TOP 5 list, executive and clinical leadership, local site liaison officer as a central 'driver', clinical champions within the wards, multidisciplinary involvement (reinforcing that 'care is everyone's responsibility'). Barriers: difficulty in translating the carers' tips into a workable strategy for the hospital environment, lack of confidence in writing strategies based on 'non-clinical' tips, clinician resistance to change, time constraints.
Wu 2018[17]	**Technology-facilitated care model** – using automated telephone assessment technology, integrated with disease management registry systems to automate aspects of	**Outcome measure(s):** patient satisfaction with care (rated from 1 to 5). **Key findings**: mixed evidence of improvement in patient satisfaction with health services:	Implementation issues not specifically explored.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
	depression care provided by a collaborative care team for management of depression in adults with type II diabetes, in a primary care setting. **Control:** usual care, delivered by primary care physician, including referrals for psychological therapy and/or prescription for antidepressant medication, as indicated.	• Significantly higher satisfaction with diabetes care and care for emotional problems in the subgroup with major depression in the technology-facilitated care arm, compared to usual care. • No evidence of difference in satisfaction between technology-facilitated care and supported care.	
Bjorkelund 2018[18]	**Care Management** – collaborative care model involving a trained nurse acting as a "care manager" for all adults presenting to primary care services with a new diagnosis of depression. **Control:** usual care, delivered by primary care physician, only.	**Outcome measure(s):** patient satisfaction with care (measured through proportion of participants recording "good/ excellent" rating in the Psychiatric Outpatient Satisfaction Scale administered at 3 months and 6 months). **Key findings:** evidence of improvement in patient satisfaction with health services: • Significantly higher percentage of respondents in the intervention group compared to the control group were highly likely to recommend the treatment to others at three months (95.8% vs 89.0%) and six months (97.8% vs 86.9%).	Implementation issues not specifically explored.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
Thoegersen 2019[24]	**Assertive Community Treatment** – community-based care model for adults with serious mental illness to maintain engagement with patients following discharge from inpatient mental health care. **Comparator:** standard community mental health treatment.	**Outcome measure(s):** patient satisfaction with care (measured through Client Satisfaction Questionnaire score at 2-year follow-up). **Key findings:** evidence of improvement in patient satisfaction with health services: • Significantly higher satisfaction with care at 2 years in the intervention group compared to control group.	Fidelity: Higher treatment fidelity (91%) in Assertive Community Treatment group, compared to the standard community mental health treatment group (40%), which may have inflated the relative benefits of Assertive Community Treatment.

Table 7 – Summary of findings for Outcome 5: improvements in in attitudes, knowledge, and skills of health service staff

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
Luxford 2015[5]	**TOP 5 –** clinician-carer communication tool to aid inpatient care for patients with dementia. **Comparator:** pre-TOP 5 implementation.	**Outcome measure(s):** clinician collaboration with carers in management of patients with dementia (measured through agreement with statement rated from 1–5 that they 'always obtain key strategies from carers to manage the care of patients with dementia'), and clinician confidence caring for patients with dementia (rated on a 5-point Likert scale). **Key findings:** evidence of improvement in attitudes, knowledge, and skills of health service staff: • Significant increase in clinician-reported likelihood to collaborate with carers in post-implementation period compared to pre-implementation. • Significant increase in confidence in caring for patients with dementia in post-implementation period compared to pre-implementation.	Facilitators: acceptability to staff, an existing culture of engagement with carers, focused training for clinicians in how to effectively write the "TOP 5" list, executive and clinical leadership, local site liaison officer as a central 'driver', clinical champions within the wards, multidisciplinary involvement (reinforcing that 'care is everyone's responsibility'). Barriers: difficulty in translating the carers' tips into a workable strategy for the hospital environment, lack of confidence in writing strategies based on 'non-clinical' tips, clinician resistance to change, time constraints.
Brooker 2016[10]	**Focussed Intervention Training and Support (FITS) program** – a training intervention for nursing home staff to deliver effective, person-centred psychosocial care to nursing home residents with dementia, thereby decreasing inappropriate	**Outcome measure(s):** knowledge of dementia care (measured through Dementia Knowledge Questionnaire) and attitudes to dementia care (measured through Approaches to Dementia Questionnaire).	Barriers: Dementia Care Coaches (DCCs) noted lack of time, lack of management and/or organisational support, and having a role unsuited to being a care coach, as major barriers to implementation.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
	prescription and use of anti-psychotic medications. **Control:** usual care without additional training.	**Key findings:** evidence of improvement in attitudes, knowledge, and skills of health service staff: - Significant improvement from pre-to post-training and from pre-training to post-supervision.* - Significant improvement in overall score and on subscale factors of 'Hope' and 'Person-Centredness', from pre-training to post-supervision.*	Burden on Dementia Care Coaches due to FITS: Overall, the vast majority of experienced FITS positively and showed improvements personally, and in their care homes. However, DCCs who encountered substantial, insurmountable, organisational barriers to implementation reported that the experience had a negative impact on their own well-being. Increased stress and frustration were reported by DCCs where they were not given time to implement FITS, particularly where they were overloaded by other organisational requirements. DCCs often had to use substantial personal resources to participate and implement FITS. FITS, in these circumstances, contributed to at least one DCC's decision to resign their post.
Ring 2018[21,22]	**Learning Disability Epilepsy Specialist Nurse Competency Framework** – training program to support nurses in community clinical practice and professional development to improve care for	**Outcome measure(s):** reasons for, and type of care delivered by nursing staff during follow-up period (collected from nursing staff logs and categorised). **Key findings:** evidence of improvement in attitudes, knowledge, and skills of health service staff:	Implementation issues not specifically explored.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
	adults with epilepsy and intellectual disability. **Control:** usual care without additional training.	- Significantly lower number of daily episodes of care (mean difference: -1.96) in intervention group compared to control group. - Significant difference in reasons for, and types of care between intervention and control groups, with a greater proportion of episodes of care dedicated to medication issues and review and prescribing and responding to urgent health/behavioural concern, while a lower proportion of episodes of care were dedicated to patient and family or carer education.	
Qian 2019[25]	**Active Support Training** – training program for group home staff (classroom-style instruction + mentorship) to improve care for adults with intellectual or developmental disability. **Control:** usual care without additional training.	**Outcome measure(s):** proportion of observed time during which the group home resident was observed receiving staff assistance. **Key findings:** no evidence of improvement in attitudes, knowledge, and skills of health service staff: - No evidence of greater staff assistance provided in the intervention group (7.8%) compared to the control group (6.4%).	Barriers: organisational factors, particularly staffing instability/turnover, and extended time to complete Active Support Training in a facility (almost 6 months due to logistical challenges).

** These results should be interpreted with caution as authors did not report summary statistics, confidence intervals, or p-values to support the findings stated in the text.*

Table 8 – Summary of findings for Outcome 6: system-level improvements that lead to better health outcomes

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
Killaspy 2015 [1]	**GetREAL** – staff training in occupational therapy-based strategies, aiming to increase patient engagement in inpatient mental health rehabilitation unit activities. **Control:** no additional training provided (i.e. usual care).	**Outcome measure(s):** service quality (measured through Quality Indicator for Rehabilitative Care scale) and cost-effectiveness (incremental cost to achieve 1% increase in patient engagement in activities). **Key findings:** no evidence of system-level improvement: • No evidence of greater improvement in service quality when comparing pre-intervention and post-intervention periods, in the intervention group, compared to control. • The cost was (GBP)£101 per percent increase in patient engagement.	Fidelity: despite high intervention fidelity, few units made spontaneous contact with the GetREAL team during the 10 month "reinforcing" stage, suggesting that units may not have been consistently implementing learnt strategies.
Luxford 2015[5]	**TOP 5 –** clinician-carer communication tool to aid inpatient care for patients with dementia. **Comparator:** pre-TOP 5 implementation.	**Outcome measure(s):** frequency of falls (number of falls per month), frequency of 1:1 nursing care (mean instances of 1:1 nursing care per month), antipsychotic medication prescribing (total costs of antipsychotic medications per month). **Key findings:** evidence of system-level improvement: • Significant reduction in mean number of falls per month in intervention ward compared control ward (6.85 additional falls prevented	Facilitators: acceptability to staff, an existing culture of engagement with carers, focused training for clinicians in how to effectively write the “TOP 5” list, executive and clinical leadership, local site liaison officer as a central ‘driver’, clinical champions within the wards, multidisciplinary involvement (reinforcing that ‘care is everyone’s responsibility’).

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
		per month) in the same hospital, during the post-implementation period. - Significant reduction in mean instances of 1:1 nursing care per month (0.84 per month) during post-implementation period compared to pre-implementation period. - Significant reduction in antipsychotic medication prescription costs (68% per month) during the post-implementation period compared to pre-implementation period.	Barriers: difficulty in translating the carers' tips into a workable strategy for the hospital environment, lack of confidence in writing strategies based on 'non-clinical' tips, clinician resistance to change, time constraints.
Singh 2016[8]	**Mindfulness-Based Positive Behaviour Supports Training –** for paid group home carers to aid them in delivering care for those with developmental disabilities, using less restrictive procedures. **Comparator:** pre-delivery of Mindfulness-based Positive Behaviour Supports Training.	**Outcome measure(s):** - Frequency of staff-administered brief physical holds per week. - Frequency of physical injuries to peers by another individual during a physical altercation per week. - Frequency of physical injuries to staff responding to an aggressive individual or intervening in aggression between two other individuals per week. - Number of staff member resignations attributed to work-related injury or stress. **Key findings:** evidence of system-level improvement:	Fidelity: group home staff maintained good adherence to meditation practice with staff meditating on an average of 82% (range = 69–94%) of days during the post-training phase.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
		- Significant reduction in mean number of instances of physical restraint per week (14.0 pre-implementation versus 2.0 post-implementation). - Significant reduction in mean number of peer injuries per week (5.0 pre-implementation versus 1.0 post-implementation). - Significant reduction in mean number of staff injuries per week (3.0 pre-implementation versus 1.0 post-implementation). - Significant reduction in staff resignations (13 pre-implementation versus 0 post-implementation).	
Brooker 2016[10]	**Focussed Intervention Training and Support (FITS) program** – a training intervention for nursing home staff to deliver effective, person-centred psychosocial care to residents with dementia, thereby decreasing inappropriate prescription and use of anti-psychotic medications. **Control:** Usual care without additional training.	**Outcome measure(s):** proportion of residents prescribed an antipsychotic medication. **Key findings:** evidence of system-level improvement: - Significant decrease in overall antipsychotic medication prescribing from 20% (n=301), pre-intervention, to 14% (n=216), post-intervention.	Barriers: Dementia Care Coaches (DCCs) noted lack of time, lack of management and/or organisational support, and having a role unsuited to being a care coach, as major barriers to implementation. Excess burdens: DCCs who encountered substantial, insurmountable, organisational barriers to implementation reported that the experience had a negative impact on their own wellbeing. Increased stress

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
			and frustration were reported by DCCs where they were not given time to implement FITS, particularly where they were overloaded by other organisational requirements. DCCs often had to use substantial personal resources to participate and implement FITS. FITS, in these circumstances, contributed to at least one DCC's decision to resign their post.
Szczepura 2016[11]	**National Dementia Strategy** – government strategy launched in February 2009, with the overall aim to improve dementia care (including reducing inappropriate antipsychotic medication use in nursing home residents with dementia). **Comparator:** pre-implementation of National Dementia Strategy.	**Outcome measure(s):** proportion of nursing home residents prescribed an antipsychotic medication. **Key findings:** no evidence of system-level improvement: • No significant difference in the proportion of antipsychotic prescribing in nursing homes between pre-intervention (18.0% SD: 12.0%) and four years post-intervention (19.0%, SD: 15.2%) periods.	Implementation issues not specifically explored.
Gustaffson 2017[14]	**Comprehensive medication reviews** – clinical pharmacist-led medication review as part of hospital-based care, to address	**Outcome measure(s):** drug-related readmission rate over 30-day and 60-day follow-up periods. **Key findings:** evidence of system-level improvement:	Implementation issues not specifically explored.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
	drug-related hospital admission in older adults with dementia or cognitive impairment. **Control:** usual care without additional pharmacist input.	- Significant decline in drug-related readmission rate in the intervention group within a 30-day follow-up period (hazard ratio: 0.46; 95% CI: 0.23 – 0.94).	
Hassiotis 2018[15,16]	**Positive Behaviour Support Training** – training program for community intellectual disability service staff to improve care for adults with intellectual disability and challenging behaviours. **Control:** usual care without additional training.	**Outcome measure(s):** cost-effectiveness (incremental cost per 1 quality-adjusted life year). **Key findings:** mixed evidence of system-level improvement: - From a health and social care perspective (including medication costs): (GBP)£16,276 per quality-adjusted life year. - From a societal cost perspective: (GBP)£11,566 per quality-adjusted life year.	Fidelity: Only 30% (33/108) participants received care in line with all elements of the Positive Behaviour Support model. Barriers: The time spent by therapists on study-related work to implement Positive Behaviour Support was considered too onerous, given the existing workload and lack of additional resource provision (e.g. establishment of a dedicated accredited behavioural therapist position in the community intellectual disability service) to support the implementation.
Wu 2018[17,20]	**Technology-facilitated care model** – using automated telephone assessment technology, integrated with disease management registry systems to automate aspects of	**Outcome measure(s):** cost-effectiveness (incremental cost per 1 quality-adjusted life year). **Key findings:** mixed evidence of system-level improvement:	Implementation issues not specifically explored.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
	depression care provided by a collaborative care team for management of depression in adults with type II diabetes, in a primary care setting. **Comparator:** usual care delivered by primary care physician.	- Technology-facilitated care resulted in cost-saving, compared to usual care, but did not result in cost-saving, improved health outcomes, or improved cost-effectiveness, compared to supported care.	
Ring 2018[21,22]	**Learning Disability Epilepsy Specialist Nurse Competency Framework** – training programme to support nurses in community clinical practice and professional development to improve care for adults with epilepsy and intellectual disability. **Control:** usual care without additional training.	**Outcome measure(s):** cost-effectiveness (incremental cost per 1 quality-adjusted life year). **Key findings:** mixed evidence of system-level improvement: - Intervention provided lower quality-adjusted life year outcomes (mean difference: -0.020) at lower cost (annual cost saving of (GBP)£357 in health and social care costs and (GBP)£631 in societal costs) than usual care.	Implementation issues not specifically explored.
Westbury 2018[23]	**Reducing Use of Sedatives (RedUSe)** – Six-month intervention consisting of audit, staff education and interdisciplinary review of	**Outcome measure(s):** prevalence of antipsychotic medication prescribing and prevalence of benzodiazepine medication prescribing. **Key findings:** evidence of system-level improvement:	Implementation issues not specifically explored.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
	residential aged care facilities, to promote appropriate use of antipsychotics and benzodiazepines in residents with dementia. **Comparator:** pre-implementation of RedUSE.	• Significant reduction in prevalence of antipsychotic medication prescribing from 21.6% (pre-intervention) to 18.9% (post-intervention). • Significant reduction in prevalence of benzodiazepine medication prescribing from 22.2% (pre-intervention) to 17.6% (post-intervention).	
Gerrard 2019[26]	**Positive Behaviour Support Framework** – used in a community care setting to aid in de-prescribing of psychotropic medication in adults with learning disability and/or autism, exhibiting challenging behaviours. **Comparator:** attempting medication challenge with usual care (without positive behaviour support).	**Outcome measure(s):** • Proportion of patients who initiated of medication reduction. • Proportion of patients who successfully discontinued medication. • Proportion of patients who needed to restart or increase medication following discontinuation or reduction. **Key findings:** evidence of system-level improvement: • Significant increased proportion in intervention group (92%) compared to control group (41%) were able to initiate medication challenge. • Increased proportion in intervention group (60%) compared to control (14%) were able to successfully discontinue medication. Final	Implementation issues not specifically explored.

Study	Brief description of intervention/comparator	Outcome measure(s) and key finding(s)	Notes on implementation
		results were uncertain as medication challenge ongoing. • Significant decreased proportion in intervention group (4%) compared to control group (28%) required restarting or increasing dose of medication during the medication challenge.	

Review of grey literature

The search of selected grey literature sources identified a total of 46 potentially relevant grey literature documents that were retrieved and subjected to the two-step process.

Firstly, manual screening of the reference lists of potentially relevant grey literature documents identified a total of 7 potentially eligible peer-reviewed scientific journal articles that had not been identified by the electronic database searches. These 7 potentially eligible peer-reviewed scientific journal articles were incorporated into the systematic review of recent peer-reviewed scientific literature by retrieving full-text versions and carefully assessing them against the eligibility criteria (as described above).

Secondly, potentially relevant grey literature documents were reviewed to determine if they contained full reports on original research that had not been published in the peer-reviewed scientific literature. None of the potentially relevant grey literature documents contained a full report on original research that had not been published in the peer-reviewed scientific literature.

Discussion

Summary of findings

The purpose of this rapid review was to identify and synthesise current evidence on effective health service delivery models and best practice approaches that have demonstrated improved health outcomes for people with disability and their carers. A total of 29 peer-reviewed journal articles reporting on 24 unique studies met the eligibility criteria.[1-29]

Community-based care model

All community-based care model interventions used structured multidisciplinary collaboration to improve outcomes,[3,18,24,26] with the majority focused on improving care for people with a mental illness.[3,18,24] Collaborative care approaches in mental health frequently involved care coordination by a case manager, responsible for providing brief psychological interventions, as well as communicating patient progress and organising appointments with other clinicians.[3,18] The health professionals who undertook this role sometimes required additional training in the collaborative care approach and in the delivery of brief psychological interventions, in order to effectively fulfil their responsibilities.[3] These models of care could be further enhanced with technology-based tools, such as automated telephone assessment technology, to aid in monitoring, thereby reducing burdens on clinical staff.[20]

In contrast with other interventions for people with mental illness, such as technology-based tools[17,20] or health service staff training,[1] collaborative care was consistently effective in improving three outcomes of interest, increasing patient satisfaction with health services,[3,18,24,26] as well as enhancing continuity of care,[24] promotion of self-management,[3] and reducing the use of sub-optimal health interventions.[26] These findings are supported in other literature highlighting the benefits of collaborative care approaches for patients with severe mental illness[93,94] and patients with comorbid mental and physical illnesses,[94-96] due to difficulties maintaining engagement with these populations and the need for coordinated treatment approaches.[95] Collaborative models of care also have the potential to be effective in other disability populations, such as those with neurodevelopmental disability, where mental illness is a highly prevalent and often undertreated comorbidity.[97,98]

Hospital-based care model

Hospital-based care model interventions showed evidence of enhanced care for patients with dementia,[5,14] including decreasing the frequency of inappropriate and potential harmful medication prescribing,[5,14] and improving carer satisfaction with care, compared to pre-intervention experiences with the health servivce.[5] These interventions involved a clear pathway for the use of clinical recommendations; in particular, the TOP 5 intervention involved standardised clinical documentation of carer suggestions for improving care of the patient, to be referenced during handovers,[5] while pharmacists involved in comprehensive medication reviews would iteratively update patient records following medication reconciliation, with physicians updated on recommendations.[14] It is possible that higher efficacy of hospital-based care models was enabled by familiarity with protocol-based practice in hospital settings, enhancing uptake of this type of intervention, as opposed to health service staff training interventions, which showed lower efficacy in inpatient settings.[1] This finding is supported by systematic reviews of interventions in a hospital-based setting, indicating more robust evidence for care model interventions compared to staff training, largely due to the greater availability of high quality studies evaluating a wider variety of care models.[99-102]

Health service staff training

Health service staff training interventions aimed to improve health services for people with a range of disability types, namely, psychosocial, neurodevelopmental, neurological and dementia. These were frequently resource-intensive interventions, requiring multiple stages of training[8,23] or upskilling[15,16] and supervision of trainers[10], with mixed evidence of effect for the outcomes of interest. In particular, most staff training interventions produced observable changes in staff behaviour and/or knowledge,[8,10,21,22] with decreased use of sub-optimal health interventions, such as the use of psychotropics[10,23] or physical restraint[8] for behaviour management, as well as decreased need for routine care activities, such as patient/carer education.[21,22] When service quality-related outcomes were measured, there was evidence of decreased adverse outcomes, including injuries and reductions in staff turnover due to work stress.[8] Staff training interventions that showed no evidence of benefit included those that reported implementation challenges, namely insufficient engagement of staff,[1] and staffing instability and turnover leading to prolonged duration of training and logistical challenges.[25] Other staff training interventions with demonstrated effectiveness also reported implementation issues which may have decreased the effect size, including difficulty integrating new training or strategies into existing practices,[10] and insufficient support provided to staff or lack of organisational resources to facilitate delivery of the intervention.[10,15] Overall, health service staff training interventions were found to improve care for people with disabilities, particularly for people with neurodevelopmental disabilities and dementia; however, there are many potential implementation issues, including staffing instability and logistical challenges with training delivery, which can compromise efficacy.

Patient/carer training

One patient training intervention, involving eight weekly educational sessions, largely delivered through telephone appointments with accompanying written materials, was evaluated in two separate studies focused on people with epilepsy and cognitive impairment.[9,29] These two studies[9,29] indicated mixed results, with some improvements in cognitive function,[9] but no evidence of increased engagement in self-management compared to those who did not receive the training.[29] These mixed results, despite positive participant feedback, are likely due to implementation challenges, including difficulties reaching participants via telephone and participants having difficulty remembering appointments.[9,29] Thus, a longer self-directed program or introducing greater flexibility in appointment scheduling, may enhance efficacy of training.[9,29]

Paediatric-to-adult transition service model

Paediatric-to-adult service transition is a high-risk time for young people with childhood-onset disabilities, due to increased potential for service interruption and disengagement,[103] which can lead to poor long-term health outcomes.[41] The two included studies evaluating paediatric-to-adult service transition models,[6,7,28] highlighted the benefits of a dedicated transition team to facilitate continuity of care,[28] while also identifying structural factors within health services that posed implementation challenges.[6,7] These factors included differences in the structure of adult versus paediatric services (e.g. less availability of rehabilitation physicians and absence of specific sub-specialty providers in adult care), confusion over the scope of practice of transition team clinicians, and difficulties with facilitating parental involvement in transitional care while maintaining the autonomy of the young person.[7] Previous similar studies have advocated for a structured approach to transitional care with the involvement of dedicated transition clinicians, while also emphasising that transition models need to be tailored to the care needs of specific disability groups.[104,105]

Technology-based intervention

Technology-based interventions were found to be beneficial in supporting self-management for people with physical disabilities.[4,19,27] On the other hand, there was equivocal or no evidence of technology-based interventions being beneficial in the care of people with mental illness.[12,13,17] In particular, feedback regarding a text message intervention encouraging antipsychotic medication adherence in patients with severe mental illness, showed that less than two-thirds reported that it was useful (61%), and would continue to use it in future (64%).[13] A previous systematic review of digital behaviour support interventions for people with severe mental illness supports these findings, indicating that this group may require additional health professional or carer support to improve efficacy and usability of digital interventions.[106]

Health policy intervention

Of the two health policy interventions evaluated,[2,11] only the US government-funded medication cost subsidy,[2] was effective in reducing cost-related medication non-adherence. There was no evidence of the England's National Dementia Strategy having an impact on psychotropic medication prescribing in dementia care.[11] However, while England's National Dementia Strategy may not have improved care, it did lead to increased rates of dementia diagnosis and the prescription of anti-dementia medication for the affected population identified.[107]

Strengths and limitations

The strengths of this rapid review include its well-developed and comprehensive search strategy, including complementary searches of grey literature sources, and its systematic approach to study selection process, including the use of two independent reviewers during the abstract and full-text screening phases.

The limitations of this rapid review pertain to both the methodology of the review itself, as well as the extent and heterogeneity of the resulting evidence base. There was a scarcity of evidence for a wide range of combinations of types of disability, types of interventions, and outcomes of interest. While the search strategy involved searching five major electronic databases, the searches were restricted to studies from high-income countries similar to Australia and published in English language from 1 January 2015 to 31 July 2025. As such, the findings of this review should not be generalised beyond high-income countries similar to Australia. Moreover, although the eligible high-income countries included in this review were selected for their similarity to Australia, it is important to note that the health systems vary across these countries, and this may limit the applicability of the findings from an Australian perspective. In addition, comprehensive risk of bias assessment and quality appraisal of individual included studies, and meta-analysis and assessment of certainty of evidence of the body of included literature were not performed due to the expedited nature of this rapid review. In the absence of meta-analysis and full assessment of the certainty of evidence of the body of included literature, the judgements on the consistency of evidence across studies were inevitably somewhat arbitrary. Given these limitations, the conclusions of this rapid review should be interpreted with caution.

Conclusion

This rapid review indicates that health service staff training has been shown to be an effective intervention in improving health outcomes for people with disability, although the efficacy of the training interventions is moderated by implementation challenges and likely reduced implementation fidelity. Community-based collaborative care models were shown to be useful in facilitating care for individuals with mental illness, either as a primary diagnosis or as a comorbid diagnosis along with another type of disability, while technology-based interventions were found to be more effective in promoting self-management for those with physical disability.

There is a need for further research to evaluate patient and carer education and training interventions, health policy interventions, hospital care model interventions, and paediatric-to-adult transition service models in a variety of cohorts of people with disability. Further research is also required to identify effective interventions for individuals with physical and/or sensory disabilities; in particular, there is a need to focus on interventions that can improve patient or carer experience and satisfaction with care, health service staff attitudes, knowledge, and/or skills, and health system-level improvements that show promise to lead to better health outcomes, as well as a need to conduct interventions involving people with a wider range of disabilities.

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Appendices

Appendix 1 – Search strategy

Table A1 – Search string for MEDLINE (Ovid) database

No.	Query	Results*
1	exp Persons with Disabilities/	78,242
2	(disab$ or amputee$ or paraplegi$ or quadriplegi$ or (impaired adj1 person$) or (impaired adj1 people) or ((mobility or activity or functional) adj1 limitation$) or ((mobility or vision or hearing or cognitive) adj1 impairment$)).ti,ab.	402,488
3	1 or 2	437,516
4	exp Health Services/ or exp Delivery of Health Care/	3,398,113
5	(health$ adj1 (services or access$ or provision or delivery or model or system$ or literacy)).ti,ab.	236,177
6	4 or 5	3,477,787
7	(Canada or Denmark or England or Finland or Iceland or “New Zealand” or Norway or Scotland or Sweden or “United Kingdom” or “United States” or Wales).ti,ab.	682,913
8	(intervention? or trial? or quasi?experiment$).ti,ab.	2,277,758
9	3 and 6 and 7 and 8	2,240
10	limit 9 to English language	2,221
11	limit 10 to yr=”2015-Current”	1,271

** Search date 31 July 2025.*

Table A2 – Search string for EMBASE (Ovid) database

No.	Query	Results*
1	exp disabled person/	66,033
2	(disab$ or amputee$ or paraplegi$ or quadriplegi$ or (impaired adj1 person$) or (impaired adj1 people) or ((mobility or activity or functional) adj1 limitation$) or ((mobility or vision or hearing or cognitive) adj1 impairment$)).ti,ab.	700,613
3	1 or 2	729,170
4	exp health service/ or exp health care delivery/	8,074,323
5	(health$ adj1 (services or access$ or provision or delivery or model or system$ or literacy)).ti,ab.	390,837
6	4 or 5	8,202,205
7	(Canada or Denmark or England or Finland or Iceland or “New Zealand” or Norway or Scotland or Sweden or “United Kingdom” or “United States” or Wales).ti,ab.	1,057,683
8	(intervention? or trial? or quasi?experiment$).ti,ab.	4,078,293
9	3 and 6 and 7 and 8	6,163
10	limit 9 to English language	6,139
11	limit 10 to yr=”2015-Current”	4,226
12	limit 11 to ("remove clinical trial (clinicaltrials.gov) records" and "remove medline records" and "remove preprint records")	1,377

** Search date 31 July 2025.*

Table A3 – Search string for PsycINFO (Ovid) database

No.	Query	Results*
1	exp disabilities/	78,991
2	(disab$ or amputee$ or paraplegi$ or quadriplegi$ or (impaired adj1 person$) or (impaired adj1 people) or ((mobility or activity or functional) adj1 limitation$) or ((mobility or vision or hearing or cognitive) adj1 impairment$)).ti,ab.	225,760
3	1 or 2	246,742
4	exp health care services/	346,786
5	(health$ adj1 (services or access$ or provision or delivery or model or system$ or literacy)).ti,ab.	84,713
6	4 or 5	382,848
7	(Canada or Denmark or England or Finland or Iceland or “New Zealand” or Norway or Scotland or Sweden or “United Kingdom” or “United States” or Wales).ti,ab.	265,331
8	(intervention? or trial? or quasi?experiment$).ti,ab.	705,053
9	3 and 6 and 7 and 8	516
10	limit 9 to English language	511
11	limit 10 to yr=”2015-Current”	307
12	limit 11 to "remove medline records"	159

** Search date 31 July 2025.*

Table A4 – Search string for AMED (Ovid) database

No.	Query	Results*
1	exp disability/	11,952
2	(disab$ or amputee$ or paraplegi$ or quadriplegi$ or (impaired adj1 person$) or (impaired adj1 people) or ((mobility or activity or functional) adj1 limitation$) or ((mobility or vision or hearing or cognitive) adj1 impairment$)).ti,ab.	29,166
3	1 or 2	33,481
4	exp health services/	18,926
5	(health$ adj1 (services or access$ or provision or delivery or model or system$ or literacy)).ti,ab.	3,157
6	4 or 5	20,945
7	(Canada or Denmark or England or Finland or Iceland or “New Zealand” or Norway or Scotland or Sweden or “United Kingdom” or “United States” or Wales).ti,ab.	9,231
8	(intervention? or trial? or quasi?experiment$).ti,ab.	48,674
9	3 and 6 and 7 and 8	37
10	limit 9 to English language	37
11	limit 10 to yr=”2015-Current”	12

** Search date 31 July 2025.*

Table A5 – Search string for CINAHL (EBSCOhost) database

No.	Query	Results*
S1	MH "Persons with Disabilities+"	73,813
S2	XB (disab* OR amputee* OR paraplegi* OR quadriplegi* OR (impaired N1 person*) OR (impaired N1 people) OR ((participation OR mobility OR activity OR functional) N1 limitation*) OR ((mobility OR vision OR hearing OR cognitive) N1 impairment*))	205,661
S3	S1 OR S2	242,552
S4	MH "Health Services+" OR MH “Health Care Delivery+”	1,618,781
S5	XB (health* N1 (services OR access* OR provision OR delivery OR model OR system* OR literacy))	231,083
S6	S4 OR S5	1,719,114
S7	XB (Canada OR Denmark OR England OR Finland OR Iceland OR “New Zealand” OR Norway OR Scotland OR Sweden OR “United Kingdom” OR “United States” OR Wales)	321,617
S8	XB (intervention? or trial? or quasi?experiment$)	945,278
S9	S3 AND S6 AND S7 AND S8	1,265
S10	limit S9 to English language	1,253
S11	limit S10 to ”01-JAN-2015 to Current”	795

** Search date 31 July 2025.*

Appendix 2 – NHMRC evidence hierarchy

Table A6 – NHMRC evidence hierarchy for intervention studies

Level	Study design
I	A systematic review of level II studies
II	A randomised controlled trial
III-1	A pseudorandomised controlled trial (i.e. alternate allocation or some other method)
III-2	A comparative study with concurrent controls: • Non-randomised, experimental trial * • Cohort study • Case-control study • Interrupted time series with a control group
III-3	A comparative study without concurrent controls: • Historical control study • Two or more single arm study ** • Interrupted time series without a parallel control group
IV	Case series with either post-test or pre-test/post-test outcomes

** This also includes controlled before-and-after (pre-test/post-test) studies, as well as adjusted indirect comparisons (i.e. utilise A vs B and B vs C, to determine A vs C with statistical adjustment for B).*

*** Comparing single arm studies (i.e. case series from two studies). This would also include unadjusted indirect comparisons (i.e. utilise A vs B and B vs C, to determine A vs C but where there is no statistical adjustment for B).*

Appendix 3 – List of excluded studies

Table A7 – List of excluded studies

Study	Primary reason for exclusion
Clausen et al 2016[30]	Wrong study design
Clausen et al 2016[31]	Wrong study design
Davison et al 2020[32]	Wrong study design
Feldman et al 2018[33]	Wrong study design
Gee et al 2024[34]	Wrong study design
Gibbs et al 2024[35]	Wrong study design
Gray et al 2021[36]	Wrong study design
Haahtela et al 2021 [7]	Wrong study design
Jiwa et al 2020[38]	Wrong study design
Moloney et al 2023[39]	Wrong study design
O'Brien et al 2015[40]	Wrong study design
Ouellette-Kuntz et al 2018 [41]	Wrong study design
Owen et al 2017 [42]	Wrong study design
Oystrick et al 2024[43]	Wrong study design
Rasmussen et al 2018[44]	Wrong study design
Srasuebkul et al 2021[45]	Wrong study design
Thayer et al 2021[46]	Wrong study design

Study	Primary reason for exclusion
Weise et al 2018[47]	Wrong study design
Fesler et al 2020[48]	Wrong study design
Nolan et al 2018[49]	Wrong study design
Huber et al 2015[50]	Wrong patient population
Mitchell et al 2022[51]	Wrong patient population
Yates et al 2024[52]	Wrong patient population
Bennell et al 2019[53]	Wrong patient population
Breitenstein et al 2016[54]	Wrong patient population
De Souto Barreto et al 2016[55]	Wrong patient population
Gilbody et al 2017[56]	Wrong patient population
Gorman et al 2020[57]	Wrong patient population
Bennett et al 2024[58]	Wrong outcomes
Beukes et al 2018[59]	Wrong outcomes
Bjorkedal et al 2023[60]	Wrong outcomes
Cassard et al 2023[61]	Wrong outcomes
Choque et al 2017[62]	Wrong outcomes
Davis et al 2017[63]	Wrong outcomes
Duncan et al 2023[64]	Wrong outcomes
Feldner et al 2025[65]	Wrong outcomes
Frith et al 2020[66]	Wrong outcomes

Study	Primary reason for exclusion
Gedin et al 2025[67]	Wrong outcomes
Geraghty et al 2017[68]	Wrong outcomes
Gillard et al 2022[69]	Wrong outcomes
Granbom et al 2017[70]	Wrong outcomes
Harwood et al 2023[71]	Wrong outcomes
Hassett et al 2020[72]	Wrong outcomes
Hollis et al 2021[73]	Wrong outcomes
Hunter et al 2025[74]	Wrong outcomes
Jahoda et al 2018[75]	Wrong outcomes
Jolstedt et al 2018[76]	Wrong outcomes
Kongstad et al 2024[77]	Wrong outcomes
Lovell et al 2017[78]	Wrong outcomes
Noetel et al 2025 [9]	Wrong outcomes
Rantakokko et al 2015[80]	Wrong outcomes
Ris et al 2016[81]	Wrong outcomes
Sackley et al 2016[82]	Wrong outcomes
Sackley et al 2015[83]	Wrong outcomes
Salzer et al 2016[84]	Wrong outcomes
Schmidt et al 2021[85]	Wrong outcomes
Schmidt et al 2020[86]	Wrong outcomes

Study	Primary reason for exclusion
Schwarz et al 2024[87]	Wrong outcomes
Taylor et al 2016[88]	Wrong outcomes
Tran et al 2023[89]	Wrong outcomes
Turner et al 2021[90]	Wrong outcomes
Wenborn et al 2021[91]	Wrong outcomes
Keown et al 2016[92]	Wrong outcomes

Appendix 4 – Detailed description of interventions

Table A8 – Detailed description of interventions

Study	Description of Intervention and Comparator/Control
Killaspy 2015[1]	**GetREAL** – staff training in occupational therapy-based strategies, aiming to increase patient engagement in inpatient mental health rehabilitation unit activities. **Target population:** patients with severe mental illness, receiving inpatient mental health rehabilitation. **Setting:** inpatient mental health rehabilitation unit. **Mode of delivery:** in-person staff training and onsite support, followed by email-based support. **Delivered by:** senior occupational therapist, an activity worker, and a patient expert (person with lived experience of mental health service use). **Structure of delivery:** three stages – "predisposing", "enabling" and "reinforcing": 1. “Predisposing stage” – to gain support from senior unit managers and clinicians through consultation meetings at each participating site, facilitated by a senior psychiatrist on the research team. 2. “Enabling stage” – • Barriers to change identified and addressed through team-level action plans and training of staff in relevant new skills • 1-day training course, specific to the unit, focused on occupational therapy and motivational techniques to encourage patient engagement in activities, delivered by a senior occupational therapist, an activity worker and a patient expert. • Daily support provided, for the next five weeks, by the occupational therapist and activity worker, to staff on the unit, to facilitate and model the intervention. 3. “Reinforcing stage” –

Study	Description of Intervention and Comparator/Control
	- Workshop to review the implementation of the intervention over the preceding five weeks and discuss strategies to incorporate the acquired skills into usual structures and processes. - Action plan created by the GetREAL occupational therapist, to reflect the outcomes of the workshop, and a staff member in the unit selected to oversee delivery of the action plan. - Email support to the unit from the GetREAL team provided over the next 10 months. **Total duration:** 12 months. **Control:** no additional training provided (i.e. usual care).
Blumberg 2015[2]	**Medicare Part D prescription drug benefit** – the US Medicare Modernization Act Part D was implemented in 2006, to allow adults covered by Medicare to purchase insurance for prescription drugs, with the aim to increase the availability of prescription medication to Medicare beneficiaries and decrease cost-related non-adherence to prescription medication in the Medicare beneficiary population. **Target population:** all Medicare beneficiaries; however, this study focuses on people with glaucoma (primary or secondary diagnostic code included in Medicare claims indicating a diagnosis of glaucoma), 94% of whom had some form of Medicare prescription drug coverage prior to Part D implementation. **Setting:** outpatient. **Mode of delivery:** health policy change. **Delivered by:** health policy change. **Structure of delivery:** health policy change. **Total duration:** not applicable. **Comparator:** people with glaucoma pre-Medicare Part D implementation (i.e. 2004 and 2005).

Study	Description of Intervention and Comparator/Control
Coventry 2015[3]	**Collaborative Care Model** – for management of depression in adults with comorbid type II diabetes and/or coronary heart disease with depressive symptoms, in a primary care setting. **Target population:** adults with a diagnosis of diabetes and/or coronary artery disease, and depressive symptoms for at least two weeks. **Setting:** primary care. **Mode of delivery:** in-person appointments conducted at general practice clinic or at Improving Access to Psychological Therapies business premises. **Delivered by:** trained case managers, known as “psychological wellbeing practitioners”, employed by Improving Access to Psychological Therapies services in England’s National Health Service. **Preparation/training required for delivery:** psychological wellbeing practitioners received 5 days of training, delivered by psychological therapists, an academic general practitioner with special interest in mental health and a primary care psychiatrist, covering the following areas: • Education in collaborative care model • Cultural competency training specific to working with patients from a South Asian background • Education sessions regarding diabetes and heart disease • Training in strategies to maintain health and prevent relapse as well as effective liaison, supervision, and monitoring. Practice nurses attended a half-day workshop in which were introduced to the collaborative care model by the psychological wellbeing practitioner. During the intervention delivery period, psychological wellbeing practitioners received one hour of weekly individual supervision by an experienced psychological therapist, to discuss new patients or high-risk patients, with all patients discussed during monthly case management supervision. A psychiatrist provided additional support to guide supervisors on management approaches.

Study	Description of Intervention and Comparator/Control
	Structure of delivery: participants received up to eight face-to-face sessions of brief psychological therapy with their psychological wellbeing practitioner, with the following general structure: • First treatment session – 45 min session including: ○ Structured, patient-centred interview to gather information about the nature of the patient's key problems, including their experience of autonomic, behavioural, and cognitive symptoms associated with low mood and anxiety, any modifying factors, and the impact of these symptoms, including level of risk. ○ Link between the patient's mood and management of their diabetes and/or heart disease was explored, and they were introduced to the standardised treatment manual and workbook to help develop a main problem statement and personalised goals. • Subsequent treatment sessions – 30-45 min focused on: ○ Behavioural activation, graded exposure, cognitive restructuring, and/or lifestyle changes, as appropriate to patient needs and goals. • Collaborative care meetings: ○ 10-minute meeting by telephone or in person, between the patient, case manager and a practice nurse from the patient's general practice held immediately following second and eighth treatment sessions. ○ Focus of meeting was on ensuring that psychological treatments did not complicate management of physical health and patient safety, reviewing the patient's progress with their problem statement and goals, reviewing relevant physical and mental health outcomes (such as depression, anxiety, diet, exercise), and planning future care. ○ Adherence to antidepressants and side effect concerns were reviewed, and appointments with their general practitioner were arranged, if necessary. **Total duration:** Three months. **Comparator:** usual care from general practitioner, including referrals for psychological therapy and/or prescription for antidepressant medication prescription, as indicated.
Chan 2015[4]	**Active Support Training** – electronic monitoring device providing audiovisual reminders to aid adherence to preventive asthma treatment in children with asthma.

Study	Description of Intervention and Comparator/Control
	Target population: children aged 6-15 years, who have attended an emergency department with suspected diagnosis of asthma exacerbation, or a diagnosis of acute asthma, undertaking or needing treatment with twice-daily inhaled corticosteroids. **Setting:** outpatient. **Mode of delivery:** self-administered. **Delivered by:** inhaler self-administered by participant. **Structure of delivery:** Electronic monitoring device was connected to usual preventve inhalers, with audiovisual function enabled. The device records the date, time, and number of actuations used and has 14 different ringtone reminders that ring twice daily, stopping once the correct dose is taken, or after 15 min. If the correct dose is taken within 6 h before the set reminder time, the reminder does not go off. A visual display shows the date and time of the most recent use. **Total duration:** six months **Comparator:** use of an identical preventative inhaler delivering corticosteroid therapy, with attached electronic monitoring device, but with audiovisual reminder function disabled.
Luxford 2015[5]	**TOP 5** – clinician-carer communication tool to aid inpatient care for patients with dementia. **Target population:** older adults with dementia **Setting:** public or private hospitals delivering inpatient care for people with dementia (typically in aged care, medical or surgical wards). **Mode of delivery:** in-person conversation between clinician and carer, facilitated by use of TOP 5 tool. Conversation documented in a standardised format and included in patient documentation by the bedside. **Delivered by:** clinical staff (nursing, medical and/or allied health). **Preparation/training required for delivery:** A local implementation team for each hospital, comprising a local site liaison (usually senior clinicians or managers with nursing, medical or allied health background), executive sponsor, clinical champion and a carer

Study	Description of Intervention and Comparator/Control
	support group contact, was first identified. The local site liaison coordinated the implementation process and collection of data at their hospital. Two site visits were made at start-up and at six months, by the external project team to each hospital, to promote clinician engagement. Three forums were held throughout the year, for the local site liaisons from different hospitals to network and exchange ideas. Staff education was provided in the use of TOP 5 at each hospital, along with a toolkit including TOP 5 forms, information brochures for family and carers, background information and promotional material for local use. Each implementation team determined the scope of implementation, varying from specific wards through to hospital-wide uptake, depending on where dementia-specific care was most frequently provided. **Structure of delivery:** clinical staff engaged carers in a structured process to elicit and record up to five important non-clinical management strategies to aid communication and support personalised care, for the patient with dementia. The strategies are recorded on a one-page form included as part of the patient's bedside chart, for easy access during reviews and handover. **Total duration:** 12 months **Comparator:** pre-TOP 5 implementation.
Lindsay 2016 [6,7]	**Inter-agency transition model** – transition support healthcare service for young people with spina bifida (aged 14 to 25 years), to aid transition from paediatric to adult community health services for ongoing disability management. **Target population:** young people, English speaking, aged 14 to 21 years, with spina bifida, regularly attending a spina bifida outpatient clinic at a paediatric rehabilitation hospital. **Setting:** outpatient clinic. **Mode of delivery:** in-person appointments and supporting documentation. **Delivered by:** transition team comprising an adolescent medicine specialist, a transition-focused nurse practitioner, and a transition-focused life skills coach who helps with independence skills and post-secondary education supports. **Structure of delivery:**

Study	Description of Intervention and Comparator/Control
	1. At age of 14, the young person's paediatrician hands over care to the transition team, and is provided transition support documents, health education and promotion of self-care, self-advocacy, communication, negotiation and life skills 2. From age 18 to 25, the young person attends in-person appointments with the transition team at the adult community health centre (regularity of appointments determined based on needs of young person). **Total duration:** 11 years (support offered from age 14 to 25). **Comparator:** no formal transition of care support.
Singh 2016[8]	**Mindfulness-Based Positive Behaviour Supports Training** – for paid group home carers to aid them in delivering care for those with developmental disabilities, using less restrictive procedures. **Target population:** residents of small (3-4 residents) adult community group homes, with developmental disabilities and known to exhibit some form of physical and/or verbal aggression. **Setting:** group home. **Mode of delivery:** in-person group training program. **Delivered by**: staff training was delivered by an experienced behaviour analyst with 35 years professional experience with developing and implementing behaviour support plans and 40 years personal meditation practice and mindful delivery of behavioural health services. **Structure of delivery:** Staff underwent a 7-day group training program spread over 10 weeks, in which they received instruction on mindfulness and meditation skills (including Samatha sitting meditation, Kinhin walking meditation and Insight meditation) and their application to Positive Behaviour Support practice. Staff were guided to practically apply their training in their work over the 10 week training period, and log their daily meditation practice. **Total duration:** 10 weeks. **Comparator:** pre-delivery of Mindfulness-based Positive Behaviour Supports Training.

Study	Description of Intervention and Comparator/Control
Caller 2016 [9]	**HOBSCOTCH** – training and education program for adults with epilepsy, to aid in self-management of cognitive impairment. **Target population:** adults aged 18-65 years, with epilepsy (with or without uncontrolled seizures), with Quality of Life in Epilepsy Inventory, QOLIE-31 cognition subset score of 7 or less indicating subjective memory complaints. Participants were excluded if they had severe mental disability or estimated IQ less than 70, visual impairment precluding reading or writing, or lack of reliable phone access. **Setting:** outpatient. **Mode of delivery:** in-person and telephone-based instruction. **Delivered by:** nurse practitioner or registered nurse, specialised in epilepsy care and trained in Problem-Solving Therapy (PST) and Memory and Attention Adaptation Training (MAAT) approaches to cognitive impairment management. **Preparation/training required for delivery:** Training in PST was achieved through reviewing written material, receiving one in-person didactic training session, role-playing, and three sessions of supervision. Training in MAAT was achieved by reviewing the modified provider manual adapted from MAAT and attending an in-person didactic training session. **Structure of delivery:** Eight sessions, 45-60 min in length, delivered weekly by a trained health professional, with the first session delivered in-person in a group format, and the rest delivered via telephone call. The intervention covered the following domains: organisational skills, seizure management, and social skills. Participants were provided with a handbook containing educational materials about memory function and epilepsy, as well as worksheets to be completed during each telephone session, and information on compensatory strategies derived from MAAT. For the "H+" intervention group, the intervention also included additional cognitive training using the Brain Age program on the Nintendo DS console. **Total duration:** Eight weeks. **Comparator:** usual epilepsy care, did not receive HOBSCOTCH training.

Study	Description of Intervention and Comparator/Control
Brooker 2016[10]	**Focussed Intervention Training and Support (FITS) programme** – a training intervention for nursing home staff to deliver effective, person-centred psychosocial care to residents with dementia, thereby decreasing inappropriate prescription and use of anti-psychotic medications. **Target population:** nursing home residents with dementia, prescribed antipsychotic prescriptions. **Setting:** nursing home. **Mode of Delivery:** in-person training and supervision. **Delivered by:** nursing home staff member, trained as a "Dementia Care Coach" (DCC). **Preparation/training required for delivery:** The DCCs were the main vehicles for change within the care homes and were existing staff within the care home, chosen by their managers to undertake the role. A "Dementia Practice Development Coach" (DPDC), a university-based educator with in-depth experience of working with people living with dementia in care homes and excellent skills in training, delivered a nine month education and supervision to "Dementia Care Coaches" to enable them to safely reduce antipsychotic medication and implement evidence-based practice to reduce behavioural and psychological symptoms of dementia (BPSD). Only one DCC was chosen per care home, but they could also be allocated to provide support to neighbouring care homes without their own DCC. The requirements for a DCC were a keen interest in improving care home resident wellbeing, with the DCC performing the role of a care assistant, senior care assistant, registered nurse, or activity coordinator in the care home. The DCC was expected to attend training and supervision sessions and implement their learning within the care home, between sessions. Care home managers were recommended to allow DCC to have dedicated time 1-2 days a week, separate from other roles/duties to attend training sessions and implement their learning. DCCs were trained in groups of 10 by the DPDC – this included a free, 10-day, face-to-face education program held in two-day blocks across a 3-month period. The components of training included tools to assess their care home's strengths and areas for development, a framework for understanding and responding to behaviour as unmet needs, knowledge of psychosocial interventions such as strengths-base care planning, life story work, supportive environments and meaningful activity using the Cohen-Mansfield toolbox and personalised music. They were also instructed on learning styles and basic training skills in order to be able to teach

Study	Description of Intervention and Comparator/Control
	others in their care home. DCC were coached in initiating reviews of antipsychotic drug prescriptions with GPs and other healthcare professionals. **Structure of delivery:** DCCs were responsible for supporting other staff and external health care professionals by sharing best practice in reviewing antipsychotic drug prescriptions. DCCs were expected to implement their new skills from the course between training, and then perform full-scale intervention of their learning in a supervised period of six months following the completion of training. During this 6-month period, DCCs attended half day group supervisions each month, facilitated by the DPDC. The focus of supervision was on critical reflection, peer support and continued implementation and improvement. A minimum attendance requirement of 8/10 training days and 4/6 supervision sessions was the cut-off to receive a certificate of completion. **Total duration:** 12 months. **Comparator:** pre-implementation of FITS training.
Szczepura 2016 [11]	**National Dementia Strategy** – launched by UK Government in February 2009 for England, with the overall aim to improve dementia care (including reducing inappropriate antipsychotic medication use in nursing home residents with dementia). **Target population:** long-term care home residents. **Setting:** nursing home. **Mode of delivery:** health policy change. **Delivered by:** nursing home staff, guided by health policy directives. **Structure of delivery:** The purpose of the National Dementia Strategy is to: provide a strategic quality framework within which local services can deliver quality improvements to dementia services and address health inequalities relating to dementia; provide advice, guidance and support for health and social care commissioners, strategic health authorities (SHAs), local authorities, acute hospital trusts, mental health trusts, primary care trusts (PCTs), independent providers and the third sector, and practice-based commissioners in the planning, development and monitoring of services; and provide a guide to the content of high-quality health and social care services for dementia to inform the expectations of those affected by dementia and their families. The Strategy is

Study	Description of Intervention and Comparator/Control
	designed to be inclusive of dementia of all types in all groups affected. It applies to services in England only. The strategy covers three broad themes: raising awareness and understanding of dementia, early diagnosis and support, and living well with dementia. Suggested review of antipsychotic use in dementia appears in Objective 11 recommendations for care homes as part of the third theme. **Total duration:** not applicable. **Comparator:** pre-implementation of National Dementia Strategy.
Valimaki 2017[12,13]	**Mobile.Net** – a tailored and automated text message-based tool to encourage medication adherence in adults with mental illness taking antipsychotic medications. **Target population:** aged 18-65 years, taking antipsychotic medications on discharge from a psychiatric hospital, have a mobile phone, able to use the Finnish language. **Setting:** outpatient. **Mode of delivery:** telecommunication. **Delivered by:** automated text message service (with human input to set preferences before intervention was commenced). **Structure of delivery:** delivered selected messages from three categories, medication, treatment appointment and free time. The messages included "Have you taken your medication – feel well?", "It is important to comply with your follow-up appointment, isn't it?" and "Get up, go out and exercise". Participants elected to receive messages between one and six times a month, at the beginning of the week (Monday/Tuesday) and in the morning between 0600 and 1200. **Total duration:** 12 months. **Control:** usual care, with no additional reminder tool.

Study	Description of Intervention and Comparator/Control
Gustafsson 2017[14]	**Comprehensive medication reviews** – clinical pharmacist-led medication review as part of hospital-based care, to address drug-related hospital admission in older adults with dementia or cognitive impairment. **Target population:** older adults aged 65 years or older, admitted to either the Internal Medicine of Orthopaedic ward, had dementia or cognitive impairment. **Setting:** inpatient, acute hospital ward. **Mode of delivery:** on-person ward rounds. **Delivered by:** clinical pharmacist. **Structure of delivery:** Three clinical pharmacists provided additional services in medication reconciliation, medication review, and participation in ward rounds for patients included in the intervention group. The three clinical pharmacists met continuously throughout the study period and discussed interventions to harmonize the advice given during ward rounds. By conducting medication reconciliation, the pharmacists ensured that the medication administration records used at the wards were updated, accurate, and complete. Advice was given about drug selection, dosages, and possible monitoring needs. The attending physicians made the final decision concerning proposed changes to therapy. **Total duration:** 36 months. **Control:** usual care without additional pharmacist input.
Hassiotis 2018[15,16]	**Positive Behaviour Support Training program –** for community intellectual disability service staff to improve care for adults with intellectual disability and challenging behaviours. **Target population:** adults with intellectual disability who exhibited challenging behaviours as indicated by a score of ≥15 on ABC-C scale, without primary clinical diagnosis of a personality disorder or substance misuse or relapse of pre-existing mental disorder. **Setting:** outpatient. **Mode of delivery:** in-person training and supervision.

Study	Description of Intervention and Comparator/Control
	Delivered by: expert trainers in Positive Behaviour Support. **Structure of delivery:** Two health staff, designated "therapists", from each included community intellectual disability service volunteered to receive training in the form of three 2-day in-person workshops supported by a manual and delivered by an established clinical training organisation. The content of the training covered the following areas of Positive Behaviour Support: (a) functional behavioural assessment and formulation skills, using the Brief Behavioural Assessment Tool for brief functional analyses (b) primary prevention of challenging behaviour (c) secondary prevention and reactive strategies (d) periodic service review and problem solving to develop individualised periodic service reviews and troubleshooting. After in-person training was completed, each therapist was assigned to one of the four trainers for a one-year mentorship, to aid in maintaining motivation and enhancing practice skills. **Total duration:** 12 months. **Control:** usual care without additional training.
Wu 2018[17, 20]	**Technology-facilitated care model** – using automated telephone assessment technology, integrated with disease management registry systems to automate aspects of depression care provided by a collaborative care team for management of depression in adults with type II diabetes, in a primary care setting. **Target population:** adults with type 2 diabetes. **Setting:** primary care. **Mode of delivery:** in-person appointments and automated telephone calls. **Delivered by:** diabetes disease management team (including nurses, social workers, and primary care physician), aided by automated telephone assessment with clinical decision support software. **Preparation/training required for delivery:** • Primary care physicians attended webinars hosted by a psychiatrist expert, presenting evidence for collaborative depression care as well as screening and treatment for depression.

Study	Description of Intervention and Comparator/Control
	- Mandatory training in depression care for nurses, nurse practitioners, and social workers, conducted by psychology and social work experts. **Structure of delivery:** - Written educational materials about depression provided to patients in English and/or Spanish. - Quarterly depression screening for patients without diagnosed depression, and monthly symptom monitoring for patients with diagnosed depression using the automated telephone assessment system. - Screening and symptom monitoring data used to identify at-risk patients and trigger follow up reviews and reviews of medication adherence. **Total duration:** 12 months. **Comparator:** usual care, delivered by primary care physician, including referrals for psychological therapy and/or prescription for antidepressant medication, as indicated.
Bjorkelund 2018[18]	**Collaborative care model** – involving a trained nurse acting as a “care manager” for all adults presenting to primary care services with a new diagnosis of depression. **Target population:** adults with a diagnosis of mild or moderate depression (Montgomery-Åsberg Depression Rating Scale – Self assessment (MADRS-S) < 35, and satisfying DSM-IV criteria for mild/moderate depressive disorder). **Setting:** primary care. **Mode of delivery:** in-person appointments with care manager. **Delivered by:** nurse designated as a “care manager”. **Preparation/training required for delivery:** A nurse allocated to the primary care centre devotes 20-25% of working time to serving a "care manager" role for patients with a new diagnosis of depression. Training sessions were provided for both the "care manager"

Study	Description of Intervention and Comparator/Control
	nurse (initial three days of training and two 1-day sessions early in their role) and GPs (two 1-day training sessions) in participating primary care centres. **Structure of delivery:** The care manager scheduled initial 1 hr sessions with each patient with a new diagnosis of depression, and provided them an individual care plan. During the following 12 weeks, they provided further telephone contact 6-8 times (for a duration of 15-30 min each time) to assess depressive symptoms and provide behavioural activation. All patients could contact the care manager between scheduled phone calls, if needed. The care manager did not provide psychotherapy, instead providing support and facilitating continuity care through communication with other clinicians. They also had regular contact with the patient's GP, therapist and any other primary care centre clinician who was involved in that patient's care, to enable coordinated care. **Total duration:** 3 months. **Control:** usual care, delivered by primary care physician, only.
Worobey 2018[19]	**Web-Based Transfer Training** - to improve independent wheelchair transfer technique in adult manual and power wheelchair users who can transfer independently. **Target population:** adults using a wheelchair as primary means of mobility for ≥40 hr/week, able to independently transfer to and from a surface within 30 sec. Exclusion criteria: arm pain limiting ability to transfer or bear weight through their arms, use of legs while transferring, neurological condition that impaired learning, history of heart or lung conditions that could be worsened by 6 back and forth transfers. **Setting:** outpatient. **Mode of delivery:** online. **Delivered by:** online video module. **Structure of delivery:** based on the components of in-person training, namely education of participants on the impact of poor transfer technique, and description, rationale and demonstration of all the component transfer skills as defined by the Transfer Assessment Instrument, provided through verbal, pictorial and video aids.

Study	Description of Intervention and Comparator/Control
	Total duration: 1 hour. **Control:** no additional transfer training provided.
Ring 2018[21,22]	**Learning Disability Epilepsy Specialist Nurse Competency Framework training program** – to support nurses in community clinical practice and professional development to improve care for adults with epilepsy and intellectual disability. **Target population:** adults <65 years, with developmental intellectual disability, IQ of 70 or less, a diagnosis of epilepsy with a history of at least one seizure in the six months. Exclusion criteria: presence of a rapidly progressive physical or neurological illness, or alcohol or drug dependence. **Setting:** outpatient. **Mode of delivery:** in-person training. **Delivered by:** senior specialist nurses experienced in nurse education, research and epilepsy. **Structure of delivery:** training followed guidelines laid out in the Learning Disability Epilepsy Specialist Nurse Competency Framework. The framework outlines competencies related to supporting participants with epilepsy and ID, including clinical diagnosis and management of epilepsy, assessing and managing risk, impact of daily life on epilepsy, evidence-based practice, multidisciplinary team working and professional development. The framework can be tailored to the experience level of each individual nurse using it, according to their self-assessed competence level (‘novice’, ‘competent’ or ‘expert’). **Total duration:** Three hours. **Control:** usual care without additional training.
Westbury 2018[23]	**Reducing Use of Sedatives (RedUSe)** – a 6-month intervention consisting of audit, staff education and interdisciplinary review of residential aged care facilities, to promote appropriate use of antipsychotics and benzodiazepines in residents with dementia. **Target population:** nursing home residents prescribed antipsychotics and/or benzodiazepines.

Study	Description of Intervention and Comparator/Control
	Setting: nursing home. **Mode of delivery:** in-person. **Delivered by:** pharmacist. **Structure of delivery:** Initially, the RedUSE team visits the Residential Aged Care Facility (RACF) and the RACF nominates a champion nurse and provides the consultant pharmacist, community pharmacy and key prescriber details to the team. The consultant pharmacist undergoes 1 day training and the champion nurse undergoes half day training. This is followed by a baseline psychotropic audit of the RACF, followed by didactic training of RACF staff, tailored to the results of the audit and including a 1hr education session from the consultant pharmacist. The consultant pharmacist and champion nurse review current resident psychotropic prescriptions and provide recommendations to the prescriber. At 3 months, the audit is repeated, and staff training and psychotropic prescription reviews are repeated. Finally, at 6 months there is a final psychotropic audit. **Total duration:** Six months. **Comparator:** pre-implementation of RedUSE.
Thoegersen 2019 [24]	**Assertive Community Treatment** – a community-based care model for adults with serious mental illness to maintain engagement with patients following discharge from inpatient mental health care. **Target population:** Inclusion criteria: age 18-65 years, within the four catchment areas of the community mental health teams, with primary diagnosis of severe mental illness (ICD-10 Codes: F20, F22, F25, F31) identified as having difficulties engaging with standard community care indicated by meeting at least one of the following criteria: (1) at least four admissions within the last 2 years, (2) at least 40 days of inpatient service use within the last two years, (3) a secondary diagnosis of substance abuse, (4) repeated failure (at least 25% absence) to attend outpatient appointments after discharge, (5) poor medication compliance. **Setting:** outpatient. **Mode of delivery:** in-person appointments in non-clinical settings.

Study	Description of Intervention and Comparator/Control
	Delivered by: usual community mental health team consisting of psychiatrists and allied health professionals, trained in assertive community treatment model. **Structure of delivery:** Assertive Community Treatment is an established care model based on the following characteristics: total team case load of 80 to 100 consumers, maximum individual caseload of 10 consumers, extended hours of operation (0800 -1800 every weekday and 0900-1500 on Saturdays), appointments with consumers conducted in their homes/cafes/parks rather than in the office, a "no drop-out" policy where the team continues to try and engage consumers in long-term care even if they have difficulty with making or consistently maintaining contact, assertive engagement with consumers with flexibility in approach and continued contact during hospitalisation, team approach to management (multiple team members involved with one consumer's care), increased frequency of meetings (up to daily) between team members to discuss consumer care, limited outsourcing of skills/responsibilities to outside agencies. **Total duration:** 24 months. **Comparator:** usual care through community mental health (i.e. total team case load of 300 consumers, maximum individual caseload of 30 consumers, available during office hours only, office-based appointments as a general rule, with occasional home visit, discharge from service if unable to make or maintain contact, contact with hospitalised patients only during treatment conferences, weekly team meetings, case management by single team member, referral to outside agencies for advice).
Qian 2019 [25]	**Active Support Training programme** – for group home staff (classroom-style instruction and mentorship) to improve care for adults with intellectual or developmental disability. **Target population:** small group home (3 to 8 residents) residents with intellectual and/or developmental disability. **Setting:** group home. **Mode of delivery:** in-person instruction and mentorship. **Delivered by:** experts in Active Support.

Study	Description of Intervention and Comparator/Control
	Structure of delivery: 12 hours of classroom-style instruction for group home staff (including supervisors and direct support professionals) delivered over 2 to 4 days, with individual mentoring for each staff member delivered over the next 3–6 months. The content of the classroom instruction explored the following areas: individual and household routines and activities, preferences and needs of individual group home residents, and potential opportunities for each resident to participate more actively in routines and activities. The individual, on-the-job 2-hour mentoring session focused on implementation of a protocol developed through classroom instruction, by the staff member to support one or more residents in engaging in an activity. The mentor offered strategies, observations, and feedback, as needed, to support the implementation and foster positive interactions between the staff member and resident(s). **Total duration:** up to six months. **Control:** usual care with standard training including CPR and First Aid.
Gerrard 2019[26]	**Positive Behaviour Support (PBS) Framework** – used in a community care setting to aid in de-prescribing of psychotropic medication in adults with learning disability and/or autism, exhibiting challenging behaviours. **Target population:** adults with learning disability and/or autism with stable behaviours (no worsening of baseline frequency), stable physical health (well-managed physical health without significant physical health comorbidity) including stable epilepsy (no more than two anti-epileptics and well controlled seizure activity), no documented mental health diagnosis (historical or current) and taking a psychotropic medication (including antipsychotics, antidepressants, mood stabilisers, anxiolytics, hypnotics, excluding anti-epileptics prescribed only for epilepsy). **Setting:** outpatient. **Mode of delivery:** in-person appointments. **Delivered by:** community pharmacist and PBS-trained nurse practitioner. **Structure of delivery:** The pharmacist met with each patient and their care team, including paid and family carers, to discuss and potentially challenge the psychotropic prescription, with one medication challenge occurring at a time (where multiple psychotropics

Study	Description of Intervention and Comparator/Control
	had been prescribed. Weekly support was provided to the patient and care team from the PBS-trained nurse practitioner, in between the medication reviews. Weekly support included the following components: • Development of a behaviour support plan (BSP), aimed at carers, to provide a description of how an individual's environment should be redesigned to reduce challenging behaviour and develop alternative behaviours. • Carer training to assist in understanding challenging behaviour, as well as supporting them to understand and implement the BSP. • Active support principles to promote meaningful engagement in activities and relationships by people with intellectual disabilities. **Total duration:** unclear. **Comparator:** attempting medication challenge with usual care (without positive behaviour support).
Johnson 2020[27]	**Physitrack** – an online exercise prescription tool to deliver home exercise programs for children with cerebral palsy or other neurodevelopmental disability. **Target population:** children aged 6–17 years, with a diagnosis of cerebral palsy or other neurodevelopmental disabilities (any childhood diagnosis that leads to physical impairment and disability), with the cognitive ability to follow an exercise programme in either written or electronic format, with or without support from their parents **Setting:** outpatient. **Mode of delivery:** Physitrack mobile app. **Delivered by:** physiotherapist. **Structure of delivery**: Individualised 8-week home exercise programme designed by participant's usual physiotherapist as appropriate for participant's goals, and delivered through the Physitrack mobile app. Features of this app include videos showing how to perform each exercise and a calendar showing when exercises should be performed. The purpose of the intervention is to improve

Study	Description of Intervention and Comparator/Control
	adherence to physiotherapist-prescribed exercise programmes, promote achievement of individual goals, and improve performance of prescribed exercises. **Total duration:** Eight weeks. **Control:** home exercise program with paper-based delivery.
Kingsnorth 2021[28]	**Living Independently and Fully Engaged (LIFEspan) Model of Transitional Care** – a two-year period of multidisciplinary team-supported preparation for healthcare transition to improve continuity of care for young people with childhood-onset disabilities, transitioning from outpatient paediatric to adult rehabilitation services. **Target population:** young people aged 16 years, with acquired brain injury or cerebral palsy. **Setting:** outpatient. **Mode of delivery:** in-person appointments. **Delivered by:** multidisciplinary transition team (including nurse practitioner, youth/ life skills facilitator, or social worker). **Structure of delivery:** The LIFESpan model comprises a 2-year period of multidisciplinary team-supported preparation for healthcare transition from paediatric to adult services for young people aged 16 years with childhood onset disability. From age 16-18, the young person is seen 2-4 times, by a “Paediatric LIFESpan team”, including an occupational therapist and life skills/youth facilitator, and are medically followed by a paediatric physician/ambulatory care nurse/nurse practitioner. During this time, they are referred to adult services and linked to an adult LIFESpan team (physiatrist, nurse practitioner, occupational therapist, social worker, life skills facilitator, physiotherapist, speech language pathologist, youth facilitator). They are also supported to work on transition-related goals, including social participation and community involvement, by a youth facilitator, life skills facilitator, and/or social worker. At age 18, they are formally discharged from paediatric care and undergo a coordinated transfer of care to adult services, led by the adult LIFEspan team. **Total duration:** Two years.

Study	Description of Intervention and Comparator/Control
	Comparators: - Concurrent control group of 16-year-old participants with spina bifida receiving "standard of care" - Historical control group of participants with acquired brain injury or cerebral palsy who had previously undergone transition of care between ages 16-19 years.
Streltzov 2022[29]	**HOBSCOTCH** – training and education in self-management of cognitive impairment for adults with epilepsy. In this study, there were two intervention groups, one offering entirely virtual delivery (“Distance delivery” group), and the other with some face-to-face delivery (“In-person delivery” group). **Target population:** adults with a diagnosis of epilepsy confirmed by an epilepsy specialist, recent self-reported memory problems, a stable regimen of antiepileptic medication for one month prior to enrolment, and a stable regimen of antidepressants for patients with depression. Exclusion criteria: intellectual disability, defined as an estimated IQ under 70, or indications of a dementing illness. **Setting:** outpatient. **Mode of delivery:** combination of in-person and telephone-based instruction, or only telephone-based instruction. **Delivered by:** “HOBSCOTCH coach”, a nurse practitioner/registered nurse/clinical psychologist/social worker/physician, specialised in epilepsy care and trained in Problem-Solving Therapy (PST) and Memory and Attention Adaptation Training (MAAT) approaches to cognitive impairment management. **Preparation/training required for delivery:** All coaches were certified following completion of a standardized, 2-day, in-person curriculum that included supervised role-playing and practice. Coaches received continued supervision and meetings in which challenging cases were discussed, and skills were refreshed. **Structure of delivery:** Eight sessions, 45-60 min in length, delivered weekly by a trained health professional. The intervention covered the following domains: organisational skills, seizure management, and social skills. Participants were provided with a handbook containing educational materials about memory function and epilepsy, as well as worksheets to be completed during each telephone session, and information on compensatory strategies derived from MAAT.

Study	Description of Intervention and Comparator/Control
	Total duration: Eight weeks. **Control:** no formal training in addition to usual epilepsy care.