Centre for excellence
for Children's Care and Protection

CHILDREN'S SERVICES REFORM RESEARCH:

RAPID EVIDENCE REVIEW

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CELCIS, the Centre for Excellence for Children's Care and Protection is a leading improvement and innovation centre in Scotland. We improve children's lives by supporting people and organisations to drive long lasting change in the services they need, and the practices used by people responsible for their care.

How to read this report

Thank you for reading this report. We recognise that it is long, and you may not have the all the time it would take to read it in full. This page explains the report's structure to help you to get to the sections that we hope will interest you.

This review is for everyone

We have tried to present the information as clearly as possible, so we hope it is accessible to anyone who is interested. If you prefer, there is also a summary of this report available, which gives an overview of its key findings.

Flexibility

Many people may be coming to this report with particular questions or priorities. We have tried to make it as easy as possible to find the things that are of interest by giving the sections what we hope are self-explanatory titles, which tell you what information you will find there. It is written in a way so that there are no sections that you need to have read to understand the sections you are especially interested in. While reading all of this report will help you understand the evidence as a whole, if you have a particular burning question or issue you want to read about, you should be able to go straight to the section or sub-section that you are interested in to find that information.

We have tried to ensure that we present the evidence from the context of that particular heading, and if you read the entire report, there will be points that recur because it is important to understand these points from a variety of perspectives.

Referencing

Each of the 87 items of source material we identified for this review has been given a number (1-87), and where a paper gives support to a statement being made in this report, this paper has been referred to by adding this number in superscript after the statement it supports. You can find the detail of the references in a table in the References section. All other references will show the authors' names in brackets in the text of this report and are listed separately in the Additional References section.

The language used in this report

People needing the support of services

This research study uses the phrase 'people needing the support of services' or 'children needing the support of services' to identify any and all who may at any time need the support of public services, which might include social care services, or social work services, or health services, for example. There are many different terms used as an alternative to this form of words and some of these will be more commonly used in different contexts and places. This study's researchers acknowledge that the terms 'service-user' and 'client' are used by services and others, but these are not the terms the researchers choose to use.

Social care services

In the context of this review and research study, the phrases social care and social care services can be understood as the care and services designed to meet the needs of children, young people or adults who need extra support. This might take the form of personal care or other practical assistance. Worldwide, social care is provided through national and local public services, not for profit organisations, and commercial providers. It should be noted that outside Scotland, the phrases social care and social care services are also used to refer to social work services with children and families.

Social work services

In the context of this review and research study, the phrases social work and social work services can be understood as the specialist services that operate at a local government level that have a statutory responsibility to meet the welfare needs of children, young people and adults who need support. Their responsibilities are discharged in line with the relevant national and local laws and policies where the services are located.

Papers

For simplicity, all the 87 sources of information this review looked at are referred to as papers. These are published, written documents which include peer-reviewed academic articles, literature reviews and other relevant information.

Studies

For simplicity, the research the papers that we reviewed is based on are referred to as studies.

Systematic reviews

The Campbell Collaboration, an international social science research network, defines a systematic review as “an academic research paper that uses a method called 'evidence synthesis' to look for answers to a pre-defined question. The purpose of a systematic review is to sum up the best available research on that specific question. This is done by synthesizing the results of several studies.” Systematic reviews will therefore look at evidence from a large or varied number of places across the world and/or over a long time period” (www.campbellcollaboration.org).

Most of all, we hope you enjoy reading our report, and come away with a greater understanding of what this evidence tells us about integration.

Overview of Children's Services Reform Research

This is a Scotland-based research study being undertaken by CELCIS, the Centre for Excellence for Children's Care and Protection. CELCIS was asked by the Scottish Government to carry out this research study with the aim of gathering evidence to inform decision-making about how best to deliver children's services in Scotland in light of the proposed introduction of the National Care Service, and its commitment to keep The Promise of the Independent Care Review.

The purpose of the research is to answer the question: **What is needed to ensure that children, young people and families get the help they need, when they need it?**

The research study has four separate strands of work, which together aim to provide a comprehensive and holistic approach to answering this question. The findings of each strand of work will be published separately, in a full research report and a shorter summary report. We hope that this overview acts as a guide to help you to navigate through each strand of the research, and the different evidence that these will present. A final report will be published at the end of the study which will draw together and synthesise all four strands of the findings to address the research question.

This report is Strand 1: Rapid Evidence Review, and all strands of the research study are outlined below:

Strand 1: Rapid Evidence Review is a review of existing published national and international research evidence focused on better understanding the evidence associated with different models of integration of children's services with health and/or adult social care services in high income countries, as defined by the World Bank. The research questions which this review seeks to address are:

What models of integration exist for the delivery of children's social work services with health and/or adult social care services in high income countries, and what is the strength of evidence about their effectiveness in improving services, experiences and outcomes for children, young people and their families?

Strand 2: Case Studies of Transformational Reform Programmes is examining a range of approaches to the delivery of children's services, from national to highly decentralised structures and modes of delivery, in five high-income countries: Finland, Northern Ireland, the Netherlands, New Zealand and the Republic of Ireland. A sixth case study is drawing on learning from Scotland's experiences of national service reorganisation through the development of Police Scotland. These case studies will be brought together in one report, which will also consider the key learning and messages for Scotland.

Strand 3: Mapping integration in Scotland: A statistical analysis is mapping the range of different approaches to integrated service delivery across Scotland's 32 local authority areas and investigating, through the statistical modelling of administrative data, any potential effects of integration on a range of outcomes over time for people being supported by public services. In doing this, we are also taking into account different factors such as geography, poverty and the impact of the COVID-19 pandemic, to increase the likelihood that any findings are directly about integration rather than as a result of other factors.

Strand 4: Children's Services workforce experiences of supporting children, young people and families is exploring, through an online survey, interviews and focus groups, the opportunities, challenges, barriers and facilitators that are found to bring about high quality experiences and outcomes for children, young people and families using services; close multi-agency working between professionals across different services; continuity of support when young people transition to adult services; and high quality support for the workforce and transformational change in services. This strand of work will also aim to produce additional insights regarding workforce perceptions of the association between integration and outcomes for children, young people and families and the wellbeing of the workforce that will complement and contextualise emerging findings from Strand 3.

An Independent Steering Group chaired by Professor Brigid Daniel, Professor Emerita at Queen Margaret University, Edinburgh, has supported the design, implementation and delivery of this research study. Their remit has been to provide independent support and oversight to the research team, and to ensure the research is robust and will provide the best possible evidence.

Throughout the Children's Services Reform Research study we have taken very careful account of existing evidence which details the views that children, young people and their families have already shared about their experiences, the support and services they have identified as being needed, and what matters to them. This information has been taken from relevant research and reviews into services for children, including the Independent Care Review in Scotland, and is included in a range of ways within the different strand reports. In this research report, where these have been reported and expressed in the papers reviewed, we have considered the views of children, young people and their families in different countries about their experiences of services and support.

Background

Legal and policy context

The Scottish Government has ambitious aims for the country to be the best place in the world for children and young people to grow up (Scottish Government, 2018). Supporting this aim is a complex legislative and policy landscape which seeks to address fundamental issues of poverty, inequality, exclusion and the welfare of all children by providing the right support at the right time, by the right people, irrespective of where families live in the country. These aims are underpinned by a rights-based approach, and a commitment to ensure that Scotland keeps The Promise to all children and young people that they grow up safe, loved and respected.

The United Nations Convention on the Rights of the Child (UNCRC, 1989) lays out the rights of all children, defined as individuals under the age of 18, with these rights being seen as interrelated, indivisible and interdependent. This means that the enjoyment of one right can be impacted by the fulfilment or infringement of another. Scotland plans to directly incorporate the UNCRC into domestic law, making it unlawful for public authorities, such as a local authority, to act in ways which are not compatible with children’s rights under the UNCRC, and giving children more legal power to enforce their rights. Every Article of the UNCRC has relevance to children’s services, from prioritising the best interests of a child, to supporting a child’s family and the rights of children unable to live with their family. The Children and Young People (Scotland) Act (2014) sets out the duties to support the implementation of UNCRC in Scotland.

Scotland’s Independent Care Review, which took place over three years, concluded with the publication of The Promise in 2020. Since its the publication there has been widespread commitment in Scotland from local and national government, as well as the third sector, to keep The Promise. The publication of ‘Plan 21-24’ (The Promise, 2021b) and ‘Change Programme ONE’ (The Promise, 2021a) by The Promise Scotland sets out a collective vision and the key areas for change required to improve the lives of *all* children and families across Scotland, with a target date of 2030 for these changes to be fully implemented.

The UNCRC also forms the basis of Scotland’s Getting it Right for Every Child approach. GIRFEC is the national practice model to promote, support, and safeguard the wellbeing of babies, children and young people. The model advocates a range of approaches to consistently support babies, children and young people as their needs change, through providing the right help, at the right time, to them and their families, by the right people and services. It focuses on a range of wellbeing indicators which aim to take a holistic approach to children’s wellbeing, namely that children should be Safe, Healthy Achieving, Nurtured, Active, Respected, Responsible and Included (SHANARRI). GIRFEC aims to provide families with a clear point of contact (usually known as the ‘named person’) to help families navigate accessing the support they need, with joined-up working required between services to meet these needs and improve wellbeing.

This approach aims to ensure that the child's needs are at the centre of all support and decision-making processes across the continuum of the support they are given, including children in need of care and protection, from when a support need is first identified, to when the child and their family need more sustained and specialised support. GIRFEC supports co-ordination and joint-working for any child who needs support from more than one agency or organisation, while also aiming to incorporate a holistic approach through analysing the wider settings of the family and the community around them.

Corporate Parenting duties in Scotland (Children and Young People (Scotland) Act, 2014) stipulate that all public sector organisations must collaborate with each other to take actions necessary to uphold the rights and safeguard the wellbeing of care experienced children and young people until they turn 26. This is a responsibility shared across all services and departments within a local authority, including social work, housing, education, and leisure services, as well as health services and the Police, to listen to what babies, children and young people need, and to work collaboratively to set out the steps they will take to ensure children and young people can realise their rights and do not experience any unnecessary disadvantage.

The Scottish Government's commitment to addressing poverty and inequality and promote inclusion is enacted through a range of measures across multiple areas of policy and governance. For example, the Scottish Attainment Challenge seeks to address inequality in pupils' attainment across different areas of Scotland, particularly areas classified as deprived through the Scottish Index of Multiple Deprivation (Scottish Government, 2021b). The Fair Scotland Duty is another key measure to enact commitments to equality and inclusion. This places duties on public bodies to pay due regard to how they can reduce inequalities of outcome caused by socio-economic disadvantage (Scottish Government, 2021d).

Tackling poverty is crucial to improving the wellbeing of babies, children, young people and families, and doing so is core aspect of The Promise (ICR, 2020). Furthermore, evidence has demonstrated that there is a relationship between poverty, child abuse and neglect in Scotland and other countries in the UK (Bywaters *et al.*, 2016; Bunting *et al.*, 2018; Bywaters *et al.*, 2022). The Child Poverty (Scotland) Act (2017) sets targets for reducing child poverty, placing a duty on local authorities and regional health boards in Scotland to produce joint Local Child Poverty Action Reports. National plans are set out in the Tackling Child Poverty Delivery Plan 2022-26. Whilst there have been a range of actions from national and local government to mitigate the impact of poverty, the impact of the COVID-19 pandemic and associated public health restrictions and the cost-of-living crisis since late 2021 in the UK pose significant challenges to ongoing policy approaches.

Barriers to the implementation and delivery of children's social care

Despite this ambitious policy landscape, a considerable implementation gap between policy, practice and experience has emerged across many areas of children's services in Scotland. One example is the Continuing Care and Aftercare duties set out in the

Children and Young People (Scotland) Act 2014, of which practice implementation and access to appropriate support can be highly inconsistent (Lough Dennell *et al.*, 2022). Whilst the GIRFEC model has been noted to be beneficial in practice for providing a "unifying practice framework, shared language and an approach to working together", inconsistencies in its implementation have also been identified, meaning that the experiences of children and families differ across Scotland (Scottish Government, 2021b). There is a growing acceptance that system-wide local and national changes are needed to support the intention and aspiration of GIRFEC in practice (Coles *et al.,* 2016; CELCIS, 2022):

- The need to address barriers and a lack of resources that prevent universal services managing wellbeing concerns earlier, when a child and their family first need support from services.
- Recognition of the importance of community-based, non-statutory services for families.
- Resolving tensions around balancing wellbeing against child protection
- How the numerous systems involved in multi-agency responses to a child's needs can result in fragmented responses that therefore do not best support the needs of each child.
- The need for consistent implementation of GIRFEC across local areas.
- The need for collaborative, multi-agency working, assessment practices and support for the meaningful participation of children and families in the decisions that affect them.
- Support and clarity in the roles and functions of practitioners.
- Resolving issues around data gathering.

Many factors can lead to circumstances where the implementation gap between policy, practice and experience on the ground remains. These include wider challenges that cause inconsistency in support and resources across Scotland, such as differing levels of need and resourcing across local areas. Whilst the factors that lead to differences in people's experiences of support are complex, financial pressures, workforce capacity and morale in services, as well as the level of local need for services, have all been significantly exacerbated by the impact of the COVID-19 pandemic and the cost-of-living crisis (Miller & Barrie, 2022; Observatory of Children's Human Rights Scotland, 2020).

Integration in Scotland

The integration of services for different people who need support across children's and adult's health and social work and social care services has been influential in Scottish and UK policy over the past 20 years (Brown & White, 2006; Baxter *et al.*, 2018; Audit Scotland, 2018). It is perceived to improve outcomes for to meet these differing needs, as well as improve service delivery, efficiency and reduce costs. Within Scotland specifically, the aim that integration would improve the experiences or outcomes of the people that the integrated services support has meant that integration has often arisen as a critical element required to carry out the Scottish Government's vision to improve the wellbeing of the population, including the reduction of poverty and inequality (Audit Scotland, 2018).

A significant effort to integrate health, education and social care services for children was made in across England in the 2000s, through the Children’s Trust Pathfinder model, which is explored in more detail in our strand 3 report. Though improvements in the outcomes of children were recorded, it was not possible to causally link these outcomes with the integration of services, partly due to the short time period since integration, and because it was impossible to separate out other factors such as practice changes and geographical differences from integration (O’Brien *et al.*, 2009). Strand 3 of our research study, ‘Mapping Integration and Outcomes Across Scotland: A Statistical Analysis’ (Anderson et al., 2023), to be published in July 2023, has explored the relationship between integration and outcomes for children, young people and families in Scotland.

In 2011, the Christie Commission reviewed how public services should be delivered in Scotland. Integration was one of four key pillars of public service necessary to the extensive reforms required (Christie, 2011). The Public Bodies (Joint Working) (Scotland) Act 2014 sought to enact this recommendation through mandating the integration of health and social care services in Scotland, stipulating that the primary purpose of integration must be to promote the wellbeing of the population. It did not require that children’s services be included in integrated services, enabling each local area to decide about the inclusion of these services.

In the same year the Scottish Government also introduced the Children and Young People (Scotland) Act 2014, which established a new legal framework and duty for services to work together in support of children, young people and families. Organisations providing health and social care services to children were expected to jointly plan and deliver services. Prior to this Act, the Children (Scotland) Act (1995) required local authorities to produce strategic plans for children’s services, and to consult with health boards and other relevant organisations who had a duty to co-operate with the local authority to deliver services (The Scottish Office, 1997). These strategic plans were referred to as Integrated Children’s Service plans.

The Children and Young Person (Scotland) Act 2014 was described at the time as the most significant piece of children's legislation in Scotland in recent years. The Act replaces the responsibility of local authorities to lead on the production of the Integrated Children’s Service plan with a requirement that every local authority and its relevant health board jointly prepares a Children’s Services Plan every three years.

Guidance on Part 3 of the Children and Young People (Scotland) Act 2014 relating to children’s services planning was published in December 2016, and notes “that ‘integration’ does not refer to the formal delegation of functions (such as that taking place within adult health and social care). The focus here is on securing a joined-up approach, between local partners, to service planning and delivery” (Scottish Government, 2016: 29).

The current landscape for delivering children's services in Scotland is varied and complex, in part as a result of the Public Bodies (Joint Working) (Scotland) Act 2014 which allows flexibility for transferring the responsibility for some services to Integration Authorities, to be delivered through Health and Social Care Partnerships (HSCPs) in and across local areas in Scotland. Some of these Partnerships have responsibility for Community Children's Health and Children's Social Care and Social Work Services; some Partnerships do not have children's services in their responsibilities; while others have children's health but not social work services. There is also variation in how and where responsibilities for the health services lie within different Partnerships. The third strand report of our research project 'Mapping Integration and Outcomes across Scotland: A statistical analysis' (Anderson et al., 2023), to be published in July 2023, will provide more detailed information about the development and operation of Health and Social Care Partnerships in Scotland.

Concerns arose about the lack of clarity regarding the relationship between the Public Bodies (Joint Working) (Scotland) Act 2014 and other key policy frameworks for children's services, such as the GIRFEC approach, and the Children and Young People (Scotland) Act 2014, all of which were perceived to adversely affect the integration of services for children, young people and their families (Brock and Everingham, 2018). There was also concern that the profile and needs of children's services were not prioritised in comparison to adult services in planning processes, alongside a lack of clarity and variation in the strategic planning and accountability for children's services. Both were seen to have a potentially grave impact on achieving the desired improvements intended for children and families (Brock & Everingham, 2018).

In 2018, Audit Scotland reported that integration in Health and Social Care had been impacted by several factors. The need to improve strategic planning and change the delivery of health and social care services were identified as critical issues. Additionally, the exclusion of financial planning from integration measures, and that financial planning was not long-term and had not focused on how to improve outcomes for people who need support, was found to be a fundamental barrier to making the improvements to health and social care as set out in the 2014 Act. Furthermore, Audit Scotland outlined a range of features seen as supporting integration (see Figure 1). However, the report did not outline the concrete components needed to achieve each of the features identified.

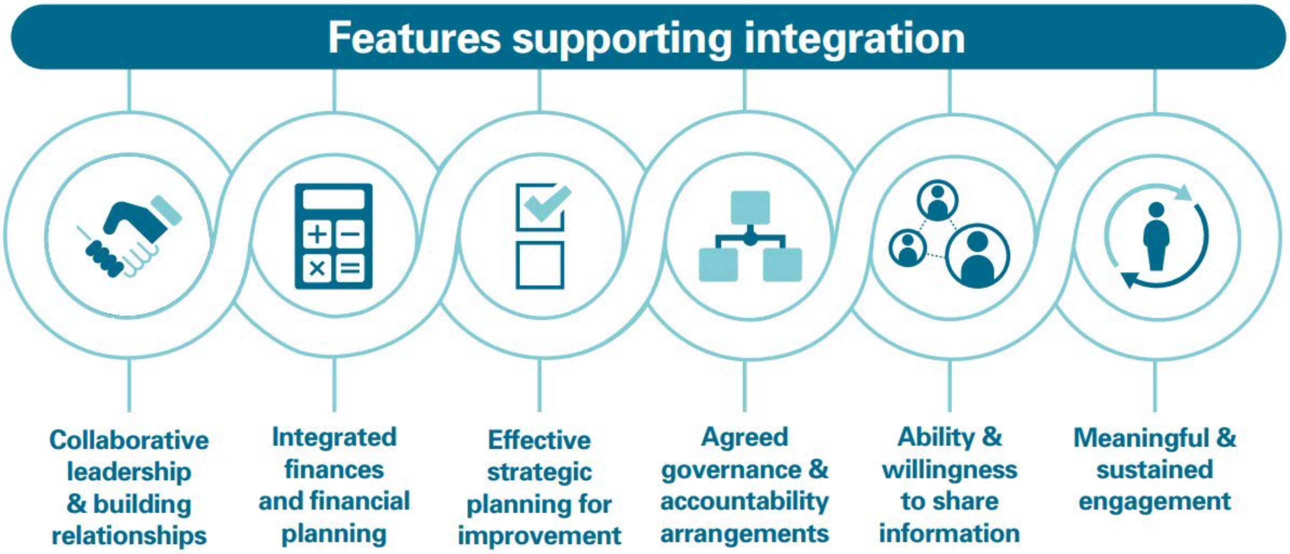


Figure 1: Exhibit 7, Audit Scotland 2018 (Health and Social Care Integration: Update on Progress)

In September 2020, Scotland's First Minister announced an Independent Review of Adult Social Care in Scotland with the principal aim to recommend improvements to adult social care. The report was published in February 2021 and recommended the creation of a National Care Service for adult social care, to be delivered locally through reformed Integrated Joint Boards (Feeley, 2021).

In August 2021, Scottish Government launched a consultation on the National Care Service, which included a proposal that children's social work and social care services should be included within the National Care Service (Scottish Government, 2021a). In the National Care Service Statement of Benefits report produced by Scottish Government in June 2022, the proposal that the National Care Service could include children's social work and social care services was considered in more detail, with a recognition that further evidence is required to inform future decisions around inclusion or exclusion of these services (Scottish Government, 2022).

In Scotland, children, young people, families, carers and those working to support them, have shared their experiences of what helps them and what they need, with a broad recognition and agreement that improvement is needed in children's services in response to this, as evidenced in the conclusions of the Independent Care Review (ICR, 2020), the Morgan Review (Morgan, 2020), and other areas of focus on the health, care and protection needs of Scotland's children and young people (Brock and Everingham 2018; Christie 2011).

Rationale for the Rapid Evidence Review

Whether or not to integrate systems, processes, services, or agencies is a big decision. When the systems in question include the nationwide delivery of support through children's social work and social care services, the implications are even wider. For Scotland, such a decision will impact on the lives of thousands of families each year, affecting their wellbeing, health, and education among other aspects of their lives. It is important to note that this is true *regardless of whether changes are made*. A decision to take no action is a decision with consequences as much as a decision to make a change.

In this context, it is important that any decision is made with the fullest understanding of all the available evidence and information. There are many sources of information and evidence which are accessed across the different strands of this research. This Rapid Evidence Review focuses on one particular source of evidence: existing published research into integration in high income countries. This evidence has been gathered systematically and across a wide range of contexts and reflects what is known about integration in academic studies.

Given the possible implications and impact of any decision, it is fair to ask: Why a *rapid* review? The answer is practicality. There is always a balance to be struck between gathering the most complete, thorough, and exhaustive set of information, and making that information available in a time and manner which enables it to be used. This is a 'rapid' review in the context of academic reviews which can take many years to complete. We have struck a balance which allows us to conduct the systematic sourcing and synthesising of information in a timescale that allows that information to both inform the subsequent strands of the research, and to be absorbed, understood, and used to inform real-world decision-making.

Understanding what we already know is a key step both for decision making now, and for knowing what we need to understand in the future. This review is one contribution to this process.

The research questions

In the development of this review, one overarching research question with seven more specific sub-questions were identified by the review team in partnership with stakeholders. The seven sub-questions are designed to complement and 'flesh out' the overarching question to provide focus for the analysis and synthesis of the data included in the review. The numbering or sequencing of the sub-questions does not denote any priority or relative importance.

Overarching research questions

1. What models of integration exist for the delivery of children's social work services with health and/or adult social care services in high income countries?

2. What is the strength of evidence about their effectiveness in improving services, experiences and outcomes for children, young people and their families?

Sub-questions

1. What are the evidenced rationales for integration (or not) of children's services within national health and social care contexts?
2. What evidence is available which informs understanding of the challenges, enablers, and experience of integrating children's services with health and/or adult social care?
3. How and in what ways does integration affect the availability, quality, timeliness, cost and relevance of health and social care services for children and their families support, and satisfaction with these services?
4. Can links be drawn between the nature of integration within Children's Services and outcomes for children, young people, and their families?
5. How and in what ways do different integrated models of children's services impact on the workforce?
6. Were the views of children, young people and their families/carers sought prior to or during the integration of children's services, and if so, what were these views and how were they included in design processes?
7. What evidence is there about the impact of integration on the realisation of children's rights?

Methods/methodology

Rapid evidence reviews

Rapid evidence reviews (often called Rapid Reviews) are a method for conducting an assessment of the evidence relating to a specific question(s) using structured and documented methods, within a tight timescale. While there is no one accepted definition or approach to rapid evidence reviews, the Cochrane Collaboration provides the following definition:

> *"A rapid review is a form of knowledge synthesis that accelerates the process of conducting a traditional systematic review through streamlining or omitting various methods to produce evidence for stakeholders in a resource-efficient manner" (Garritty et al., 2021: 15)*

The Cochrane Collaboration is an international network which promotes and supports the synthesis of evidence relating to health and is recognised internationally as providing the 'gold standard' for undertaking evidence reviews and synthesis.

While the speed at which a review is conducted does not place a limit on the quality of the review (Schünemann and Moja, 2015), it is important to recognise that a rapid timeframe within limited resources makes following gold-standard systematic review methods impossible, and that rapid evidence reviews require compromises to ensure these are completed within key timescales (please see Limitations section for details relating to this review). Table 1 outlines some of the differences between non-structured reviews, rapid evidence reviews, and systematic reviews. Key differences relate to the timescales, sources, and inferences that are possible from the different methodologies.

Attribute	**Non-structured Review**	**Rapid Evidence Review**	**Systematic Review**
Timeframe	1-6 months	1-6 months	6 months – 2 years
Question	Identified by researchers	Identified through collaboration of stakeholders and researchers	Often a focused clinical question
Sources and Searches	Opportunistic/wide-ranging	Limited, but made explicit prior to start	Comprehensive, made explicit prior to start
Selection	Researcher judgement	Criterion based	Criterion based
Appraisal	Varies dependent on source	Rigorous and consistent	Rigorous, consistent with critical appraisal
Synthesis	Descriptive	Descriptive summary and categorisation of data	Qualitative summary and meta-analysis
Inferences	Describe the literature	Limited/cautious inference	Strong evidence-based inference

Table 1: Comparison of review types (adapted from Khangura et al., 2012)

The Cochrane Rapid Reviews Methods Group provide guidance (Garritty *et al.*, 2021) in the conduct of rapid reviews which was adopted in the design and conduct of this review and provides for systematic approaches and analysis to be conducted within limited timescales.

One of the strengths of rapid evidence reviews is that questions and outputs are tailored to the needs of the 'knowledge user' (Khangura *et al.*, 2012), ensuring that the results of the review are immediately useful to the commissioning body. It has also been noted that the overall findings from rapid reviews do not normally differ significantly from systematic reviews conducted on similar topics (Watt *et al.*, 2008) although they have less capacity to conduct in-depth meta-analyses or to assess financial impacts.

Overall, the strength of a rapid evidence review comes from the transparency of the methods used in identifying, appraising, and analysing the papers included, as well as the clarity with which the findings are presented.

Research protocol and search strategy

A key part of the transparency relating to methods used in a rapid evidence review is the creation of a research protocol which defines in advance of the review how papers will be identified for inclusion, and the data extraction and analysis that will be conducted. For this review, a research protocol was developed by the research team and signed off by the Independent Steering Group.

This protocol (Appendix 1: Research Protocol) defined in detail the search terms, databases, inclusion/exclusion criteria, data extraction, and risk of bias assessments that would be conducted. The key elements of the protocol are presented in *Table 2*.

Search Strategy	
Databases to be searched	SCOPUS Applied Social Science Index and Abstracts (ASSIA) Social Care Institute for Excellence (SCIE)
Common elements to all searches	Children and young people Social Care Integration/structure
Four elements added to common elements to create four individual searches	Rationales (for or against integration) Process (of integration) Outcomes (of integration) Children's Rights (impacts of integration)
Date range	2012-2022 (Inclusive)
Inclusion Criteria	English Language Based (in part) in a high-income country (as defined by the World Bank 2022-23) https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups Empirical research OR systematic review
Exclusion criteria	Do not include any social care services relating to children or their families Texts not in the English language

	Historical Accounts/Autobiographies/non-empirical work Published prior to 2012
Appraisal	
Study Appraisal	1. Application of inclusion/exclusion criteria to title and abstracts of all identified literature 2. Application of inclusion/exclusion criteria to full texts of those included after step 1
Risk of bias assessment	Mixed Methods Appraisal Tool
Data Extraction	
Data extracted	Key information in relation to: • Definitions of integration • Definitions of Social Care • Rationales for integration • Process of integration • Outcomes of integration • Rights impact of integration was extracted from all papers included after Study Appraisal step 2.

Table 2: Summary of key information from the review research protocol

Peer-review searches

Four searches were conducted within the Applied Social Science Index of Abstracts (ASSIA) and SCOPUS databases, each of which contained the common search elements (‘children and young people’, ‘social care’, and ‘integration/structure’) alongside one of the four elements of ‘Rationales’, ‘Process’, ‘Outcomes’ and ‘Rights’. Each of these elements consists of search text containing words or phrases (sometimes abbreviated by the * symbol, which allows any (or no) character to be appended to that piece of text) which may identify this element within a paper, linked by the ‘OR’ Boolean operator. These elements were then combined with the ‘AND’ Boolean operator, and the completed string used to search within titles, abstracts, and keywords within the selected databases. Boolean operators are specific words which are used to help expand or narrow search parameters when using databases or search engines. Appendix 1: Research protocol gives the complete search string texts for each element.

Accordingly, eight individual searches were conducted to identify potentially relevant literature, four within each database - one relating to each of the individual search elements.

Papers identified through these searches were imported into the Zotero reference management software, to facilitate record management and the tracking of decisions. Each paper went through the following review stages:

1. The search results were combined and scanned to remove duplicates and reduce the reviewing burden.
2. The author, year, journal, title, abstract, and keywords fields were exported from Zotero to Excel for ease of use.
3. One researcher conducted an assessment of the above fields to determine if the paper met the inclusion/exclusion criteria. At this stage, researchers could identify

the paper as ‘include’ (meets the inclusion criteria for inclusion in the review), ‘exclude’ (does not meet the criteria for inclusion in the review), or ‘unsure’.

4. Those that were marked as ‘include’ were passed on to the next step of the appraisal, those marked ‘exclude’ were excluded at that stage, while those which were marked as ‘unsure’ were discussed at a team meeting and a group consensus was reached on whether they should be marked as ‘include’ or ‘exclude’ and handled accordingly.
5. A full text version of all papers identified as ‘include’ was sourced.
6. Researchers conducted a full text review and data extraction using an online Qualtrics survey alongside the full text paper, in order to facilitate management of responses, and ensure consistency of approach.

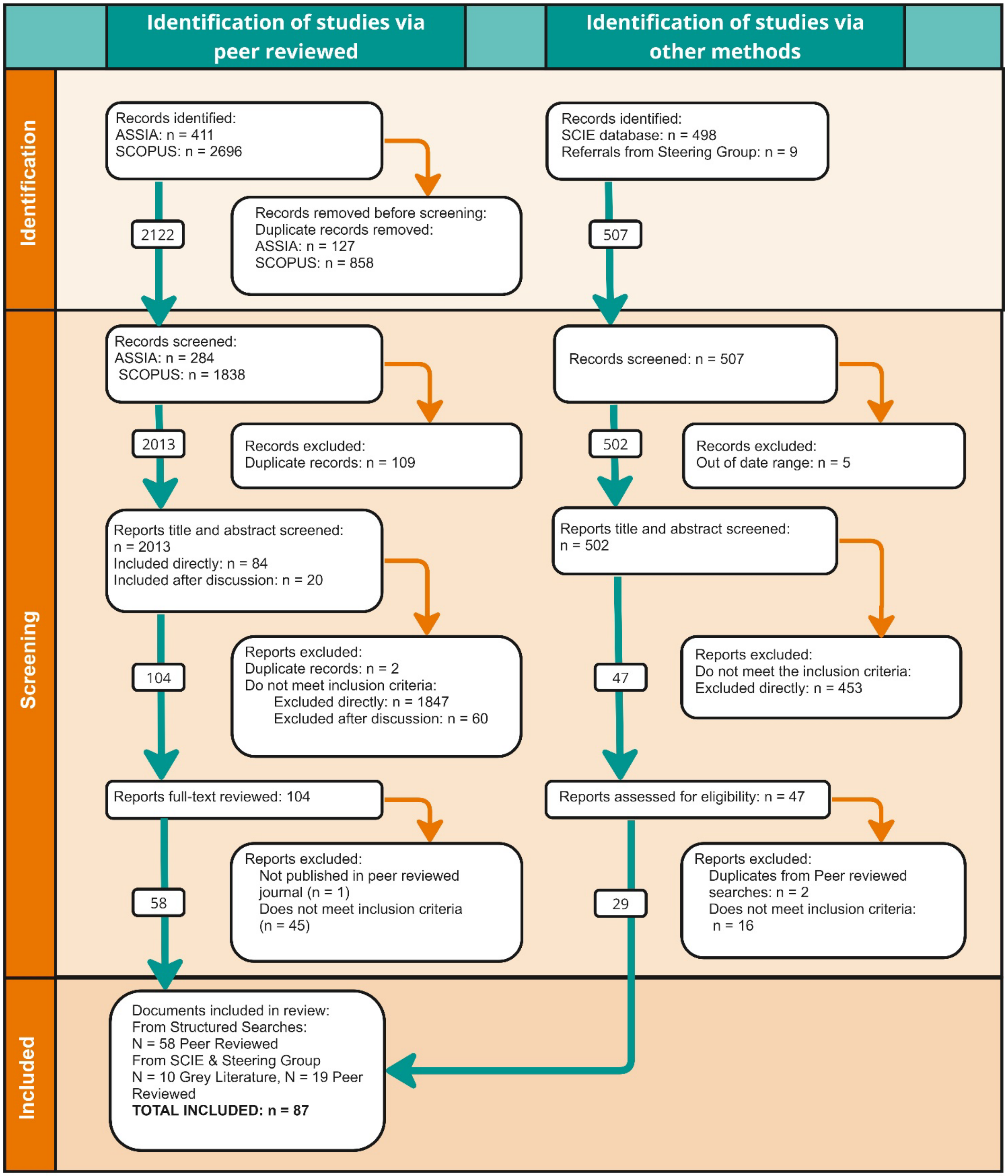
Grey literature search

Grey literature refers to materials that are not published by a commercial publishing organisation, that is, organisations whose primary purpose is to produce and publish literature. This includes literature that is available in print or accessed electronically and may have been produced by governments, public bodies, businesses, charities and academics (Lefebvre et al., 2022). Due to the nature of grey literature databases, it is often not possible to use Boolean operators in the search terms or filters, such as year of publication. As a result of this, an alternative strategy was used, which consisted of simply searching for the term ‘integration’ within the Social Care Institute for Excellence (SCIE) database, and extracting all documents identified that were published from 2012 onwards. In addition, in order to ensure that relevant documents were not missed, a list of the included peer-reviewed literature was shared with the Independent Steering Group for this study, who were asked to share any additional documents that they thought would be relevant for the review. This resulted in an additional nine documents being included.

The review process for all of the grey literature identified was the same as described for the peer-reviewed papers.

The Prisma Diagram (Figure 2) illustrates the number of documents that were sourced, excluded, and included at each stage.

Prisma diagram of systematic searches



Adapted from: **Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. For more information, visit: http://www.prisma-statement.org/**

Figure 2: PRISMA diagram of systematic searches (Page et al., 2021)

Data extraction, analysis and synthesis

Data was extracted from each of the papers during the full text review. In this stage, reviewers again assessed the full text paper against the inclusion/exclusion criteria, and if the paper met the criteria, data was extracted via a number of questions within the Qualtrics survey (Appendix 2: Data Extraction Tool and Appendix 3: MMAT Questionnaire) including:

- Summary of the key findings of the paper in the reviewer's own words.
- Completion of the Mixed Methods Appraisal Tool.
- How Social Care and Integration are defined.
- What the authors have written about rationales, and reviewer reflections on how the paper answers the research question related to rationales.
- What the authors have written about process, and reviewer reflections on how the paper answers the research question related to process.
- What the authors have written about outcomes, and reviewer reflections on how the paper answers the research question related to outcomes.
- What the authors have written about rights, and reviewer reflections on how the paper answers the research question related to rights.
- Summary of the strengths and weaknesses of the paper.
- Any other findings of relevance not mentioned elsewhere.

The text created from these questions was then extracted from the Qualtrics survey and entered NVivo (computer assisted qualitative data analysis software) for analysis.

At this stage, following the full text review, the whole research team came together to discuss the themes and concepts that were emerging from the reviewing the papers in reference to the research questions. From this discussion, eight themes were identified which were formed into top-level codes, along with a small selection of sub-codes (please see Appendix 4: Coding Structure). In order to expedite the analysis process, the lead reviewer then identified which extracted data would be expected to contain information of relevance to each high-level code and should therefore be coded within them. Table 3 shows which text responses from the Qualtrics survey were coded to each high-level code.

High level code	**Rationales**	**Process**	**Outcomes**	**Rights**
Experiences of integration		✓		
How integration is done		✓		
Integration at different levels		✓		
Impact of integration			✓	
Impact of integration on rights				✓
Outcomes			✓	

Rationales for integration	✓			
What works in integration		✓	✓	

Table 3: What extracted data is coded to which high-level code

Two reviewers were then assigned to each of the high-level codes, to conduct the coding task together. Coding pairs were mixed across the team as far as possible, and only two high-level codes had the same coding pair. This both ensured that all extracted data was coded by two reviewers, and that the coding approach was made as consistent as possible through discussion across the team and working alongside different reviewers. Reviewers worked on between three to five codes each, depending on the time commitment available.

A thematic analysis approach was taken to the coding and analysis of the extracted data (Braun *et al.*, 2019). Reviewers were already familiar with much of the data following the full-text review process, and in their coding pairs, the reviewers worked through the extracted data identifying themes and concepts relevant to the research questions that emerged. Although coding pairs were allocated to specific high-level themes, reviewers were encouraged to code data which they felt was relevant to other high-level themes to the high-level code. This data would then be analysed by the coding pair assigned to that high-level theme in the same way as other data.

Due to licensing constraints, each reviewer worked within their own copy of the complete data, in a stand-alone NVivo project. These were then merged into a master copy by the lead reviewer at the end of each week, and a copy of this file was then used by all reviewers from that point on. Reviewers were also encouraged to discuss their coding, and the research team met as a whole to do so. As a result of this coding and analysis approach, a complete coding structure with 89 sub-codes under the seven high-level codes was created (please see Appendix 4: Coding Structure).

A process of rationalisation was undertaken where duplicate themes were removed, and some sub-themes were merged. To synthesise the data effectively, the structure of this report was created and also discussed with the Independent Steering Group.

Limitations

In our design of this review, we incorporated as many elements of systematic reviews as possible and followed the Cochrane Collaboration recommendations for rapid reviews (Garritty *et al.*, 2021) in order to minimise the limitations of the methods selected. However, rapid evidence review methodology has limitations which need to be kept in mind when considering the findings that emerge. In addition, as is the case with any review, decisions taken by the research team in the course of the review will have an impact on the data that is included, and therefore the findings that are derived from that data.

For this review, we selected two databases of peer-reviewed papers to search (ASSIA and SCOPUS). The two identified databases were selected on the basis that these provided access to journals encompassing papers on both health and social care, as well as being extensive so were likely to capture a larger volume of relevant evidence. While these were selected to facilitate gaining access to any papers relevant to our research questions, they are not exhaustive databases, and accordingly there will be papers which may have been of interest to include, which were not identified. Similarly, it is possible that where authors described their topic in different terms, papers may not have been identified through these searches.

Requiring the paper to be written in the English language is a further limitation on the papers that were included, as is the requirement for the research to be based at least in part in a high-income country as defined by the World Bank (World Bank, 2023). Both of these requirements represent practical approaches to prioritise the analysis of papers which are most likely to have relevance to the Scottish context, as well as to ensure that it was possible to complete the review with the resources available. However, it is clear that there may be much to learn from studies of service integration that are written about in languages other than English or are from lower- or middle-income countries (World Bank, 2023).

Due to resource constraints, only one reviewer conducted reviews on each paper. Two reviewers would ideally review each paper to ensure consistency of process and of data extraction. This was mitigated as far as possible through the clear articulation of the data to be extracted, development of a shared understanding of the research questions, and frequent, regular meetings of the whole team to discuss the process and experiences.

Finally, in this rapid evidence review, we extracted data for analysis during the full-text review of papers, rather than including the full text as our source material for coding. This allowed us to conduct the review within resources, but it is possible that some data may have been overlooked or missed from papers in the process of extracting data from full texts for coding. However, when needed, the research team referred back to the source material to check any issues, clarify points and gain additional information.

Findings

Descriptive analysis of included papers

As indicated in the Prisma Diagram in the Methods/Methodology section (Figure 2), a total of 87 papers were included in the review. As part of the full-text review of these papers, a range of quantitative data was collected regarding the nature of the papers included.

Methods and methodologies

As can be seen in Figure 3, a range of methodologies were used by the papers selected for inclusion in the review. A large majority are primary research (qualitative, quantitative, or mixed methods) where original data was collected. This is to be expected as part of the inclusion criteria required that they were a piece of empirical research, systematic literature review, or other review type. Further, we can see that just under half the papers exclusively used a qualitative methodology, with smaller numbers using quantitative, or mixed, approaches. It is also notable that none of the grey literature used quantitative methods alone, but employed a mix, while two of the grey literature documents were reviews.

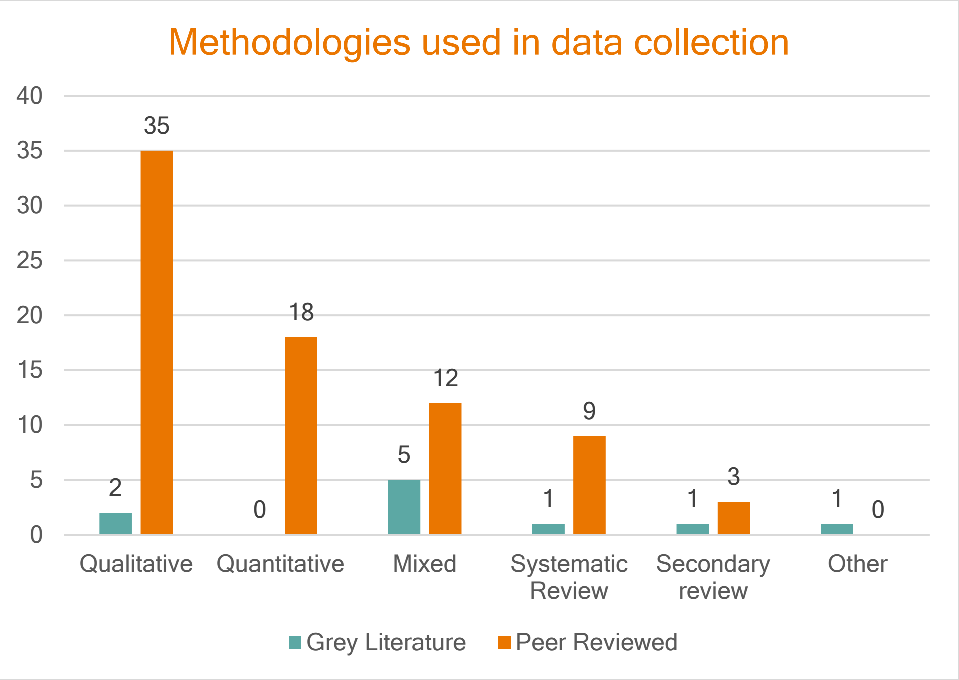


Figure 3: Methodologies used in included papers

When we look at the methods employed in the papers included in the review (Figure 4), we can see that there is a wide range of methods used, from qualitative methods such as interviews and focus groups, through to more quantitative methods such as survey and observation, and in some cases multiple methods were used within papers. Given the topic of interest, it is unsurprising that interviews were the most popular method of data collection in both the peer-reviewed and grey literature identified for the review. It is also to be expected that systematic reviews were more prevalent in the peer-reviewed papers.

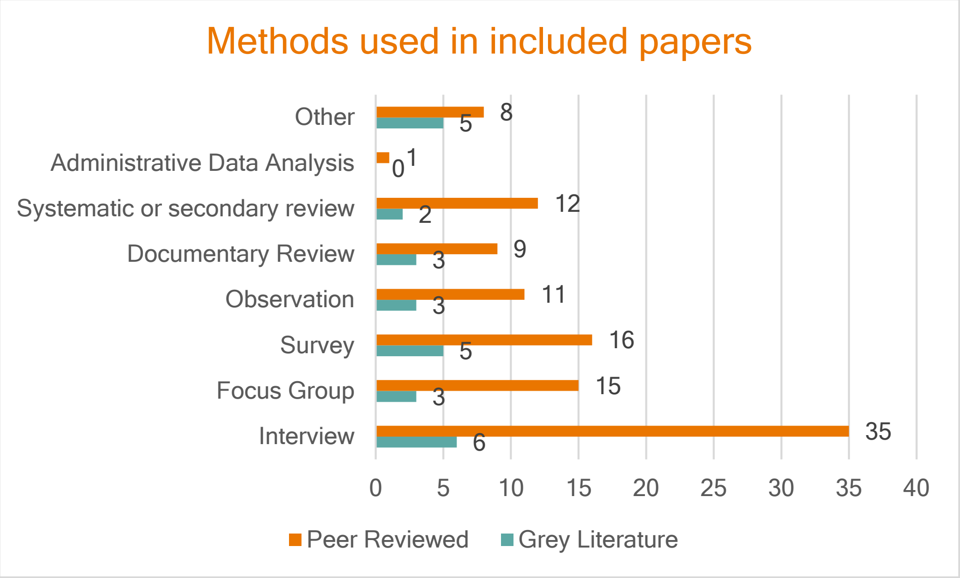


Figure 4: Data collection methods used in included papers

Geographical coverage

To ensure that findings were as applicable as possible to the Scottish context, only papers which featured findings from high income countries were eligible for inclusion (see Methodology and Appendix 1: Research Protocol) for more information). As a result of this decision, there were many more countries eligible for inclusion within the continents of Europe and North America than Africa, Asia, or Latin America. Alongside the fact that some papers include data from more than one geographical region, this partly accounts for the distribution of geography covered seen in Figure 5. There are two papers which include data from Africa and Asia included in this review, and both of these were systematic literature reviews.

It is unsurprising that North American countries were most represented in the papers given the size of North America, its position as a high-income country, and our requirement for included texts to be published in the English language. However, it is interesting that there are more papers from the UK (combined Scotland and 'UK (Other)' than from the rest of Europe. This may indicate that interest in integration is more prevalent in the UK.

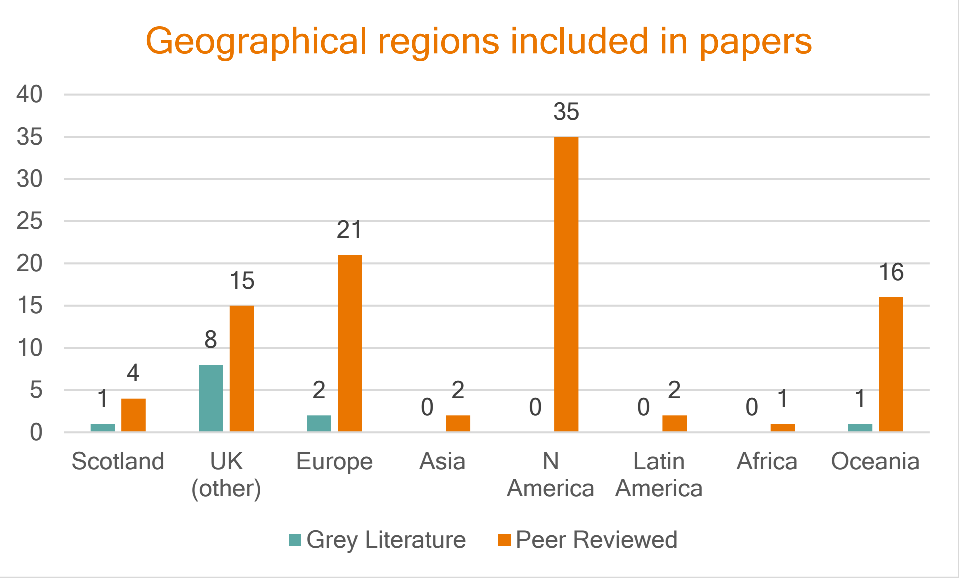


Figure 5: Geography of regions studied within included papers

Year of publication

Our search strategy included papers which were published in an 11-year period between 2012-2022 (inclusive). As can be seen in Figure 6, the results indicate a surge in publications and interest in integration around 2017, when five grey literature papers were published, and among the peer-reviewed sources identified we also saw a marked increase in the number of publications from 2016-2018, with then a gradual decline across 2019-2022.

This rise in publication of papers with a focus on integration starts a year after the beginning of health and social care integration within Scotland, and perhaps reflects the growth in integrative efforts across the UK and further afield. The rise in the publication of grey literature related to integration from 2017 is certainly in part driven by the conduct of evaluative work relating to integration.[14,18]

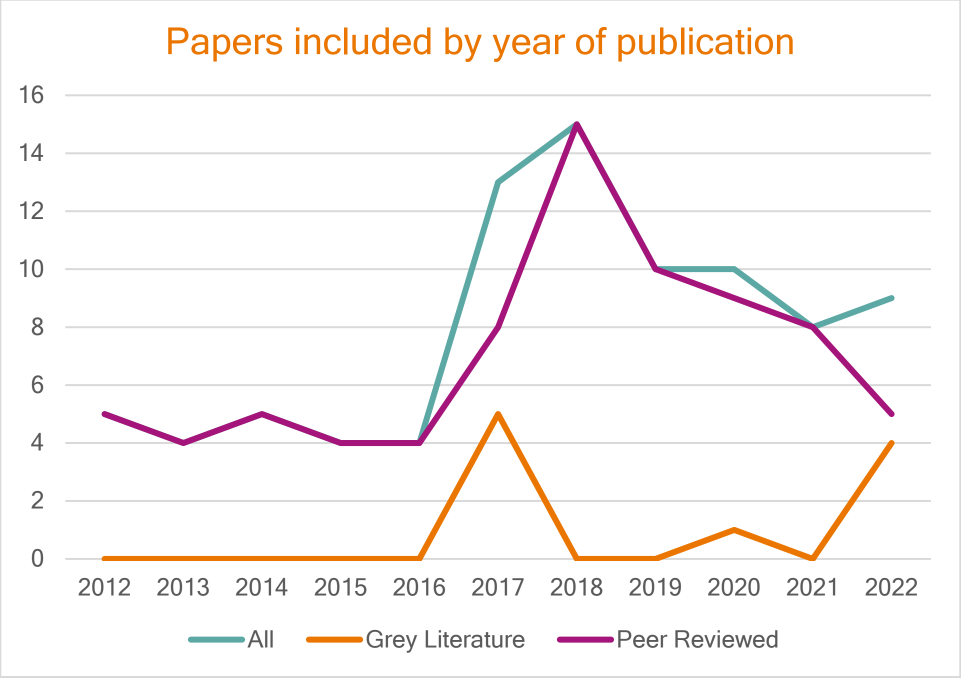


Figure 6: Year of publication of papers included

Representation of participant groups

Across the papers included in the review, a wide range of participants were included in the studies (see Figure 7). The two most common participant groups by some distance are health and social work practitioners. This illustrates the strong focus on workforce perspectives on integration which is apparent throughout the papers included in the review. It is also worth noting that while many papers are listed as including infants, young children, older children, young people, and parents/carers as participants, the numbers engaged in these studies was typically very low, and these groups are often engaged in less substantive ways, for example, only collecting quantitative data;[11,7] or where fewer young people were interviewed compared with professionals. For example, in one study, five interviews were conducted with young people, while 156 professionals completed a survey, of which 14 were also interviewed.[18]

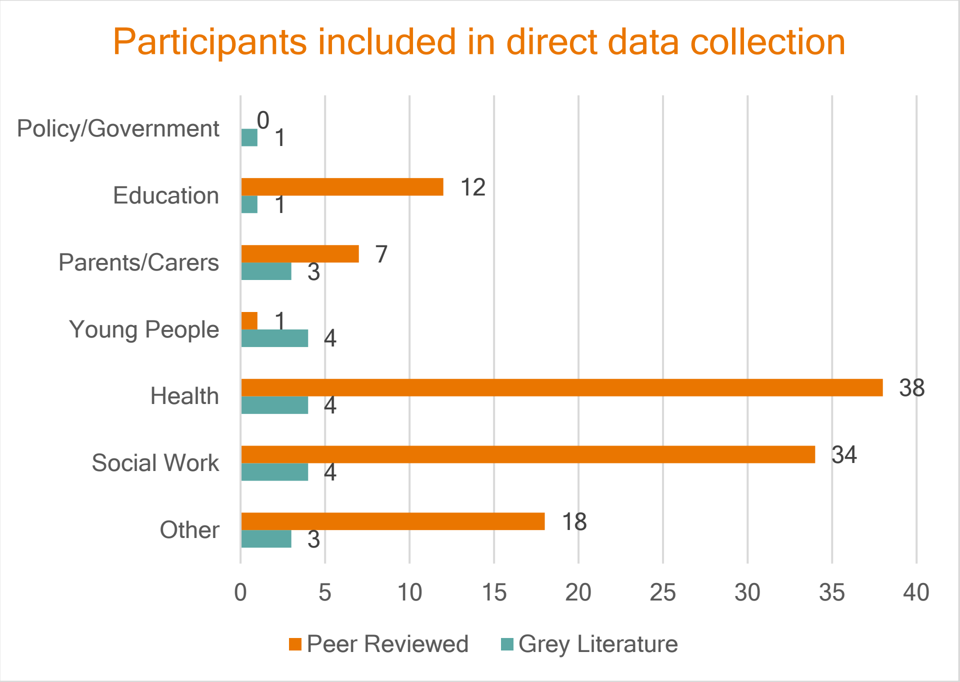


Figure 7: Participants represented in direct data collection in the studies reviewed

As we can see, there are a wide range of participants involved in these studies. However, this does not tell us about the number of participants who are involved, which has implications for our understanding of the strength of the evidence presented. Figure 8 shows us the number of papers which represent the views of different numbers of professionals. In total there are 51 papers which represent the views of professionals, with a majority of papers representing more than 25 professionals in each. By contrast, Figure 9 shows us the number of papers with direct representation of the views of children and young people, and the views of parents and carers. There are just seven papers which represent the views of young people, with six of these representing fewer than 25 respondents, and 11 papers representing the views of parents/carers, which have a higher average number of participants than the papers representing the views of children and young people.

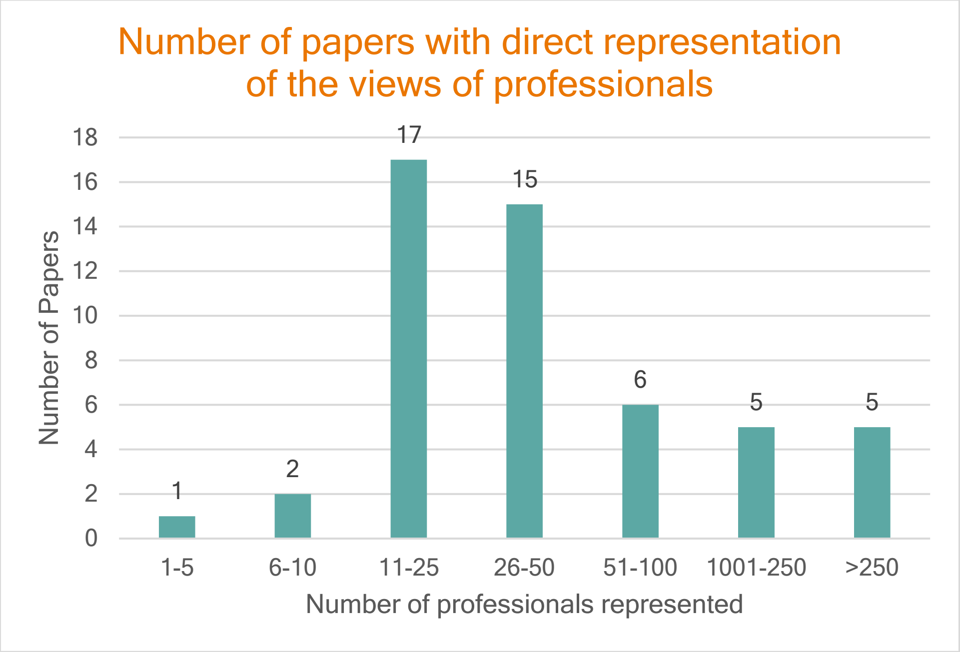


Figure 8: Number of papers with direct representation of the views of professionals

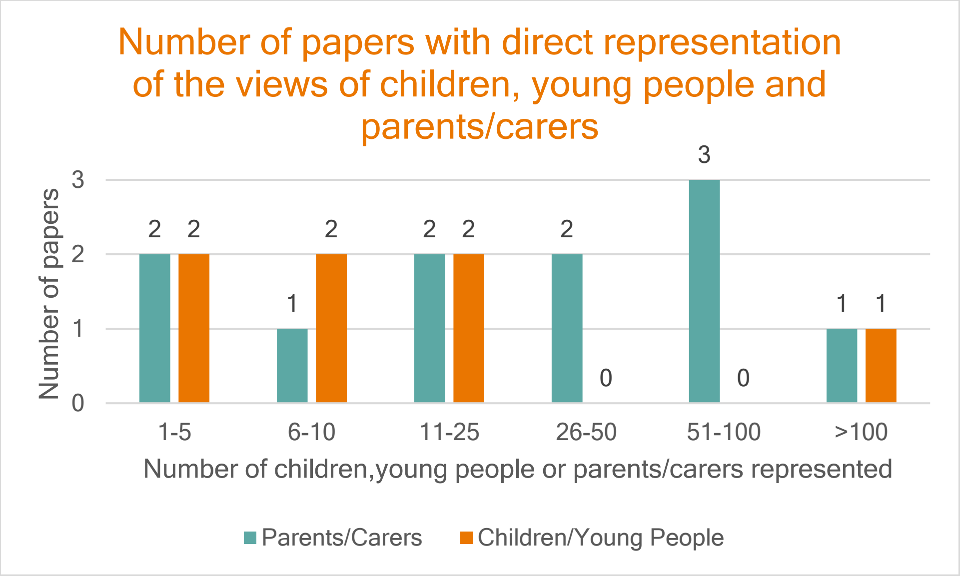


Figure 9: Number of papers with direct representation of the views of young people and parents/carers

Finally, Figure 10 shows that a large majority of papers use only a single timepoint for data collection, and only five papers look at a timescale of over two years.

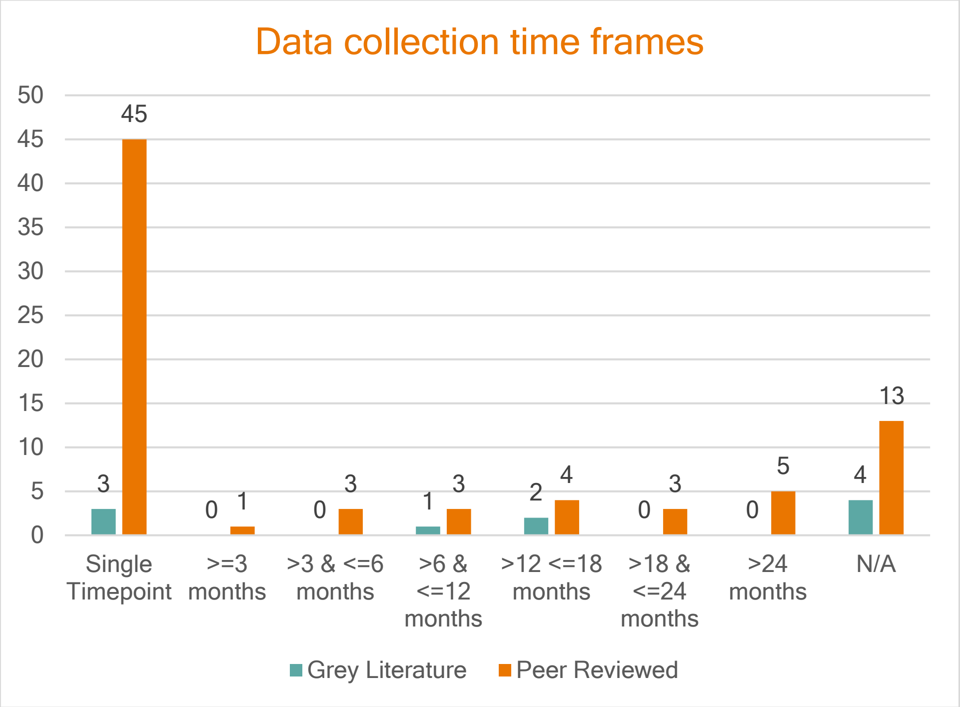


Figure 10: Data Collection Timeframes for primary research papers

Most studies explored integration of services at just one timepoint, or over a relatively short period of time. This means that it is difficult to draw meaningful conclusions about the process, experiences, and outcomes of integration over the longer-term.

What is the quality of the evidence identified?

To illustrate the quality of the evidence identified in this review, our reviewers completed the Mixed Methods Appraisal Tool (MMAT) for each included paper. The reporting of these assessments follows the guidelines provided by the creators of the tool (Hong *et al.*, 2018; Hong, 2020). This appraisal tool consists of an identification of the methods used (qualitative, quantitative, or mixed methods), and then items appraising the quantitative elements, items appraising the qualitative elements, and items appraising the mixed methods elements. Across the qualitative and quantitative appraisals, the items relate to the appropriate use of methods, whether the complete data are presented, and the links between the sources and interpretations made. The mixed methods elements relate to the rationale and integration of the qualitative and quantitative methods used.

It should be noted that these items most often relate to the internal consistency of the paper itself, and the appropriate use of different methods, and accordingly does not relate directly to the 'strength' of evidence provided by a paper. Thus, a paper with a very small number of participants from a very specific sub-group, which accurately and clearly describes the methods, approach, and link between data and conclusions within it, could receive a five-star rating. Indeed, it would be expected that all peer-reviewed papers should reach a four- or five-star rating, and this reflects the quality of the paper, but not the strength of the evidence that is contained within it.

Across all the papers included in the review, Figure 11 shows the numbers of papers that were graded as 1-5 stars, as well as those which could not be assessed (systematic and secondary reviews).

Appendix 5: MMAT scores for all papers provides the scores for each paper included in this review, while within each of the sections which follow, the quality of the literature that was used to inform that particular section is provided in a text box.

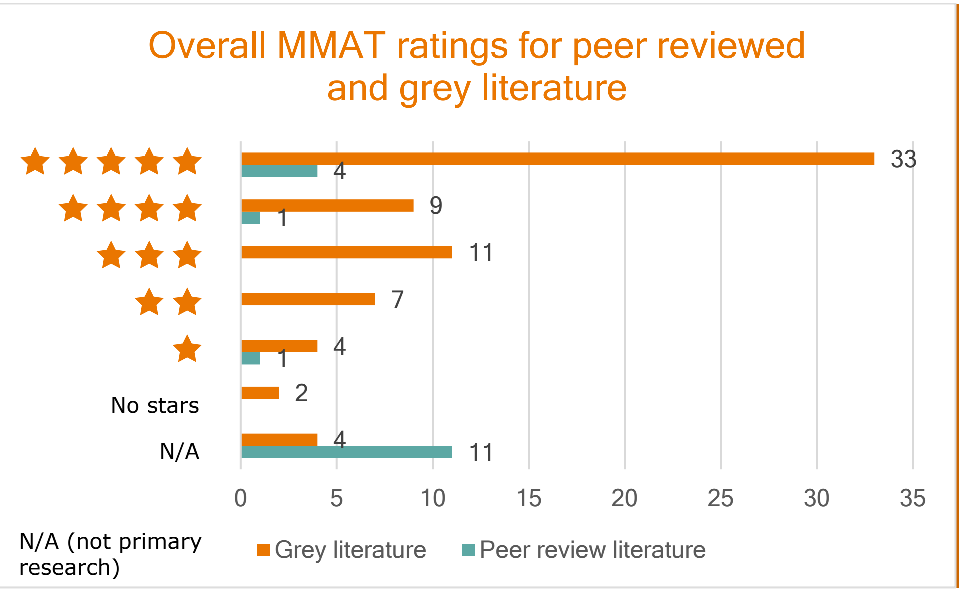


Figure 11: Overall MMAT rating for all papers included in the review

As shown in Figure 3, a range of different methodologies were used in the papers included in the review. Through the MMAT scores in Figure 12 we can see that within the papers which conducted primary or secondary data collection, 37 papers used qualitative methods exclusively, 18 used quantitative methods exclusively, while 17 used a mixed methods approach. The MMAT score distribution for each of these approaches are shown in Figure 12.

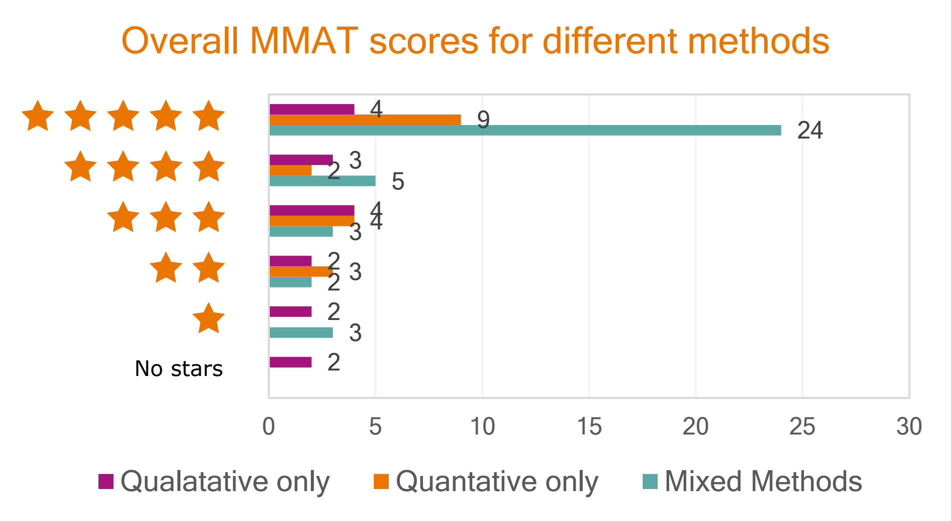


Figure 12: Overall MMAT scores split by methods used

Our analysis suggests that the quality of the papers included in this review is high. In general, the studies have been carried out to a high standard, and we are confident that the findings presented are an accurate reflection of the context and experiences studied. Given the predominance of small-scale qualitative studies within the papers reviewed however, caution must be taken in assessing the strength of the evidence presented and in generalising these findings to other populations.

What does the evidence tell us about definitions?

What is meant by 'integration'?

To understand what the papers we reviewed tells us about integration, it is important that we understand how the papers identified for review were using this term. We examined all papers for explicit and implicit definitions of integration as part of the data extraction process and found 18 papers that offered some sort of definition of integration. While our search terms sought to identify papers which looked at integration in relation to social work and social care, it is important to note that we did not explicitly search for those papers which provided a definition.

The key finding across all the papers we reviewed was that there was no shared, consistent, concrete definition of integration. Indeed, this lack of consistency, or 'conceptual ambiguity' is recognised within some of the papers in the review.[58] It was notable that rather than exclusively using the term 'integration', papers often used related or adjacent terms, such as 'collaboration', 'multi-agency working', 'cross-sectoral networks', 'care co-ordination' or 'unified service'. In some instances, authors appeared to be using these terms as direct synonyms, while in others they appeared to be used to reflect particular practices or organisational structures.

One author commonly referenced amongst the papers included in this review was Leutz (1999), who identified three possible levels of working together: linkage, coordination, and full integration. Horwath & Morrison (2007) were similarly referred to in a number of reviewed papers, who offered a 'model of collaboration' with five levels, ranging from communication to co-operation, then to co-ordination, coalition, and finally full integration. A number of other authors offering models or conceptualisations of the integration process were also referenced within the papers we reviewed.[83,25,21,57]

Many authors used similar terms in relation to a 'continuum' representing the extent to which services work together (Horwath & Morrison, 2007; Leutz, 1999; Morgan *et al.*, 2019. This concept of a continuum of integration appeared in a number of the papers in relation to the level of integration as well as ideas around 'horizontal' and 'vertical' integration:

> *"Integration can happen at different levels and through different mechanisms and exists on a continuum from formalised agreements and arrangements between services, through services using the same referral and assessment processes or sharing administrative processes, medical records and team meetings, to collaborative care approaches and dedicated multidisciplinary onsite teams with a common culture of care." ([30]Hetrick et al., 2017: S5)*

One of the clearer articulations of this continuum of integration was found in a study conducted in New Zealand,[54] where the authors present the diagram at Figure 13, which articulates an increasing intensity of integration and inter-dependency of systems as greater 'integration' activities are undertaken.

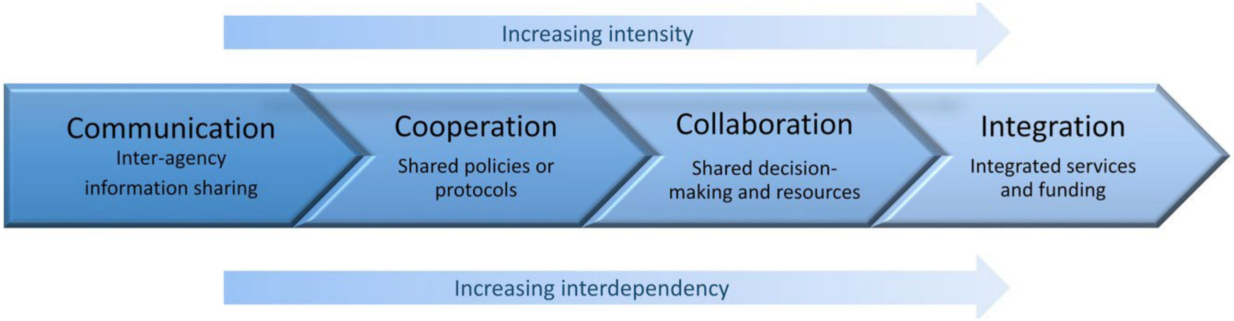


Figure 13: Continuum of integration (Morgan et al., 2019: 1020)

Leutz (1999) and Horwath & Morrison (2007) also included an additional level of 'co-ordination' which in Morgan *et al.'s* (2019) model would sit between cooperation and collaboration. This level is where formal joint working occurs but there was no consequence if this did not happen.

Even in the papers where there were no direct references to a continuum of integration, it was usually clear that integration was being treated as a continuum. Although services could be described as 'integrated', there was no clear end-state of 'full integration', and different services could be described as 'more' or 'less' integrated. The key difference in these papers was that they did not explicitly acknowledge or name lower 'states' of integration, such as those identified in Figure 13.

These models offered broad conceptualisations of integration, rather than describing the specifics of particular services or teams being integrated, and how this would look to, or be experienced by, the workforce or the people intended to be supported by those services.

Components of integration

Through the review process we were able to identify a range of components of integration in the language used by authors to describe programmes and services that had some degree of integration. These components were wide-ranging and included ideas around the purpose of integration, such as the provision of holistic or comprehensive support, as well as elements thought to support, or enable progress towards, full integration, both at a systems level and at an operational level.

Through our analysis of the papers we reviewed, we compiled the components that were identified and conceptualised these as elements that may be part of integration, as shown in Figure 14. We depict these identified components in this way in order to avoid implications about the relative importance of the different elements, about which there is no clear evidence, or any sequencing of these in terms of where these fall in a continuum such as that shown in Figure 13. Although these elements were identified in different articles, it was not suggested by the authors that all were necessary, nor that any of them in isolation were sufficient, to achieve a high level of integration.

Figure 14: Components of integration identified from the review of the papers

This diagram helps us to understand both how integration may be identified the papers we reviewed or within a system or organisation, as well as providing guidance on the elements that may need to be attended to in order to increase integration in any given setting. Although there is no explicit priority or importance allocated to any of these elements, it is likely that the more of these elements realised within a system, the more integrated we might understand that system to be.

Models of service delivery

The papers reviewed focused on models of service delivery too. Distinct from models of integration, the models of service delivery were programmes or services which had been developed within specific contexts or in response to specific needs. These were sometimes 'named models', for example, Family Safeguarding Hertfordshire in England[19].More often though, the papers offered broad descriptions of the original services prior to integration and the ways in which these had been connected, or in which closer collaboration had been encouraged, without being specific named models of service delivery or practice. Although these models varied considerably in their design, implementation, and intended outcomes, they contributed to our identification of a number of common factors which may be considered features or components of integration, such as shared governance, finance, infrastructure, goals, and organisational processes.

One paper included analysis of case studies from seven OECD (Organisation for Economic Co-operation and Development) countries and identified that there is no single model for integrated care. The authors here noted that integration evolves over time and should be built from both the top-down and the bottom up using a model already designed to improve care. They suggest that developing integrated care requires transparency in funding, data management systems, leadership and collaboration, roles and responsibilities, care planning and user involvement.[68] The focus of these models was largely on how the 'integrated model' might appear and function as it progressed towards, and achieved, the desired level of collaboration or integration. Another paper that reviewed service delivery models found that local authorities have to decide where they want to position themselves on a continuum of delivery models, and that this is informed by their "political context, budgetary priorities, and the strength of their voluntary and community services".[73]

What is meant by 'social care'?

It was also important for us to understand how the papers identified were using the term 'social care'. To understand this, we examined all the papers we reviewed for explicit and implicit definitions of social care as part of our data extraction process. We found a similar lack of clear articulations of 'social care' within the papers we reviewed as we did when we looked for articulations of 'integration'. Only one paper offered an explicit definition of 'social care', which focused on service types and purposes:

> *"Social care includes extensive service wholes promoting and maintaining the functional capacity, social wellbeing, safety, and inclusion of individuals, families and communities" ([43]Leväsluoto et al., 2017: 18)*

A large number of the papers did, however, provide information on services which were included and considered 'social care'. Again, while our search terms sought to identify papers which looked at integration in relation to social care, it is important to note that we did not explicitly search for those papers which provided definitions.

Across the review then, our understanding of authors' concepts of 'social care' is predominantly derived from the ways in which 'social care' is contrasted with other sectors and services. Most commonly, the distinction was made between social care, education, and/or health services; that is, social care was often named separately from health and education, implying that authors see these as distinct.

> *"Integrated care joins up primary mental and physical health care services with social care, so that services are organised and coordinated around the needs of the individual." ([30]Hetrick et al., 2017: S5)*

In the absence of clearly articulated and explicit definitions of social care, we identified a number of ways in which authors described projects and services, which demonstrated a range of perspectives on how social care is understood. These included:

Service types or job roles: The language used in the papers reviewed often referred to service types, such as prenatal care, youth services, housing services, or in relation to the job roles or professional qualifications of individuals working within these services, for example, a social worker or youth worker. Rarely was there any clear articulation of how authors understood these organisations and roles in context, for example, whether they consider these to be part of 'social care' or otherwise. Furthermore, there was a degree of overlap and ambiguity in how services and job roles were articulated both between and within the papers, which exacerbated the challenge of understanding how social care was conceptualised here. For example, it was unclear whether a nurse working in a youth welfare might be considered to be part of 'health' services or 'social care' services,[82] or the extent of the 'crossover' or shared meaning of 'social services' and 'social care'.[87]

Meeting the needs of groups or individuals: Services and programmes were sometimes described in the context of what would be required to meet the needs of an individual, family, or specific so-called 'client group', for example, women, refugees, or First Nations communities, or which groups the services were intended to benefit. This was often done in the absence of any explanation of whether these services were considered to be 'social care' or not. Relatedly, there were some implications of an inherently interdisciplinary nature of social care, that is, that a range of services must be involved in meeting the needs of children and families, which also reflected the challenges of isolating 'social care' from other domains.

> *"Child and family services are also an illustrative example of the dispersion of social care: there are multiple services requiring different expertise and professional practice, and part of these services are tightly linked to healthcare and schools." ([43]Leväsluoto et al., 2017: 18)*

Other, less common patterns of description: These included descriptions based on what the service offers, for example, screening/assessment; prevention work; named programme/ intervention/ type of therapy, or based on the physical location or setting of the service/where it is offered from or delivered, that is, schools; hospitals/health centres/clinics; in individuals' homes; youth or community centres; service-specific locations/the service's own premises.

The identification of definitions of social care within the papers we reviewed was also challenging due to the level at which the work that many of the papers described was conducted. Most of the papers we reviewed looked at relatively 'low level' integration, in that integration was focused on the service level rather than at a broader structural level. This meant that their focus was normally on describing or defining the services involved, with little need to discuss the specifics of what constituted 'social care' more broadly.

Summary

From the papers reviewed, there was no single shared or consistent definition of either the terms ‘integration’ or ‘social care’. Nevertheless, the reviewed papers contained a range of features and perspectives which can contribute to our understanding of how the authors conceptualised these. In relation to ‘integration’, we identified a number of components which were commonly used in descriptions of integrated services or structures, as well as the frequent allusion to integration as a spectrum or continuum.

‘Social care’ is broadly conceptualised as being distinct from health and from education services. Identifying the boundaries between ‘social care’ and other supports and services (including health, education, social work, child welfare, youth work, and a range of others identified in the papers we reviewed) is challenging.

The lack of shared definitions, and the variety of ways in which authors have conceptualised both integration and social care, may have implications for how we understand the extent to which these supports and services are working, or are perceived as working, in integrated ways.

What does the evidence tell us about the rationales for integration?

In this section we look at what the evidence in the papers we reviewed tells us about the rationales for integration. There was rarely a single reason given for integration. Some reasons that focused on the needs of children, young people and families were about improving their access to services and meeting their holistic needs to improve their quality of lives, while other reasons focused on organisational change to improve the design and delivery of services.

A total of 34 publications were relevant to the discussion of rationales for integration, of which three were grey literature and 31 were published in peer-reviewed academic journals. Of the 31 peer-reviewed papers, almost all discussed primary research, with the remaining either secondary reviews or systemic literature reviews. The papers were fairly evenly split geographically from the UK (seven), North America (11), Europe (eight) and Oceania (six), with one study across multiple sites and no details were given for another. Where the data was available on who took part in this research, health practitioners were involved in 16 studies, social work professionals in 11 studies, and education professionals in seven. The views of children and young people were only collected in two studies, as were the view of parents or carers. The studies predominantly employed qualitative or mixed methodologies, with seven of those studies undertaking surveys as part of data collection. The three grey literature documents were either literature reviews or used previously collected data for secondary analysis.

In general, the papers showed strengths in the integrity of the methods and analysis, but sample sizes were often small and self-selected, and the focus was usually on a discrete service or context. The extent to which the findings from these papers can be generalised is therefore limited. Furthermore, much of the data included in these papers focused on integrated services at local level, rather than the integration of structures and governance.

The rationales explored ranged from specific outcomes, usually around health, education, or experiences of services,[67,18] to broader statements on improving or promoting children's wellbeing in everyday life in all developmental contexts,[57] or to improving both practitioner and families' access to services.[82] The range of rationales we identified from the papers we reviewed are in many instances closely connected or inter-related to each other. One paper, for instance, noted that in the USA, "interagency and cross-system collaboration is mandated to improve child welfare outcomes" (p.226).[59] This implies that, while collaborative efforts may be initiated in response to federal policy, the overarching rationale for the policy itself is to improve child welfare services and outcomes.[59]

Improving access

The potential to improve access to services was a key rationale for integration within the papers we reviewed. Overall, the focus of effort was on providing equality and equity of access to services, particularly to children and families in need or at risk. Services were brought together to work across professional boundaries and to make decisions around action, to ascertain and reduce risk of harm to individuals, and to reduce opportunities for people needing support to 'slip through the net'.[71,24]

This was discussed in relation to clinical health services and social care in particular, and within local communities and for those living in rural areas.[41,86] Providing collaborative integrated care in friendly accessible environments, such as schools, was advocated in one study as essential for improving the health outcomes for young people.[21] This paper highlighted that young people often need access to and support from a range of services simultaneously, such as education, justice and health. This is particularly true for young people with a high level of needs, who may struggle to navigate services even when these are available to them.[21] Similarly, another study from Finland emphasised the importance of access alongside service continuity:

> *"In the intervention strategies, the improvement of access and continuity of services is an important goal. Integration across sectoral and organizational borders and collaboration between the service providers and users have been central means to achieve this goal" ([43]Leväsluoto et al., 2017: 18)*

Meeting needs and improving lives

Many of the papers reviewed focused on integration as a path to meeting the needs of particular groups, such as children and young people on 'the edge of care', or people struggling with their physical or mental health, addictions, or living with disability. Meeting the needs of people requiring the support of multiple services from health, social care, and other services, was often a rationale for integration. There was some indirect reference to the importance of integration for meeting a child's or young person's developmental, health and support needs.[60,1,24] One study implied that a lack of youth or adolescent mental health resources, and the need for multi-disciplinary approaches, had influenced decision-makers to increasingly favour collaborative care models to address the mental health needs of children and adolescents.[63] As well as the potential of integration to contribute to meeting the needs of specific groups, including those in need of multiple services, other rationales for integration included minimising professional duplication, and reducing costs.[81,78,74,33,22,50,11,24]

The potential for integrated services to improve the lives of families by meeting the needs of parents and carers, as well as children and young people, was also a rationale for integration, based on the belief that it is essential to work simultaneously with adults and children in the same family to achieve lasting positive outcomes for children.[7] In the studies reviewed, there were examples of bringing services together through co-location in one complex or centre. One project from the USA, for example, Raising Adolescent Families Together, was designed as a 'medical home' delivering comprehensive health and social support services to adolescent parents and their children, to provide optimum health care, promote a lower rate of subsequent pregnancies and to improve life skills and transition to independence in young adulthood and as new parents.[11]

In other studies, a number of rationales were given for integrating early intervention services: health improvement, cognitive and educational development, improving relationships and social outcomes for children and also parents – most usually the mother – developing parenting skills, and to address specific needs of parents such as substance misuse or economic adversity.[10,87,86,12] In another example, the rationale was to achieve positive educational and economic outcomes for children, young people, families and communities. The goal for services targeted towards low-income families was for parents to be on a pathway towards employment, while supporting their children to be able to succeed in their education.[7] Relatedly, three studies spoke about empowering children, young people and families with language around the empowerment of 'citizens' in the welfare context, and enabling individuals and families to take responsibility for their own health and wellbeing.[67,43] One paper spoke of strengthening parents' confidence and their ability to advocate for their children.[7]

A related theme which emerged from three studies was that collaborative programmes and services intended to strengthen the wider community, as well as help improve the wellbeing of families and children.[7,9,29]

> *"The Atlanta Civic Site's work in the community involves a diverse group of partners focused on achieving measurable success in three areas: educational achievement, family economic success, and neighborhood transformation." (7Chao et al., 2014: 2260)*

It is important to note too that one study included an indirect reference to improving the care and outcomes for young people with long-term health conditions transitioning between child and adult services as a rationale for effective integrated commissioning arrangements.[46]

Service improvement

Service improvement was another rationale given for integration, based on the premise that if services shared common goals, were more co-ordinated and increased their collaboration, then this would make a positive difference to the lives of children, young people and families by reducing fragmentation and delay in providing the services and support needed. This reasoning was often in response to issues such as high numbers of re-referrals to services; duplication in key processes within and across different agencies; and an insufficient focus on the journey and experience of the young person or parent through an intervention.[18]

Four studies discussed the need to overcome the fragmentation of services and lack of common goals, which were said to be major obstacles for integrated approaches in health, social, and educational services.[57] In one example, differences in mission between education and social care, as well as differences in power structures, roles and culture between health and social care, created challenges in finding common goals.[43] Two studies identified a need to establish common goals through dialogue, which was said to often lead to a clearer demarcation of roles, better management practices, stronger commitment and greater trust among the organisations involved.[13,76]

Increased co-ordination and collaboration were also viewed as desirable components to underpin service improvement. The Gloucestershire Social Care Innovation Project in England, for example, intended to bring about a change in services for children and young people aged 10 to 25 in need of support and their families, through wholesale local systems reform. The project included a programme of workforce development, underpinned by a unified theory of adolescent risk and resilience, to determine the most suitable organisational and commissioning model. Improved co-ordination of service delivery was thought necessary to increase access to services and improve the lives of children, young people and their families.

Greater co-ordination of services aimed to address issues of system complexity, fragmented and unequal service delivery, and lack of co-ordination and communication between services and levels of government. It was suggested that improved co-ordination enabled frontline workers to address complex issues that many families face including alcohol or drug misuse, domestic abuse and problems with their mental health. Improved multi-agency working and improved co-ordination was thought to offer families a more timely and holistic service which balanced child safety concerns while maintaining trust between parents and the workers. The co-location of services was often identified as one mechanism to achieving this.[66,74,62,41,24,21]

In one approach developed by Educare Atlanta in the USA, the aim of Healthy Beginnings was to integrate early childhood education and health services to enable families to access immunisations, developmental screenings, follow-up care, frequent check-ups and assessments where indicated. Families would receive health education and partners would work together to develop a system of care that supports high-quality preventative health care for all children enrolled on the programme.[7]

Closely related to this was increased collaboration. One study strongly advocated that a team-based approach involving multiple services, rather than single practitioner, would deliver more effective community interventions for families with multiple and complex difficulties.[74,64] In other studies, there was an implication that there should be better collaborative working as a means of ensuring that children's needs are met.[78,35]

Costs

None of the studies reviewed reported that reducing costs was the primary reason for integration of services. Instead, reducing costs was cited as one of several reasons, and within the papers we reviewed there were suggestions that the primary reasons for change such as integration and collaboration would promote efficiency and effectiveness, and consequently result in cost savings.[43,81,82,86]

> *"In addition, integration of care is likely to result in considerable cost savings due, for example, to avoiding unnecessary and overlapping care." (Tuominen et al., 2019: 124)*

To what extent are these rationales based on evidence?

The evidence base referenced on the rationales for integration was not strong. Previous literature reviews included as part of this review have noted the broad range of evidence-based interventions aimed at particular population groups such as families on the 'edge of care' and people living with disability, but these tended to focus on programmes and therapeutic treatments designed around specific needs. In the papers we reviewed, there is an absence of evidence-based service-level models for a broad range of difficulties that families and parents can face.[10,50,30,63]

In terms of service delivery, one National Institute for Health and Clinical Excellence (NICE) guidelines of services delivered to disabled children and young people in England assessed that there was qualitative evidence of moderate quality for more co-ordinated support, consistency of service delivery, clearer processes and multi-agency processes.[56] Service providers valued the different skill sets and knowledge of other practitioners in other services and opportunities to learn from each other and build expertise. A more consistent approach across services made the pathways clearer for families to get the support they needed and made services more predictable for children and young people when receiving support from a new service.

While there was qualitative evidence of moderate quality on the experience of practitioners from different services working together, there was only very low-quality quantitative evidence that children and young people benefit from services working together in terms of their inclusion or participation in services and their educational achievement. Despite this, the NICE review concluded that working together in a co-ordinated way across education, health and social care services would improve care and support for children and young people.

We also found a lack of longitudinal data on how integrated structures or services continued to evolve and impact on outcomes for children and their families and whether the integrated structures or services proved to be cost-effective. The challenge of providing longitudinal evidence is demonstrated in one study, where an approach implemented in France in 1982 had an evaluation of its operations in the 2000s[62] which identified that due to economic pressure the original integrated mission had changed:

> *"Little by little, with the continuous rise in unemployment among the young people concerned, the public authorities ordered the MLs to concentrate essentially on access to jobs and training. Originally, at certain MLs, there were social and preventive medicine consultations whose objectives were to promote health, the use of appropriate care, and social integration." ([62]Robert et al., 2019: 2)*

Summary

The rationales for establishing or promoting integration of services, identified in the reviewed papers, are interconnected, and largely based on a view that integration will in some way lead to improvements for the various groups of people requiring the support of public services such as social care. Integration is intended to improve access to these services, primarily through shared physical locations (co-location), as well as through better communication and collaboration between traditionally separate services.

As well as the general service improvements presumed and hoped to result from integration, greater connection between services is considered to lead to better access and engagement in multiple services for individuals whose more complex needs require this support. This can include families who are intended to benefit from, for example, education and employment supports as a foundation for broader improvement in their family’s circumstances. While cost was not reported as a primary driver for integration in any of the reviewed studies, the improved service efficiency expected to result from integration was assumed by those driving integration to lead to reduced costs.

There is a notable absence of information which might have improved our understanding of the rationales given for integration throughout the papers we reviewed. Few studies, for example, explicitly reported whether the initial reasons for integrating services had led to the anticipated improvements. Little attention was given in the papers we reviewed to the quality of the separate services before these were integrated, raising the question of how the integration of inadequate services might be assumed to improve services overall.

While rationales largely focused on service improvements to best meet the needs of children, young people and their families, there was little to suggest that these original intentions had been met. There was little evidence of clear links between initial rationales, implementation, and outcomes, to demonstrate that service integration achieved what was intended, and no paper clearly followed initial rationales through to changes in outcomes.

What does the evidence tell us about the process of integration?

In this section we look at what the existing evidence tells us about the process of integration – how integration is achieved, and what the barriers and enablers are to achieving integration of services.

A total of 66 papers were relevant to the discussion of the process of integration, and what challenges and facilitates integrated working. Eight of these papers were grey literature and 58 were peer-reviewed papers. Almost all the peer-reviewed papers discussed primary research, with eight being secondary reviews or systematic reviews. The studies were predominately qualitative or used mixed methods, with six using solely quantitative methods. The peer-reviewed studies were mainly conducted in North America (22 studies), Oceania (eleven studies), Europe (nine studies), UK (eight studies), Scotland (two studies), and six were across multiple countries. In the grey literature, we identified five publications based on primary research, one secondary review, one systematic review, and one publication categorised as 'other'. These were all qualitative or mixed methods studies. The geographical location of the publications included three in the UK, one in Oceania, and four spanning multiple countries.

The papers encompassed a range of strengths relating to the methodological rigour and analysis, drawing data from diverse data sources, with variation in the richness of the data and response rates reported. Many of the studies referred to a small sample size, or concerns around the lack of longitudinal data, self-selection of participants, the absence of 'client perspectives' or the attrition rate of participants as potential weaknesses.

Similarly, several studies commented that their focus on a particular population group, service or sector, limited the capacity of that study to draw conclusions about the integration of these services or sectors, or the experiences of different populations of the integration of these services.

An advantage of the qualitative studies included in this review was the rich data that was gathered regarding the process of integration for different people, services and implementation programmes. There was also helpful learning about what was useful or necessary for an implementation programme to be successful in practice. However, it should be noted that qualitative studies are not designed to investigate whether integration is the direct cause of change and generalising the findings from these often small-scale studies to other populations, services and programmes should be treated with caution.

How is integration achieved?

Service structures

The focus on how integration was achieved was primarily located within local provision and services, with far less focus given to how integration was achieved at a wider systemic and structural level.

The ways in which integration is structured can be placed on a continuum ('What is meant by 'integration'' section). In one study, a finding was that in determining where they wish to fall on this continuum, local authorities were informed by three factors: "political context, budgetary priorities, and the strength of their voluntary and community services" (p.10). [73]

In Scobie *et al.* (2022), one of the primary messages stemming from their rapid scoping review of national systems of integrated health and social care in Nordic and Scandinavian countries (including Sweden, Denmark, Norway and Finland), was that no one 'model' of national health and social care existed, rather, there was evidence of how integration of services had been approached both locally and nationally.[68] The authors found that integration of services was not an event, but a process that evolved over time, requiring transparent funding arrangements, regulation and monitoring, clarity around roles and responsibilities, and participation from people needing the support of services.[68]

Ensuring that the necessary practitioners are included within any integration process or model was a feature of collaborative working. Within some services, the identification of a 'lead' agency was viewed as central to the co-ordination of service delivery.[74] Yet, to deliver a holistic response to the individual needs of people requiring support it was recognised that the expertise of a multi-agency team was required.[15,81,74,8,9]

Continuity of care and sustainable relationships were also a consideration of who needed to be involved in providing and benefitting from integrated care. Community partners were regarded as being well-placed to provide this continuity and relational role, whilst enabling the connectivity of a range of services.[10,9] An example of an individual 'care co-ordinator' was given within the 'Healthy Beginnings' model in Atlanta, USA where a "health navigator" is used to support parents to be able to interact with health professionals, schedule appointments, advocate for their child, and connect with additional services to meet their wider needs.[7] In another example from the UK, the Adolescent Multi-Agency Specialist Service (AMASS), an edge of care service based within Islington Children's Services in London, draws on the Reclaiming Social Work model (Ferguson, 2007). The authors identified the importance of involving education and youth work professionals alongside colleagues in health and social care to provide additional expertise for supporting families.[74] Whilst several different professional agencies and groups are named across the papers we reviewed, the emphasis is on ensuring that the appropriate skills and expertise, rather job roles or agencies, are represented within the integration model to meet the holistic needs of those utilising services.

Commissioning and policy

Five papers referred to the commissioning practices undertaken in relation to how integration might be achieved.[56,68,83,9,33] Commissioning practices were seen as a means through which to encourage and foster more collaborative and integrated working between agencies.[56] Further to this, commissioning processes were viewed as providing a mechanism through which the efforts of integrated models of practice could be directed towards where their impact would be most cost effective. One review of models of integration concluded that one aspect of learning from different integration approaches adopted in Europe was that long-term investment accompanied by ongoing evaluation of practices was needed.[68]

However, fragmented funding was a barrier to the development and sustainability of integrated models.[68] Other studies acknowledged that fragmented funding arrangements require additional resource to ensure that services can remain co-ordinated and can continue to meet the needs of children and families.[9,68,33]

One paper identified a need for policies and protocols from different levels of the system to support the co-ordination of services,[56] while another recommended formalising agreements to new approaches to working.[45] However, a study in Canada which explored the experiences of child protection working in collaborating with mental health workers, emphasised the challenges of developing and implementing these shared protocols in practice. Issues highlighted included identifying which service had responsibility for delivering the intervention and providing the necessary resources, and the management of data protection between the services.[48] Alignment with the legislative framework and governance of agencies was noted by two studies as being essential to the effective and sustained integration of practices,[12,40] indicating that clarity about the role for governance and legislation in supporting integration models is needed. Two examples of this were evidenced within the papers reviewed: firstly in the use of the Children Act (2004) in England in requiring professionals to work together as part of the development of children's services,[52] and secondly, in the introduction of new legislation in 2016 in France to overcome challenges to the accessibility of care by requiring regional hospital groups to collaborate with regional providers to improve access to services.[41]

Data and progress

A small number of the papers acknowledged that integration models required a 'testing' and improvement period to develop new ways of working and relationships between agencies and professionals.[18,81,67] Flexibility was required for integrated practices to adapt and respond to emerging and changing needs, and allowing for an initial phase of testing allows for this flexibility and a culture of continuous improvement to be integrated into the model from the beginning.[18] Providing opportunities for practitioners and people needing the support of services to input into and reflect on the integration model through conversation and designated workshops was noted as one approach to facilitating the development of integrated working.[67,81] Ensuring that there is engagement from all necessary partner agencies during the testing phase was highlighted as both essential to the robustness of the model and challenging to facilitate.[18]

Multiple papers highlighted the importance of data management infrastructure as part of service integration. Four papers discuss the need for a shared data infrastructure as part of an enabling context for integration and fostering collaboration, improved co-ordination, and consensus around information sharing.[70,18,68,45] One paper highlighted that approaches for monitoring integration efforts are less well defined.[18] That study noted that one of the challenges of implementing new practice models is the need for flexible data monitoring systems which can evolve to reflect the service model and its intended outcomes as the service develops.[18] Further to this, the role of data for evaluating the impact of integration efforts was also noted as contributing to how integration practices and their impact are understood and sustained.[12,73,70]

Leadership and vision

An important component of the infrastructure required for supporting integration was committed leadership at multiple levels, particularly when challenges with integration arise. Systems leadership which provides consistent messaging[33] and solutions to systemic issues,[33] with leaders who were committed to the duration of the change process,[33] and who helped to guide the integration process,[13] were all noted. Three publications spoke to the need for leadership where there was poor collaboration between services.[68,33,53]

Having a shared vision across services was a consistent theme across many of the papers reviewed. Several highlighted a need for all services involved in an integrated initiative to have a commitment to integrated practices within a shared vision for services.[68,45,23] Through this shared vision, services were seen to be working towards the same objectives for people needing support, which contributed to collaboration and a shared identity.[69,45,67,4,64] One study suggested that having a common goal provided clarity around roles, improved management practices, and greater commitment and trust between organisations.[8] Another study emphasised that shared goals and direction of travel was particularly important when challenges arise, enabling the focus to be on providing high quality services.[12] This illustrates what another paper highlighted as the interplay between values and vision, whereby organisational values (identified as "client-centeredness, empowerment, non-judgment and holistic care"; Meixner *et al.,* p.62) can be a uniting foundation from which to build and move towards a shared purpose.[51] Conversely, differing organisational values and goals were identified as a potential threat to integrated working and consequently the responses to the needs of people requiring the support of services.[54]

Collaboration and trust

Alongside a shared vision, the papers we reviewed also identified the need for infrastructure to support and sustain collaboration and alignment between services. Factors identified as facilitating collaborative working included: appropriate professional representation;[14] interagency meetings;[54] allocated funding;[58] key contacts;[54] clarity of roles;,[45] and shared policies and procedures.[54] Two of the papers reviewed identified collaboration between services as being integral to integrated working regardless of the specific model of integration used,[44,30] and an "authorising environment" was described as key to ensuing that collaborative working was supported through the organisational culture.[45] Such collaboration between operations required attention and effort,[12] however when achieved the authors argued that this has the potential over time to establish a new distinct culture shared across organisations[52] and through this process culture and knowledge become interconnected reinforcing a new culture and knowledge.[52,50]

Trust was a recurring theme, noted as both a required feature of integration and collaborative processes as well as a product of it, across and between different levels within organisations and systems.[68,54,70,42,71] However, the relational aspect of trust meant that where there was a lack of trust or damaged trust, this could become a barrier to inter-agency working and service integration.[68,71] Building trust between professionals and organisations was noted as an integral component of integration processes and practices. Approaches to fostering trust included: in person inter-agency meetings, clarity of roles and responsibilities; relationship building; time to build relationships and trust and collaboration.[54,42,70] Where trust between professionals exists, this was noted as a mitigating feature against conflict or issues arising from integrated working.[54,50,70]

Strategies to foster good communication as a feature of collaboration included: co-location; continuity of staff; an emphasis on person-centred care; and a focus on information sharing practices.[68,6,24] Information sharing improved where multi-agency teams consulted regularly, and families reported that they experienced more 'consistent messaging' across services. This co-ordination of communication with people needing the support of services was a feature of some integration strategies.[6,68] A need for strong people skills and the development of these is identified as key to good communication and collaboration,[68] alongside information sharing processes which facilitate collaborative practices between professionals and with families.[24,13]

There was a consensus across the papers we reviewed that integrated working required greater co-ordination between different stakeholders. Different approaches to co-ordinating integrating working included the use of designated co-ordination roles,[7,38,87,9,54] service 'champions',[82,66] identified 'lead organisations',[9] and a multi-agency management and decision-making group.[43,74] Service co-ordination was considered an enabling feature of effective and timely responses to people with complex needs who require support from multiple services.[82,9] Co-ordination, both in the integrated model and with partners external to any model, was discussed, particularly in relation to the interaction with community stakeholders, whose relationship and understanding of local communities was seen as a key factor in sustaining some models of integration.[82,7,9,68] One study did caution that the over-reliance on a single agency or individual to co-ordinate and champion the integrated model of working was a risk to sustainability, particularly if key individuals move on from their role.[74] Two studies advocated for shared ownership of the integration model to prevent ownership of this becoming political and owned by part of a wider service.[66,54] Better links between services were cited as an outcome of integrated services,[16,54] and in some cases the integrated service would act as the 'broker' to other services outside their own organisation.[83] Therefore co-ordination was seen as sitting in conjunction with ensuring that there is collective buy-in to the integration model and that the agencies view themselves as part of one team.

Supporting staff through continuing professional development

The importance of attending to the professional development needs of staff alongside the more process-oriented aspects of integrating services was highlighted within the papers reviewed for this study. Three papers discussed the need to build workers' confidence to manage the complexity and risk associated with meeting the holistic needs of families.[18,74,25] Two of the studies highlighted that differing approaches to assessing and managing risk led to discomfort for professionals whilst also ensuring that child protection assessments and plans were adhered to.[18,50]

The inclusion of continuous training and development for staff as part of an integration strategy was recognised as a feature of existing international models of integrated working.[52,68,67] An examination of social care within Denmark identified workforce development as an important feature contributing to the success of the integrated offer, emphasising the importance of considering the ongoing needs of the workforce.[68]

Enhancing professionals' knowledge and understanding of other professionals' roles and responsibilities, as well as a more holistic understanding of the needs of children, young people and their families, was a feature of integration approaches.[52,1,56] In one example from Kentucky, USA, 'family mentors' who had lived experience of substance misuse and recovery were part of the approach taken to support the learning and development of staff, enhancing professionals' understanding of the lives and needs of people requiring support and the processes that they engage with, and was viewed as positively enhancing the collaborative culture and practices.[33]

What challenges integrated working?

Workloads

Across the studies we reviewed, reference was repeatedly made not only to the additional resources that multi-agency working required but also the additional time added to professionals' workloads in order to collaborate with other professionals. This additional time was sometimes thought by the papers' authors to be an overlooked aspect of integration, which when not planned for nor properly resourced had the potential to become a barrier to integration.[18,43,50] Some of the facilitators of integrated working and collaboration, such as group supervision and multi-agency decision-making, also placed additional time burdens on professionals.[2,6] Workloads and time pressures could also be a barrier to services enacting their role in brokering access to wider service provision. For example, one paper highlighted that whilst the integration model had intended for agencies to operate as "funnel organisations" to facilitate easier access to services, pressures on some professionals' time meant this was not feasible in practice.[82] In another, it was highlighted that contact with people who needed the support of services was prioritised over multi-agency planning and decision-making. Whilst this may be perceived as positive on the one hand, the lack of time and opportunity to develop collaborative practice could ultimately impact on the quality of services and support received by children, young people and families[35]

The complexity of cases requiring multi-agency input can also mean a greater number of agencies working across systems who are also required to input into management and care planning, meaning that co-ordination of professionals could become more time consuming.[2] Other papers also suggest that navigating differing work cultures and processes such as working hours or methods of communication could be a barrier to co-ordination,[29,48] whilst additional meetings to facilitate co-ordination was also noted as slowing down the response to needs.[29] Challenges around timeliness of responses appeared to be a particular concern relating to safeguarding requirements and processes; that the timeframes to enact this were being given insufficient attention within the context of integration.[41] One study noted that where the demand for multi-agency responses to complex needs outstripped capacity, this in turn impacted on the time to take decisions and allocate resources.[71] Further to this, the authors of one paper argued that the co-ordination and interaction between different professionals was often unaccounted for within proposals and funding for integrated practices and as such this was often hidden labour within integrated working.[21] As such, the scalability of integrated practices without additional resourcing was pulled into question,[50,18] and this impacted on capacity for future planning,[48] as well as staff wellbeing.[48,43]

Integrated models of practice were generally considered to be resource intensive, and a scarcity of resources was seen as a possible barrier to integration. Tension between the capacity of services and the demand for services was a recurring theme across many of the studies[71,68,6,83,55,70,55]

Staff turnover, burnout and absenteeism also contributed barriers to the implementation and sustainability of integrated models. Challenges with recruitment and retention[19,70] had implications for the mix and range of professional expertise within multidisciplinary service models,[14] as well as the relationships, collaboration,[54,23] and trust between professionals.[71]

'Transformation fatigue' (Toma *et al.,* 2022) stemming from continuous improvement initiatives was highlighted by professionals within one study.[79] The implications of introducing new ways of working for professional wellbeing within unpredictable fiscal and political contexts was viewed as requiring careful consideration to ensure that professionals had confidence in the new ways of working, and that this did not lead to retention issues.[18]

Consequently, to ensure that new models of working do not negatively impact on staff retention, the evidence suggests there is a need to consider the wider context within which changes are introduced and how change is communicated within this context.[18] This consideration does not just sit with front line practitioners; turnover at management level was also noted as negatively impacting new ways of working and the ways in which front line professionals are supported with this.[13] There is a need for the prioritisation of staff wellbeing within integrated models of working, particularly where professionals are managing high levels of risk and complexity, to build a sustainable workforce.[10]

Roles and responsibilities

Understanding and interpretation of other professionals' roles and responsibilities, and the boundaries of these, was a recurring theme in the papers we reviewed.[77,48,78,35] Similarly, the understanding of the challenges faced by professionals in other service areas,[77] the differences in their working environment,[60] the resources available to them,[55] and the policy and legislative contexts in which they operate[78], were all cited as limiting the opportunities for shared understandings. Misunderstandings were considered to be damaging to trust, especially in the context of risk assessments.[60,10] Differences in hierarchies both within and between agencies was also identified as being a barrier to collaboration, especially were there were different interpretations of roles and responsibilities by individuals in more senior positions.[71]

There was recognition that there was a need to retain relationships with services which sit outside the integrated provision,[85,83,54] with an example being the importance of maintaining relationships with education services alongside health and social care services.[24] A lack of collaboration across service areas, including statutory and community services, coupled with differing views on the scope of practice, could lead to conflict between professionals.[10]

A number of studies highlighted a range of benefits and challenges in relation to multi-agency working. One example from Tampere, Finland, described an inter-professional service network of health and social care services provided through public, private and non-governmental organisations with different perspectives and various formal and informal partnerships. The authors acknowledged that the network was still in the early stages of being embedded but was experiencing some challenges. Services remained fragmented and there was a lack of clarity about which professionals would communicate with people needing the support of services with the result that multiple professionals continued to be involved in their lives and those using services often had to navigate a complex network of service provision.[82]

In another example, whilst a single integrated referral route was the objective, variability in referral routes and thresholds meant that this was not achieved in practice.[71] Where people's needs did not meet the criteria for a particular service, a lack of co-ordination and clarity on who was responsible for meeting their needs could result in them being excluded from services altogether.[82] The experience of parents in study in Quebec, Canada, demonstrated this: where there was no clear allocation for who was responsible for helping their child, they were passed between services, and parents had to advocate for access to services.[76] The authors of another paper argued that multi-agency working was not designed to facilitate continuity of support but rather the knowledge and competency of differing professionals, and that doing so resulted in children being expected to work with multiple professionals and adapt to their practices.[41] Additionally, where services are seeking to support multiple needs (for example, where both the needs of parents and the needs of their child identified and may be different, and these fall under the remit of different services), this can be challenging and restrict which services they are provided with,[51] and who is seen to have the "primary" or priority needs for the services to work with.[50] Where people who need support are engaged with multiple services, the co-ordination of this can often happen too late and, as a result, professionals informally finding out about other service involvement.[82]

A small number of papers talked about specific barriers around transitions between services for children. The authors of one paper which explored the mental health care of children and young people in England during the COVID-19 pandemic challenged the presumption that collaboration resulted in more planned transitions between children's and adults' services.[6] A range of explanations for why this may be were given, including availability of appropriate services to refer on to, a lack information sharing and a lack of a holistic understanding of the child and their needs.[6] Similarly, variability in age restrictions for services, understanding of differing eligibility criteria between adult and child services, alongside a lack understanding of differences in the availability and intensity of adult and child services were barriers to good transition planning.[46] These issues also contributed to challenges around the commissioning of integrated services during transitions.[46]

Leadership and finance

Leadership was raised in relation to possible challenges as this had the capacity to create barriers to integration. In one paper examining CAMHS (Child and Adolescent Mental Health) services in Scotland, the authors discussed how a lack of clarity and specificity of policy recommendations within the policy context and from government resulted in uncertainty and variability at the local level in terms of how conflicting policy agendas could, or should, be integrated into front-line services.[79] Here, vague political rhetoric and recommendations for practice made the translation of a national agenda into change in systems and practices on the ground locally challenging.[79] Another study's findings echoed this by suggesting greater collaboration at the macro systems level through providing leadership on the clarity of guidance and agreement relating to policy agendas was needed.[25] A lack of adequate people and financial resourcing to fulfil policy requirements was noted as a barrier to their implementation locally.[13,41] The need for committed leadership from national governmental and strategic leaders from all services involved to drive change was also recognised as being vital to support the co-ordination and transfer of resources and responsibilities during the transition to new system structures.[55,13]

Considering leadership at a service level within a system, one paper identified concerns among frontline practitioners that their feedback is not always heard and acted upon by managers.[18] Similarly, a lack of understanding of partner organisations' services and practices were seen as leading to tension at management levels.[55]

There was acknowledgement of the interconnection between funding and service availability. In a systematic review which focused on cross-sector collaboration for First Nations children with disabilities in Australia, the authors noted that changing priorities and budgets within national government added work for services who had to adapt services in response to changes, which had implications for the services that they could provide. Funding cycles required time and resources to adapt, implement and sustain services to meet with funding requirements.[25] Additionally, studies showed that the influence of changing policy agendas on funding arrangements can create competition between providers, particularly where there isn't sufficient funding to realise the policy agenda, which in turn can be damaging to collaboration between stakeholders.[24] One paper noted that there was a lack of guidance related to interdisciplinary funding arrangements, and specifically guidance on funding arrangements for transitions between health and social care.[46]

Limited funding also had implications for retention of role and skill diversity within the relevant service workforces,[66] as well as the type of services which are funded.[12] In one paper, the authors highlighted the implications of reduced funding on the availability of intensive family support services in Quebec, Canada.[13] It was also observed that where service funding has become tied to programme evaluation work, this has created dependency between this relationship and future service development work.[12]As such when policy makers set out a programme for government, where evaluation data is seen as an integral part of funding arrangements, the decision about future funding or defunding of services is dependent on the evidence considered.[12]

Culture and beliefs

Our review identified that in the studies considered, in order for collaboration to succeed, organisations had to foster a culture centred on a common ground, regardless of any differences in existing cultures. This common ground could be easily disrupted by differences in cultures,[54,24,52] professional boundaries,[68,82] leadership and service structures,[55,43,79] and perceptions and responses to risk.[40,2,50,41,71,10] Trust was viewed as a key aspect in building collaborative ways of working, therefore, professionals' beliefs about other professional groups' roles, their understanding of practices and their trustworthiness, could equally become a barrier to collaboration.[60,35,83,24]

Professionals' own beliefs and resistance to new ways of working and service models was also noted. In one example from Finland, professionals articulated that they did not think the new ways of working would be sustained following the initial pilot.[43] In another example which focused on child health in Canada, whilst professionals identified a need for greater multi-disciplinary working, concerns about what this would mean for their job role as individuals were also present,[18] as well as a sense of competition between services,[12] and between the responsibilities to both child and adult needs.[66] Whilst resistance and anxieties about new collaborative and integrated models of practice were not explicitly identified as barriers to integration within a local integration programme for child health in Liverpool, England, these require attention to ensure that they do not evolve into barriers.[36]

Families own beliefs about services was also a challenge to service delivery, particularly where families have prior experiences of engaging with some of the services now placed within the integrated model.[74] Where families were already engaged with services, the introduction of new ways of working, particularly in contexts where there are high levels of risk, could become a barriers to practitioners implementing the new practices.[2]

It was also shown that there is a need for services to be culturally competent and reflect the communities they are supporting and working alongside in order to build a strong foundation for meeting the needs of children, young people and families.[25,24]

Information sharing

Information sharing was viewed across the papers reviewed as a potentially significant and complex barrier to integrated working. Whilst improved communication was seen as a positive benefit of collaborative working, this also creates challenges and concerns around information sharing.[60] Studies raised a need for national legislation, policy and guidance to take account of information sharing and the systems that support this.[8,86,24]

Where a lack of information sharing was a barrier for professionals working within multi-agency contexts this negatively impacted on the ability of professionals to tailor services to the needs of people needing their support.[41,6] A lack of information sharing was also a barrier for professionals who were external to the core service and working between services with different processes and requirements.[54] Additionally, in a study exploring practitioner perspectives of Multi-Agency Safeguarding Hubs (MASH) in England, where data was shared using databases, this was a barrier to tracking interventions and progress over time.[71] In one example from this study, the absence of a formalised information sharing agreement led to uncertainty amongst professionals about what information could and could not be shared, which resulted in inconsistent information sharing, and impacted on multi-agency decision making.[71] Examples of strategies adopted by practitioners to enable effective information sharing and collaborative working whilst maintaining confidentiality requirements included: the planned and facilitated introduction of people needing support with new practitioners; seeking consent to share contact information; and joint visits.[35]

The use of technology to support information sharing was seen to come with additional barriers to integration. Multiple studies indicated that practitioners were resistant to the introduction of new technology, and identified challenges around readiness to, skill and confidence to adopt new technology.[43,19] Technical issues within new systems added additional work for practitioners,[19,43] as well as a lack of co-ordination, resulting in some professionals having to duplicate information across different systems.[2]

Evaluation of integration

The evaluation of integrated services and practices was a recurring theme within the papers reviewed. The need for evaluation work and data collection to be in place at the outset of new services was raised. A lack of data, particularly performance indicators, made it challenging to measure the impact and changes resulting from new, integrated, initiatives.[18] One study attributed a lack of quality assurance and outcomes data as contributing factors to what was described as 'unacceptable levels of risk' within a new and developing service.[14]

The development of indicators and mechanisms for collecting and monitoring data required buy-in from management. In one paper, the authors reported that despite requests for greater infrastructure to support the recording and monitoring of data, an "informal status quo" (Moisan *et al.,* 2021, p.6) inhibited this from being realised.[53] Conversely, participants in another study indicated that the emphasis on evidence-based services placed too much emphasis on data, which was burdensome and detracted from practice.[9]

The importance of both process and outcome measures was highlighted,[68] as was the need to capture the quality of practice beyond what can be interpreted through quantitative data.[55] Government-mandated targets were perceived by participants in one study as narrowing the focus to the immediate outcomes of services and the behaviours needed to meet these, as opposed to wider, long-term, systemic needs.[79] Divergent mandatory reporting requirements across agencies was seen to add additional barriers to integrated working and the development of long-term shared objectives, philosophies of practice and priorities.[54] The need to strengthen national data and the interaction of different data sets was a recommendation of one paper, which specifically identified the need to strengthen the interaction between education and health data.[86]

What facilitates integrated working?

In this section we look at the facilitators of integration discussed within the papers reviewed. These include themes relating to the frequency of contact between professionals; the role of integration 'champions'; communication; an enabling practice culture; and cultural competencies. We are only able to consider the facilitators that were presented. It is possible the there are other facilitators, but these were not observed as part of the examples studied, and it is important not to make the assumption that the converse of a barrier is necessarily a facilitator. For example, where a lack of resources was seen as a barrier, we are unable to know in that example whether increased access to resources would have been a facilitator.

Frequency of professional contact

One paper highlighted that in order to achieve collaborative working, services need to have adequate resources as a basis from which to build, including "time, funding, leadership, education" (Urbanoski *et al.,* 2018, p.11).[83] Further to this, the nature and context of interactions between services and people needing the support of these services were identified as being positive facilitators of integrated working and improved outcomes. One study explored the Well Baby Program in South Carolina, USA, which aimed to enhance child safety and wellbeing in low-resource families. The study found that the addition of home visits, alongside "Group Well Visits" from paediatricians, which focused on prevention and early identification of problems, allowed for an increased frequency in engagement between the professionals providing the service and those needing that support. [65] This was described as facilitating a more holistic approach to addressing both the health and social needs of the children.[65] A study of a home medical model for adolescent parents and their children also found that the flexibility, frequency and ability for parents to be able to engage in a range of health and social care services through a single, integrated model of care, led to greater and more sustained engagement with services.[11] Increased capacity and time to spend with families was important to professionals and families in order to build their relationships and communication with one another.[19]

Communication

Studies also showed that having routine opportunities for communication between services was viewed as a key facilitator for integrated working by professionals,[55] as were formalised processes to support regular communication,[55] connection between a range of services,[83] and the opportunity for practitioners to learn from one another and exchange knowledge.[55,45] Digital platforms or tools which were not sufficiently developed were widely considered as contributing to potential barriers to collaboration. For example, not all workplaces may operate with the required digital equipment or software and there can be concerns about new technology including fears about the losing information. Where these platforms or tools were effective, the benefits of improved information sharing between services facilitated better working with children and their families.[43]

Where there was clarity of roles, responsibilities and processes, this was seen as a facilitator of collaborative working and integration. Having clear decision-making processes, clear care pathways for people needing support, clear roles for the professional involved, and shared visions within and across services were all viewed as factors that contributed to - or had the potential to - contribute to facilitating and improving integrated ways of working.[48,53,55] Improved and clear communication between professionals at different levels was found to lead to greater trust, satisfaction and, in turn, collaboration between them.[53] One paper identified a concept of an ‘Authorising Environment’, described as ‘establishing a culture that encourages and enables working together’, achieved by processes such as: appointing a liaison between agencies; ensuring that the agency and staff roles are clear; and using shared or agreed procedures and tools.[45] The need for clarity in roles was identified in many other papers.[77,14,78,26]

Co-location was identified as an approach used to try and reduce service fragmentation, support continuity of relationships and to help facilitate information sharing.[68] Professionals were reported as valuing co-location as a supportive way of facilitating collaboration and integration,[35,46,55,38,58] and facilitation of ‘warm referrals' for families when supporting them to engage with new services.[35] In one example, a co-location model of service for youth mental health was positively associated by professionals with perceptions of interprofessional collaboration. Professionals were described as having greater professional authority (that is, having influence on group processes), while at the team level, co-location was associated with a perception by professionals of improved communication, and at the organisational level with a more positive perception of organisational culture.[63]

Having a champion for integrated services

Several papers referred to a version of a 'champion' within services that supported the development of integrated working. Having a nominated individual representing a service or integrated model was described as contributing to an 'authorising environment'.[45] Having a key contact person, or 'linking role' within partner organisations was viewed by the professionals in a range of studies as facilitating engagement,[12] building a shared vision,[24] trust and respect,[87] supporting an understanding of the service landscape,[24] and identifying and overcoming service differences,[54,24] leading to better outcomes for children and their families. However, one area in which 'champions' were less facilitative of integrated working was in relation to building buy-in for the use of new digital processes.[19]

Whilst having programme 'champions' was considered by some professionals as critical to integration efforts, it was important these 'champions' were fully integrated across the infrastructure to ensure that integration happened outside of the existing infrastructure and relationships.[66] The relational skills of 'champions' and the stability of their role were important components of the perceived effectiveness of these roles.[70]

'Funnel organisations' were an alternative approach identified in a small number of studies. It was the role of a 'funnel organisation' to facilitate for people needing support and easier access into services.[82,9] For example, schools were often suggested as a 'funnel organisation' for young people. Schools are thought to be non-stigmatising and can bring services into the school for a young person enabling better co-ordination of services as well as providing an easier and less intimidating pathway for services to access support and information. This was distinct from models where a 'Facilitating Partner' was appointed to manage and co-ordinate programme delivery and information sharing in collaboration with a range of community partners. The partner allocates or 'funnels' grant funding to the community partners to deliver their programmes.[9]

A holistic approach to working with families

Adopting a culture that considers the holistic needs of a child and their family was consistently referred to by the authors of the studies as being integral to developing the common goals for collaboration. In fact, integrated working was viewed as being in keeping with the professional values of working holistically with families,[19,51,21,9] and, as a result, adopting a holistic approach to working with families was considered more likely within integrated practice models.[83]

In a recent study from the Care Quality Commission in Scotland which reviewed the mental health support of children and young people during the COVID-19 pandemic, the authors highlighted that siloed-working was viewed as being inhibitive to providing holistic care to children and young people.[6] While the impact of the COVID-19 pandemic and associated public health restrictions was described positively as reducing bureaucracy and enabling new partnerships to form, conversely these circumstances had also resulted in an increase in demand and complexity of cases.[6] Other studies echoed these points, arguing that the short-term, outcome- focussed priorities of national governments were often inhibitive to delivering more holistic models of care.[79,54] Holistic ways of working with families were also implied as contributing to better quality services,[2] service experiences and engagement,[51,50] and outcomes.[7,12] Holistic care was also seen as enabling needs from the families perspective to be identified and addressed,[27,51] and a less fragmented approach.[58,12]

Community involvement

A small number of papers identified the importance of links to specific communities to the achieving the effective delivery of integrated services. Where services were targeted to meet the needs of a specific community, involvement of community members was viewed as facilitative in the development of the vision,[67] process of integration,[44] or in demonstrating impact[73] and therefore having a mechanism through which communities could be involved in the development of services facilitated their engagement.[35] In one paper from Australia, a review of eleven studies highlighted that the involvement of First Nations community workers within the delivery of support services provided greater understanding of the challenges faced by the community needing support, which in turn aided in the quality of the support provided.[44] Conversely, the same paper highlighted that having people outside the First Nations community also involved in developing and delivering services was integral: this indicated the importance of and interest in the needs of the community by the services involved.[44] Where services did have strong connections to the community is was working to support, the impact of this was described as enabling “deep and wide links to the local community” (Lopez-Carmen *et al.,* 2019, p.10), and increased community pride and better outcomes for families in the community.[9] The authors argued that in order to build the relationship between communities and services, key factors are required: a long-term commitment to relationships; time to build trust; and involvement in the community.[24]

Summary

Amongst the papers we reviewed, most looked at integration at local service level, rather than at the integration of wider systems and structures which might span regions, states or be in place at a national or federal level. While a range of actions and activities used to promote or encourage integration were identified, explored and assessed, no single model of an integration *process* was identified.

The importance of including all the relevant people – including the children and families in need of the support of services - to ensure that an integrated service can meet the needs of the people it seeks to support, was highlighted in the studies. Interconnected processes such as effective leadership, policy-making, and commissioning, and attention to these at different levels of 'the system', could contribute to a move towards integrated services and the opportunities and barriers involved. Furthermore, the creation of a shared vision and trusting relationships, and support for staff in relation to the practical, emotional and relational aspects of change, were seen as important.

The studies also provide an insight into factors which can challenge or facilitate service integration and the provision of services in integrated ways. Often these factors can be both a challenge and a facilitator, which can depend on features such as the culture and leadership, expectations and understanding of the integrating services and the individuals within them. Integration of services could, for example, allow service delivery to become more flexible and enable increased frequency of engagement between services and the people they intended to support. In other instances, however, integration was found to increase time pressures on professionals in the early stages, by requiring more time to be spent developing collaboration with other professionals, which placed additional pressures on the time available to support children and families. There was some suggestion in the studies reviewed that this additional time burden could be overlooked in the planning of integration processes. Similarly, the necessity of staff, organisations and services making time to develop shared goals and cultures, understand the roles and responsibilities of other services, and to build relationships, was recognised. Whilst this needed to be done in a planned and intentional way, supported by effective leadership, it could also add to pressures on the capacity of members of the workforce.

The process of integration is shown in the papers reviewed to be complex and multifaceted. The ways in which these complexities are understood, in relation to the specific context or to the services which are seeking to integrate, are important to the success of the process of integration. Overall, careful attention to the needs of the workforce, and the intentional planning of activity to support the process of integration, are considered likely to mitigate against some of the challenges of integration processes.

What does the evidence tell us about experiences of integration?

This section of the report focuses on what evidence there might be on how integration *felt* to children, families, and the workforce, as well as any perceptions of the advantages and disadvantages of integration. Many of the papers identified as relevant for this review looked at how people – both those providing services and people needing the support of services - have experienced the integration of services. While there was some direct evidence recorded from parents and carers about their experiences, the majority of the papers discussed the experiences of professionals involved in the services and also their perceptions of the experiences of people being supported by these services. There were even less studies reporting directly from children and young people about their perspectives and experiences of services and service change, and where this did exist, the numbers of children and young people involved were very small. The workforce views expressed were predominantly those of health and social work professionals.

Sixty-eight papers have informed this discussion about experiences of integration. Nine of these were in grey literature and 59 were peer-reviewed papers. All but six of the peer-reviewed papers discussed primary research, with the remainder being secondary reviews and systemic literature reviews. The studies were predominantly qualitative or used mixed methods with six using quantitative methods only. Where data was available, 20 peer reviewed papers discussed studies conducted in North America, 11 in Oceania, ten in the UK, and 11 in Europe. Six studies were conducted across multiple sites and in three studies, one of the sites was based in Scotland. One study was undertaken in Scotland. In the grey literature, where data was given, we identified two systematic reviews or reports using secondary data, and six publications using primary research. The geographical location included five in the UK, one in Oceania, one in Europe, and one across multiple sites.

Much of what was reported in relation to experiences was specific and granular, relating to integrated services rather than integrated structures, limiting the ability to draw wide conclusions on structural integration. It was not possible to determine from the papers reviewed whether experiences were the direct result of integration alone, or of other concurrent factors, for example, other policy initiatives. It was also difficult to conclude whether the experience of integration for the workforce was positive or negative overall, and difficult to assess the extent to which children, young people and families experienced services as integrated. This seems to be connected to several factors, such as how the integration was done, what activities and supports were put in place to support integration, which services are being integrated, and roles, remits and relationships.

Finally, there were very few longitudinal studies measuring the impact of change over time. The additional time afforded to manage the initial engagement process was often considered to have helped gain a deeper understanding of presenting issues than under previous models of contact with families.[18] This raised whether it is the additional time given or the new configuration of services which allows for improved understanding. Often new models or new ways of working have time built into the model to work with families, or practitioners have reduced caseloads. This allows increased time to build trust and relationships which are more likely to impact on positive experiences, which is supported by a wealth of research (see for example Ruch, 2023; Morrison *et al.*, 2019; Winter *et al.*, 2019).

The involvement of children, young people, families and carers in the design and delivery of integrated services was often identified as a key goal, with a view to the creation of a more holistic and person-centred service. A number of papers however described that the complexity of systems, contexts and professional language could make it difficult for such contributions to be meaningful and realistic.[37,20,68]

Overall, the papers suggest that it is the mechanisms and supports that are put in place to facilitate the meaningful involvement of children, young people and families in planning, whether in high level service design, or in planning for their own individual support, that influences the extent and usefulness of such involvement:

> *"It may be important to reiterate that user involvement has become a mainstay of national policy. While there is little evidence that carers are able to either consistently or decisively influence service planning or service operations, policy documents attribute paramount importance to stakeholder involvement … It is here that our findings provide some material for scepticism."* ([37]Kaehne & Catherall, 2013: 610)

Experiences of children and young people

From all the relevant papers reviewed, only eight primary studies collected data about the experiences of children and/or young people, and this was usually about specific support services rather than experiences of wider structural integration.[22,14,18,5,6,85,19,62] Five studies spoke with a total of 69 children or young people, while one paper conducted interviews and focus groups with a total of 90 children and young people.[6] The findings from this paper, however, are not presented in depth, but rather reported in case studies relating to specific areas of interest, for example, 'care in unsuitable environments' and 'cross-sector challenges'.[6] Accordingly, the vast majority of our learning about the views and experiences of children and young people presented in this section is based on the views and experiences of a tiny proportion of the children and young people who are affected by these services. This presents a significant challenge to any future work that seeks to use integration to improve services for children and young people.

It is worth noting that in addition to gathering the experiences of five young people directly, one study concerned with the Gloucester Innovation Project in England also discussed the experiences of involving a group of ten young people as part of an advisory panel to the research using participatory methods. They reported that this was favourably viewed by professionals, but do not present any information as to how this was experienced by the young people themselves.[18] The five young people, who had each experienced the pilot phase of the project, were particularly positive about how practitioners had supported them in pursuing education or employment goals and developed a trusting relationship with them. They were more mixed about the ability of practitioners to understand the specific complexities in their lives, and to do all they had promised, although they often mitigated this by explaining that they believed the practitioner was 'trying their best'. Importantly, young people in this group were unable to comment on how professionals worked together to support them, as they were unaware of how this occurred.

In another study, researchers spoke with 14 young people who had parents with serious mental health difficulties who received support aimed at enhancing holistic, child-centred outcomes.[22] The young people expressed a desire to receive support separate from their parents, to allow them to express themselves freely. There was also a focus on the intervention being 'fun', while older young people valued 'anonymous self-expression', and particularly a desire for peer-focused help and information. Children and young people in this study wanted a model of intervention that would reduce isolation. They wanted greater recognition from their peers, schools and teachers to feel that their circumstances were recognised and they were understood and supported.

A further study involved 10 young people in interviews about the Specialist Health and Resilient Environment (SHARE) service they had received in England. Young people were particularly positive about the breadth of support available, reporting that this also supported their engagement:[5]

> *"They've helped me find somewhere to live, I've got a job, I'm volunteering, I'm back talking to my dad. So everything I've actually asked them to help me with they have done (Young Person 2)"*
> *([5]Calderón et al., 2017: 37)*

Young people also identified that the holistic approach, extending to the whole family, was also important, and identified the multi-professional team involved in the service as particularly beneficial. Other aspects which were reported as helpful by the young people were frequency of contact supporting trust in the relationship, and the non-judgemental, listening based, approach which empowered young people in their own care planning. Accessibility in terms of the out-of-hours availability of workers was seen as a strength, as was the adaptability of the service to the needs of each young person.

In one study, researchers spoke with nine young people in Belgium regarding a collaborative approach to supporting adolescent girls with multiple and complex needs. These interviews highlighted that young people felt that they should be informed and included in decision-making about their care, even when this care was complex, and that it was important to them to retain an element of choice about involvement in services (in this case 'therapy'), which could otherwise be viewed as "pushy" and off-putting. Young people also highlighted the importance of continuity of relationships with the professionals who supported them, and of having easy access to the support available, in this case by reducing waiting lists, and integrating the supports available within their school. Finally, these young people also highlighted the importance of privacy, and information only being available to those who need to see it.[85]

It is also notable that some young people did not experience the services as integrated at all, and in fact felt that it could be the opposite:

> *"Other professionals or services? Oh, but they're not open to that! Once I suggested something like that – maybe it was a bit difficult because it is something they don't have in this … hospital. And I asked for it and they said no, because you are supposed to go to there. (girl interview 6)"* *([85]Van den Steen et al., 2018: 210-211)*

Another study included interviews with 20 children about their involvement in the Sefton Community Adolescent Service in England. These young people noted the importance for them in having just one key worker, rather than having to contact multiple agencies, who was easy to contact whenever they needed to. They also valued having someone to talk to who took the time to get to know them, their family, and understand their issues and family dynamics. One young person noted especially the holistic nature of the service, not being limited to one issue or domain. Young people also valued being involved in setting targets and actions and having a say in their care. Young people also valued the expanded reach of the service, which would often provide support to family members as part of their work.[14]

Eleven children who lived in families receiving the Family Safeguarding Hertfordshire service in England were interviewed for another study. Unfortunately, only one paragraph is presented about this data, which is repeated in its entirety below:

> *"As only 11 interviews were completed with children or young people, the data has been analysed as a single dataset, rather than attempting to identify differences between the 2 phases. Overall, feedback was positive. There was a sense that they felt that the service was having a positive influence: for example: 'I liked that everyone is happy and joyful'. When asked what was going well at the moment, one child commented: 'social workers coming'. It was evident from the feedback that they had a good relationship with their worker, enjoyed the time they spent doing direct work: '[I liked doing] the safety plan'; and valued the time their worker took to listen to their perspective and understand their point of view: 'I liked that she asked how I felt' and 'she listens to what we say'."* ([19]Forrester et al., 2017, p39).

Finally, when the Care Quality Commission (2022) looked at the impact and response to the COVID-19 pandemic on the mental health care of children and young people in England, they conducted interviews and focus groups with a total of 90 children and young people. Some young people were frustrated by the difficulty of obtaining mental health support at an early stage, feeling "brushed off" by services and told that they "did not meet the required criteria". Others reported positively on the value of a 'care coordinator' which facilitated effective collaboration between professionals.[6]

Experiences of parents and carers

While the experiences of parents and carers are more prevalent in the papers reviewed than the experiences of children and young people, these are still limited when compared with the recorded experiences of professionals. While 17 papers reported on the experiences of parents and carers, only 11 papers included reports directly from a total 442 parents and carers in their own words.[22,65,38,27,76,37,14,5,35,85,19,7,9,43,44,68,80] We present these findings within themes identified across the papers.

The review aimed to assess the impact of integration on rights for children, young people, parents, and carers. Across the papers we reviewed, however, there was minimal discussion or consideration of the rights implications of integration. Many papers referred to the 'empowerment' of individuals, as well as the importance of children, young people and families being more actively involved decisions about their lives and identifying services,[22,7,37,9] but there was no discussion of these ideas from a rights-based perspective. There was mention in the papers to the inequity and inequalities in accessing to services, but this was in relation to professional perspectives on the rationales for integration to address socio-economic disadvantage,[68,41] geographic factors and social characteristics[68] rather than from a rights perspective.

Experience and perceived impact of integrated services

Three papers described parents' experiences of collaborative or integrated services [35,76,37] and highlighted that services were not experienced as integrated but seen as distinct and individual. In these cases, families did not find services integrated, and some families had had to choose between services, rather than accessing multi-disciplinary services.[35] Parents were often unaware of collaboration practices and found it difficult to identify examples of joint work.[76]

In contrast, in other instances, parents and carers highlighted some aspects of integration as positive elements of their experiences. Parents valued having only one contact for multiple services,[14] and another paper highlighted the importance of the combined expertise available within the service.[85]

> *"Here, they can analyze the problem of the adolescents, and "put that at the center". They ask themselves: "what does this person need?", "what can we think of to meet that need?". And not: "does that girl fit in our care program?". That is the main difference this project makes, and that's thanks to the combined expertise and all the options available, such as the different therapies, the hospital school, the other specialists…" ([85]Van den Steen et al., 2018: 202)*

Another study highlighted that parents recognised the ability of professionals to fulfil promises to parents and carers more thoroughly due to the integrated offer of the SHARE service in England.[5]

In relation to the impact of integration, it is interesting to look at the findings from one UK paper in particular.[37] Contrary to the other papers included in the review, the parents involved in this study were not engaged in a service evaluation directly but were currently in receipt of support from children's disability services. The paper does not specify how long the service changes had been in effect but reports that a majority of respondents had contact with the service within the last three months. A survey of 49 parents asked how much parents knew about imminent or recently implemented local service changes, and 80% reported not noticing any changes. When eight, who had noticed some changes, were asked to describe these changes, their descriptions did not appear to be associated with co-location of services (which had occurred). When asked whether they had heard about the new co-location of services, of those who replied, 13 respondents had (36 per cent) while the rest (64 per cent) had not heard about this. It would appear that experience of change to local services was not widespread amongst parents, even though most of them were frequently in contact with staff.

Furthermore, one study from Canada which spoke with 56 parents highlighted that:

> *"The major findings suggest that families did not benefit much from the policy, believing that the outcomes of collaborative practices among the school and the health and social professionals were not very noticeable."* *([76]Tétreault et al., 2014: 830)*

The parents in this study reported insufficient support from stakeholders of the health and social services network and, in some cases, searching and fighting for services without professional help. Most parents did not witness sufficient results from co-ordinated actions to be able to identify specific outcomes for children, while more than half were not satisfied with the complementarity of services across the networks.[76]

Access to services

Three papers highlighted that for parents and carers one of the valued experiences of integrated services was the ability to provide timely access to, or link in with, other services.[44,38,35] One of these was particularly in relation to practical aspects such as transport,[35] while the others were concerned more with the co-ordinating role that professionals within integrated services could play.[44,38]

One of the literature reviews included in this review from Australia highlighted that a key strategy was the engagement of colleagues working within the community within the service integration.[44] This involved professionals such as community workers, translation services, and using participatory frameworks, cultural immersion, formal and informal discussions, and community oversight to support community engagement. Another study highlighted that parents and carers felt the benefit of collaboration as they described their lives being less disrupted while in contact with professionals.[85]

Relationships

Parents across several studies from England, Australia and the USA highlighted the importance and value they placed on the experience of having positive, supportive, and non-judgemental relationships with professionals, and the importance of consistence in these relationships.[7,38,27,5,19,14] Key aspects of these experiences reflect those of the children and young people's views also seen in the studies with the emphasis on contact which is provided when needed, is ongoing and persistent, and sees the parents and family as a holistic whole, rather than individuals and their needs as discrete units. In one study, parents were asked to rate a series of satisfaction measures, and they strongly agreed with a range of statements about relationships. They also 'strongly agreed' with the statements about being respected, involvement in decision-making and services being available and helpful.[7]

Parents in one of these studies highlighted the importance of persistence in the development of a relationship with professionals,[38] which was linked to negative pre-conceptions of social care services due to previous experiences, an issue which was also highlighted in other papers.[5,19]

Holistic needs

The importance of attention to the context in which parents come into contact with services was highlighted by responses in studies where parents and carers valued non-judgemental approaches,[19,84] and highlighted the wider challenges which individuals and families presenting at a specialist service could be faced with. This was starkly illustrated in one paper, where it was identified that:

> *"a major focus on medical needs did not emerge because of women's pressing social and economic needs such as housing and employment" ([27]Handler et al., 2013: 25)*

In this study, a greater proportion of parents were successful in achieving their identified goals, such as those concerning housing, education or employment, than goals related to pregnancy or conception, which were the focus of the intervention.[27] In another study, parents who experienced a 'care-navigator' programme were most concerned with housing issues, before health and social care issues were raised.[38] This highlights the importance of a holistic view of the circumstances and contexts for parents.

Developing skills

Finally, parents in two studies highlighted that they valued the aspects of the services they experienced which focused on developing their skills.[65,5] In one paper, parents were reported as having experienced a greater sense of competence as a result of a school-health partnership, and equally felt that the SHARE intervention in England had provided them with increased skills and confidence to manage crisis situations moving forward.[5]

Workforce perspectives of the experiences of children, young people, and families

Many papers included in this review presented workforce reflections on the experiences of children, young people, and families within integrated services. The following section addresses these findings in relation to the key themes which emerged, with reference to 23 papers, 20 from the peer-reviewed papers, and three from grey literature.

Greater co-ordination and collaboration

Effective co-ordination was identified by practitioners in Australia as making things easier for people, especially those with complex needs, to access supports. People needing support were generally seen as being directed to the 'right places at the right times'.[9] In Tasmania, practitioners indicated that greater integration (both horizontal between services, and vertical within services) would support service provision and enable them to meet the needs of children and their families better.[35] They identified that co-location was a facilitator to collaboration and integration, and highlighted collaborative practices that were supported, such as joint visits and co-ordinated meetings,[10] while another paper reported that the service was more joined-up for children and their families.[2] It was also argued by the authors of one paper that a holistic approach facilitates positive changes in behaviours among young people which can have significant impacts on their long-term wellbeing.[62]

Three studies from the UK reported that greater collaborative working had led to improved information sharing and had helped to identify risks earlier for children and families.[19,2,71] However, in a different study, service pathways were found to be designed without appropriate regard to continuity, meaning that there were interruptions in the support provided to children at risk. This study concluded that multi-professional collaboration within the child protection system was not sufficiently focused on the child’s best interests, but instead focused on professional know-how. As a result, integrated practices were often excluded and children and young people were asked to adapt to professional processes, often needing to recount difficult experiences several times. The authors highlighted that a comprehensive approach needs to put the child at the core of the system.[41]

Trauma informed and flexible

Some papers discussed integrated services which were designed to empower families and reduce trauma.[33,10] Trauma-informed approaches suggested by staff included reducing the number of staff that people seeking support were required to interact with and avoiding multiple psychosocial assessments where people had to re-tell their trauma history. According to the practitioners, these approaches would help prevent the person they were working with from becoming overwhelmed, frustrated or re-traumatised.[10]

In an example from England, the Family Safeguarding Hertfordshire evaluation identified motivational interviewing as having a positive impact on engagement with, and outcomes for, families. Some workers identified this as one of the biggest successes of local innovations in integrated working. They reflected that this approach supporting frontline staff to empower families appeared to change, and therefore reduce, the risk to children. It also allowed for more effective engagement with parents.[19]

Another feature identified by practitioners as important for families was flexibility and a user-led approach, which sometimes proved less straightforward to implement where the support required involved a statutory order (in the context of the UK). However, in the evaluation of the Gloucestershire Innovation Project, also in England, practitioners from youth support services reported seeing social work colleagues start to openly adopt the risk assessment approach and other elements of a practice model designed by the agency to work holistically with young people and their families. Initially, practitioners had reported some discomfort at doing so while also meeting the requirements of the child in need or child protection plan.[18]

Access to services

In two studies, managers identified some services which were difficult to access for people needing the support of services due to a lack of funding and a focus on crisis prevention. These included community health, mental health, drug and alcohol programmes due to a lack of funding and as a result a focus on crisis intervention.[41,23]

Professionals in one study proposed solutions to challenges accessing health services for children, such as offering care in alternative, community-based settings, increasing home visitation programmes to reach underserved communities, providing health management support, and promoting healthier home environments for children.[86] Importantly, one paper commented that stakeholders indicated that when the wellbeing of women and children fall under the responsibility of separate ministries in Canada, this posed challenges with respect to responding to the needs of separate individuals simultaneously. This could limit service provision in terms of type of service and the person accessing these.[51]

Professionals in another study reported having access to specific services or specialists within their agencies with whom to consult or collaborate when working with families experiencing multiple challenges.[48] Accessing this help was often still described as challenging. For example, respondents reported that there were not enough staff available to do the work and/or that available staff had very limited hours.[48]

Flexible approaches to service provision were also seen as integral in a model which aimed to maintain engagement with women and maximise service accessibility. Community outreach or home visiting was considered the most accessible service model for mothers needing support, particularly after the child’s birth. Flexibility relating to appointments was also highlighted in an Australian study, with drop-in clinics seen as highly desirable if feasible given staff schedules. Staff with greater autonomy over their time were best placed to work in this way, with a non-punitive approach to missed appointments also necessary to maintain engagement with people needing their support and ensure services were accessible to them.[10]

Relationships with families

Most professionals felt that maintaining continuity for the people they are working to support by providing access to familiar, trusted staff over time wherever possible, could help to maintain engagement. In an environment of low trust of services, and, for example, mothers’ perceptions of high risk in terms of losing child custody, access to staff with whom there was an existing trusted relationship was seen as vital.[10,82,54,70,9] Trust was also identified in another paper focused on inter-professional working, where shared goals and mutual trust were rated by Nurse Family Partnership home visiting nurses in the USA as the most important dimensions of relational co-ordination.[87]

One literature review included in this review identified that person-centred care was seen by the workforce as key to providing good care in examples from Nordic and Scandinavian countries, and also highlighted that collaboration, respect and communication between care professionals, unpaid carers and users supported a successful system.[68] This joined-up working facilitated the alignment of preferences and appropriate support for individual need. The evidence also suggested that difficulties in communication between professionals, unpaid carers, and people needing the support of services was damaging to user experience. Professionals in health and social care services saw collaboration with the people needing their support as key for service delivery, however, practicalities, time, service provision and administrative processes could be barriers, especially in developing individual care plans. Co-operation and trust between different parts of the system and service providers were identified as important. This included the sharing of resources and responsibilities to deliver quality services for different target populations. This went beyond just health and social care integration and could include other sectors such as education and employment.[68]

Within a review of Youth One Stop Shops in New Zealand, staff external to the YOSS viewed the service as a lead or key role in facilitating collaboration between agencies, but the close relationship with young people could at times act as a barrier to the young person engaging with staff in another service, due to a reluctance to work with professionals other than their YOSS counsellor. One external staff member inferred that the YOSS staff could inadvertently take on parental roles.[54]

One study from Finland commented on co-production in social service networks, identifying that people using services needed to be active participants to influence service provision,[82] and family empowerment was identified as a strategy in another paper to drive effective service integration.[44] Such ideas are not without challenge however, as discussed in a paper looking at the effectiveness of parental involvement in planning the new co-located services. The authors of this study in Wales identified barriers to parents playing a more influential role in service planning. It was difficult for parents to always be able to assess whether newly agreed work practices would address existing service gaps or improve service quality for carers and children. Parents were reported to struggle to take part in service development due to a lack of understanding of services, commissioning, and professional language. This paper also demonstrates a clear disconnect between parents' perspectives of what is happening with services compared with what is taking place, as well as a general lack of knowledge of service developments in their area. While this sounds critical of parents, rather it raises concerns about how parental involvement in service design could be tokenistic with post hoc consultation on planned service changes whereas there should be proactive, considered involvement in their design.[37]

Relationships with communities

Finally, two papers from Australia explicitly looked at the importance of developing community relationships for families. One discussed the important of building trusting relationships with Aboriginal communities.[24] The appropriate routes were seen as 1) by non-Aboriginal providers working with Aboriginal providers to build trust with families, including trust that the provider would know a family's needs, or 2) building relationships with key Aboriginal contacts who enable non-Aboriginal providers to work within communities. Both approaches could support trust in the community that the providers would understand families' needs, and would also enable the sharing of advice on appropriate cultural protocols for working together. This paper highlighted the long-term investment, flexibility and perseverance necessary for working with Aboriginal providers or key contacts as they need time to build trust with communities themselves such as attending community events at in noncore work hours.[24]

The second paper discussed the impact of a community focus for the Facilitating Partner Model, a collaborative model for delivering early intervention and prevention programmes in Australia.[9] People who used services described the Facilitating Partner as the 'go-to people', providing help to access services. In addition, the community focus of the Facilitating Partner was thought to contribute to better outcomes for programme people needing support, and to have a broad positive impact on social inclusion and wellbeing. Professionals felt that the Facilitating Partner was considered to be "of" the community, approachable and trustworthy, and that a deep understanding of the local community helped them match families to the right services at the right time, and identify service delivery gaps and emerging needs.[9]

Workforces' own experiences of integration

The experiences discussed in this section reflect the themes identified in the papers of how professionals described their own experiences of the integration of services.

Introducing and implementing integration

The implementation of integration was described as both challenging and rewarding in the views of professionals represented in these papers. There were several aspects that were reported by professionals that made the establishment or longevity of integrated services more challenging. However, the principle of integration of services was reported to be viewed positively by the workforce in this evidence.

Staff reflected within these studies that multi-agency working brought them many advantages, asking 'why didn't we do this years ago?'[2] Working in partnership was viewed as compatible with safeguarding practice and consistent with social work values, but issues with motivation were also reported if professionals did not believe the change would be sustained in day-to-day practice after an "experiment" ended,[43] or if it was felt that there was an ongoing expectation of improvement to meet demand with little learning from previous experiences**.**[79]

In several studies, staff highlighted issues of workload and capacity.[85,43,82,71,24] They reported that integration had generated new tasks and challenges for them, sometimes speaking of the 'hidden' work in staff-to-staff interactions that made up a significant proportion of workloads, but was often unaccounted for in funding models,[21] and that these tasks could lead to wellbeing concerns for staff.[43] Aligned to this were reports of a tendency of staff to revert back to more familiar practices when presented with circumstances involving a higher level of risk for children and families, where there was greater pressure to act quickly and under a higher level of scrutiny.[18]

One study in Canada reflected that intersectoral collaboration required immense effort because intersectoral governance is about "strengthening relationships" and "getting existing barriers out of the way". The effectiveness of joined up governance was attributed to a culture where people know and respect one another.[12]

These papers also explicitly identified factors that the workforce reported could create barriers to implementation. These included:

- fragmentation or siloing of the service network[50]
- lack of consensus among staff regarding scopes of practice[50]
- limited finance and resources[50]
- turnover of the workforce[82,10]
- scepticism as to newly integrated colleagues' roles[49]
- divergent organisational paradigms[54]

Achieving collaboration in the long-term is challenging.[33] Structural change in the workforce was generally perceived by the workforce as an unsettling time for practitioners, and the potential for negative impact requires careful communication around changes. A tendency to rush or skip stages in a particular model of change was challenging for the workforce, which required that the confidence and competence of practitioners be developed to preserve the fidelity of the model and not revert to familiar ways of working when faced with challenges.[18] Additionally, studies found that IT systems could be experienced as challenging because of the limited scope to adjust or extend the parameters of the established IT-based social work case management system.[5,25,18]

These studies highlighted that the implementation of newly integrated working should be monitored over time with opportunity for staff feedback.[56,85,64] One reported that avoidance and hiding behind the organisation structures was caused by the professionals' own insecurity and fear caused by the workload,[82] while another identified that more support may be needed to avoid staff turnover and anxiety.[18]

Key features for integrating services

Across the papers we reviewed, several key factors for successfully carrying out increased collaboration or integration were identified by the workforce:

- investment in staff (such as training)[67,56,18,68,1,10,52,51]
- development of trust between professionals[60,68,81,82,54,70,71,23,58,64,24,29]
- provision of adequate resources[67,68,35,44,50,54,55,58,24]

- shared and clear protocols, policies, procedures and processes to support practice and also for resolving disagreements[14,56,48,54,58]
- shared governance mechanisms[35]
- importance of a clear understanding of each professional role within a team[77,56,48,78,41]

Co-location was often discussed within the reviewed papers. Having co-located teams within a shared supervisory structure was thought to help develop greater consistency in professional practice and facilitated both formal peer review and informal peer learning and processes.[14,35,55,63,58] Group supervision or opportunities to come together were regarded as a positive forum for embedding practice and improving communication between agencies, especially where there was an open dialogue.[19,2,50] Staff recognised this as helpful, but also acknowledged logistical difficulties with diary management and the high level of time commitment required. Discussion was reported as often time consuming, because the needs requiring support were complex.[2]

A clear shared vision, mission, and goals, as well as principles for the new ways of working were reported as important to integration by staff.[67,14,44,45,58,24] However, too broad a focus with too many disparate elements, and lack of strategic level buy-in or leadership during the early stages, with pressure to become operational at a pace, was challenging and could expose new systems to high levels of risk.[14]

Further, differences in mission between organisations could challenge finding common goals.[43] This is reflected in the findings of a systematic review of 18 studies from the USA and European countries which identified overarching elements that appear to stimulate interdisciplinary collaboration. These were awareness and understanding of the other discipline, team structure, willingness to work together, and shared responsibility and norms.[64]

One study from the USA reported that collaborating with community service providers was made easier when community agencies had a history of working together, as well as interest and willingness from other organisational leadership to collaborate.[87]

Another paper indicated that successful programmes for families experiencing opioid use disorder also in North America prioritised care co-ordination, removing barriers to integrating medical and behavioural services, and balancing child safety concerns while maintaining parental trust.[66]

The presence of a co-ordinating organisation or "boundary spanner" was discussed in two papers and these models were highly valued by professionals as these helped with communication, finding funding, relationships and facilitating continued co-ordination.[9,29]

Leadership

One study from Canada described a policy environment where interests at a national level were not aligned and where each government ministry connected to the needs and interests of children remained separate from the other. This resulted in the governance of child health in Ontario being perceived as chaotic at times, with the health workforce highlighting the seemingly arbitrary divisions of responsibility.[12] The multitude of players and lack of clear structure to co-ordinate their interactions were felt to be an overarching barrier. Two papers from France and Australia discussed how the structure of governmental departments and agencies, as well as policies, has an impact on facilitating inter- and intra-sector collaboration,[25,41] although no clear recommendations were identified by the authors.

At a more local level, leadership and governance was also seen to be important. One study identified that achieving a high-functioning integrated service model required at least three years of work and committed leadership with persistence and consistent messaging.[33] Intensive facilitation of the change process and leadership were fundamental to achieving collaboration. In one study, professionals in community-based health and social service institutions in Canada reported that over time, values and attitudes began to change. [55] These findings are also reported in one of the literature reviews included in this review.[33]

In another example, with the challenges in creating a new workforce structure, senior managers were reported as being cautious in how they communicated to staff about a project to avoid creating unease at further restructuring.[18] In this paper, there was some concern amongst senior managers about the retention of social workers and the project came at a time when fiscal constraints on services were being felt locally as well as nationally. This created a fragile environment to implement change and required a careful approach to disseminating the project. Within this paper it is noted that structural change in the workforce had been generally perceived as an unsettling time for the practitioners.[18] The findings from a scoping review included in this study which focused on what is needed to facilitate collaboration between child protection services and domestic and family violence services in Australia supported oversight of implementation, highlighting that clear leadership should be actioned through establishing governing committees.[45]

Commissioning

One paper examined the role of integrated commissioning in improving transitions from children's to adults' services in England.[46] Staff reported that both national and local policy was needed to guide integrated commissioning. Although co-location and inter-professional working were often valued by the workforce, it was reported that services for children and adults were commissioned separately and used a different organisational structure. The inference was that though valued, co-location and inter-professional working did not translate into practice because of this (and other) barriers such as lengthy contractual processes.

This study highlighted the lack of clarity on integrated pathways for the effective commissioning for transitions, and on service availability. The operation of different eligibility criteria between child and adult services could become a major barrier towards integrated commissioning for transitions. Other issues highlighted were more practical, such as the strict use of age as a criterion for accessing different services and that adult services generally had higher thresholds for accessing services.

Another study highlighted the importance of service commissioning in the development of multi-level integration. The learning from the workforce here was that focusing on commissioning contracts which specified outcomes (in terms of benefits for the people needing the support of services), as opposed to outputs which described what services should be provided, was found to be a support to integration.[56] It is also relevant that a literature review conducted from Australia found that time and resources are needed to establish sustainable services, and that funding cycles could inhibit this.[25]

Professional relationships

Good relationships between professionals were highlighted by many of the papers as a key element required for successful integration. This was true of the relationships within services[54] as well as with partner organisations who helped support their work.[17] This helped to ensure that professionals from different disciplines could come together effectively,[50,80] have frank and honest discussions,[71] communicate effectively,[12] share information appropriately,[29] and ultimately build a sense of belonging in the work environment.[24]

> *"Trusted individuals were on the same page in terms of overall shared goals and considered themselves accountable to each other… Relationships were strong enough to explore, resolve and benefit from disagreement or conflict" ([54]Morgan et al., 2019: 1026)*

Trust was identified by professionals as key to well-functioning professional relationships[54,82,70,42,71,24,29] that require time to establish.[55] These connections were often determined by informal connections developed by individuals personally, as opposed to through formal arrangements.[23]

> *"My experience over the years has been in this field, is that it's probably who you know, rather than [what you know] it's the relationship that you have with the worker rather than the agency." ([54]Morgan et al., 2019: 1026)*

While service managers saw this as a strength,[23] it means that integrated services may not automatically improve professional relationships.[41,63]

> *"Contrary to our expectations, time since establishment of the model was not associated with positive perception of interprofessional relations. This suggests that although time may consolidate relations it may also*

> *undermine them depending on the work climate, and that a linear relation cannot be assumed.” ([63]Rousseau et al., 2017: 203)*

The development of these relationships also served to help professionals have a greater understanding of each other's roles and work, and improved professional understanding of risk to children, and good safeguarding practice.[6,2]

The ability to build relationships was reported by the workforce to be hindered by not having the time or energy to put into building these relationships, due to other demands on their time.[9,6] Differences in aims and missions between, for example, education and social work/social care, could also make finding common goals challenging, as could power structures and divisions of labour between health and social care.[43]

New ways of working together

The development of integrated services, either through the integration of existing services or the creation of new ‘integrated’ models, requires professionals to change how they work together. Most often, the evidence in the papers we reviewed showed that these changes consisted of professionals co-working with staff from other services who they had not previously worked with as closely before.[48,4,87,34,63,76,21,9,65,53,] In these papers, there were several suggestions made as to how to ensure that these collaborations are successful (the section ‘What does the evidence tell us about the process of integrationWhat does the evidence tell us about the process of integration?’ gives more information on this).

In other studies, staff reported experiencing challenges in more collaborative work, particularly in relation to the conceptualisation and acceptance (or otherwise) of risk,[14,48,18,6] and in agreeing who the primary ‘client’ was, and therefore whose needs were the priority.[82,50,58] Similarly, two papers reported on that professionals’ experiences of differences in working culture between services could result in conflicting goals for outcomes.[50,54] One paper discussed the tension that can exist between specialist and generalist approaches, acknowledging that some degree of specialism will always exist and recognising the importance of a base level of shared knowledge.[58] Another tension identified was between fixed and flexible roles for professionals, and how this should be managed as needs change over time. Finally, contradictory work processes and cultures around working hours and different methods of communication were also experienced as challenges by staff.[9]

From interviews with 61 staff members in the Children’s Social Care Innovation Programme in England, it was highlighted that working in partnership was viewed by professionals as compatible with safeguarding practice and consistent with social work values.[2] Staff reported that they felt that the service was more joined-up for children and their families, while practitioners working with adults in the family were viewed by children's workers as improving risk assessment practice and providing immediate support to families.[2] This study, along with another from the USA,[33] also reported improved practice in the assessment of need and risks, and in the ability to immediate support to families. Staff felt that they immediately saw differences as a result of ‘multi-agency working',[2] and 'integrated service delivery',[33] in terms of accessibility and knowledge sharing, gaining assistance with cases, and access to support for families (which was contrasted with previously protracted referral processes).[2,33] In another paper, integration was also reported to have enabled skill-sharing, greater discussion and appreciation of differing perspectives, and an opportunity for the workforce to provide more effective tailored services.[50]

Information sharing

Information sharing was often considered by the people working in services to be an important feature of integration, and likely to improve experiences and outcomes for people needing the support of services.[43,82,10,2,71,51,54] Some staff articulated a reluctance to share information with colleagues in different professions at times, due to uncertainty as to the appropriate processes, data security and legal concerns, or uncertainly as to the scope of information sharing that was appropriate.[2,55,71,28]

Some of the studies showed that specific information technology systems were sometimes incorporated into service integrations, and these were reported by staff to have mixed impacts.[43,2,45] In Finland, a new digital information sharing tool was thought to better support children and new professionals working with the children's family, but the lack of co-creation with professionals limited its uptake and use.[43] In another study, a key intended benefit of the model was to record case notes within a single system and alongside the notes of social workers so that all information from different professionals about a the needs of a child and the responses to these needs was in a single place. However, while the new process was established, the old recording processes were not removed, resulting in a duplication of effort and recording.[2] This was thought to be due to children's services operating within a wider culture of blame and that many staff retained their existing recording practice to ensure they had sufficient detail to prove that they were 'doing their job properly'. This behaviour was underpinned by anxieties about the legal status of recording and the perception any legal processes would seek and require a high degree of detail.[2]

Protocols and formal agreements which clarified shared agreement and understanding about how and when information would be shared were recognised by staff as needed in some papers,[54] while inconsistencies in information sharing was felt to have an effect on joint decision-making in another.[71] In addition, technical glitches were noted in some studies with the roll-out of new systems including system crashes, an inability to open new cases, mis-assigning information, and delays in allocation of cases.[5,2] It was also noted in two studies that any information sharing systems required robust data governance structures to ensure that providers can view only the relevant data at the right time in order to protect child and family privacy,[86] while a specific data-sharing requirement was highlighted for children's services for sharing data across health care and education settings.[24]

In studies which identified that no specific information sharing processes or methods were established, this was also experienced as a challenge by professionals,[71] who could see the value in that, but lacked processes, guidance, or data sharing agreements to allow this to take place. Staff experienced the lack of information sharing as having negative implications on the quality of care children, young people and their families received. The overall perception was that a lack of liaison, difficulties in accessing information, disjointed working and silo working resulted in less effective communication systems, and limited opportunities to provide holistic care for children and young people.[6,86,24]

Skills and training

Professionals reflected on the need to ensure that they were adequately skilled and trained to adopt new practices and ways of working. Within multi-agency teams, different professional experiences and qualifications were challenging to manage when navigating case management.[14,50] Professionals raised the issues of their own confidence in their practice in relation to their interactions with other services and sectors.[2,82] Where professionals lacked confidence in their practice this could result in a hesitancy to collaborate with other service providers.[82,29] Alternatively, fear of "getting it wrong" was a barrier to developing shared ways of recording.[2] Overall, commitment to continuous learning and development was regarded as an integral component of effective services,[68] as was the importance of a shared base knowledge alongside professionals' specialisms,[58,24] and a common language.[41]

Summary

Although the evidence presented in the papers we reviewed does not go into great depth, especially in relation to the experiences of children and young people, there are some common threads running through these findings. The importance of relationships was highlighted by children and young people, parents and carers, and by members of the workforce. Similarly, autonomy, agency and choice were important features of the experience for children and young people, as well as their families and carers.

Children and young people

The studies highlighted the value and power of consistency in professional relationships for improving services and outcomes for children and young people. A truly integrated service that worked for young people would focus on ensuring that they can access all the services they need, without the expectation of building trusting relationship with several different professionals. In addition to trusting relationships, the importance of maintaining frequent contact, at a time and location that suits the young person rather than the service provider, was also recognised.

The importance of empowerment, agency, and choice for young people when they engage with their own care planning is clear from the evidence reviewed. Although these papers together represent a small sample, including elements of choice or empowerment is a key feature in many of them. This resonates with understandings and interpretations of children's rights (Daly, 2018), which are a central element of child-focused practice within Scotland and elsewhere.

Parents and carers

The experiences of parents represented in the studies are strikingly similar to those of children and young people in some key areas. In particular, the emphasis on the importance of consistent relationships, and the value of choice and autonomy. However, parents also identified some key insights in relation to integration in particular that a service that professionals see as integrated may not be experienced as such by parents.

The experiences and perspectives of parents and carers represented in these studies also highlight the challenges faced by new services in overcoming resistance based on previous experiences, as well as in recognising the complex contexts that they operate in. A service that seeks to integrate health and social care may be effective in theory, but if pressing contextual factors for families, such as housing, are not taken into account, the integration of services may not have a differential effect for families.

Workforce

The importance of relationships, between individuals as well as organisations, was also reflected in the studies that described the experiences of workforces. The need for time to be given to the development of trusting relationships within and across workforces was vital, and evidence showed that lack of time for this could hamper the development of shared understanding and common goals between staff and services. The studies showed that the establishment of an 'integrated service' in itself did not necessarily result in trusting professional relationships. While the idea of integration was often experienced positively, there were a number of related challenges for the workforce, including the unsettling experience of change and learning new ways of working, increased workload, and reverting to previous ways of working where risk was considered to be high, or an expectation that the integrated approach would not be sustained in the longer term. Committed leadership across services and within organisations, and planning for integration was identified as helping to alleviate some of these challenges.

In the main, workforce perceptions of how children, young people and families experienced integration did accord with what children, young people and families themselves said. In particular, there are common perceptions that integration supports the delivery of services, as well as the engagement and empowerment of people needing and using the support of services. The emphasis from the workforce about the use of trauma-informed approaches may also reflect the need, highlighted by families and carers, to overcome families' negative prior experiences of services.

Co-ordination and location were areas which the workforce emphasised, but were less present in the experiences of children, young people, and families. This likely reflects the different standpoint of the workforce, who have experience 'behind the scenes' of services, and for whom there is importance in the co-ordination in these processes. Co-location could also be framed as a 'professionalisation' of the need for services to be delivered in convenient times and locations for children and families, as highlighted in particular by the evidence from young people. The lack of specific information on the views of young people and families relating to the co-location of services does not mean that this is not an important or impactful aspect for them; this is more likely due to the low representation of lived experience within the research generally meaning that many aspects may be overlooked.

Overall, the evidence in the papers reviewed provides a mixed view of experiences of integration. There did not seem to be any link between experiences and the type of integration (service or structural), and positive experiences appeared associated primarily with relationships. Families rarely discussed integration directly, and generally, the perceptions of families' experiences reported by professionals appeared to be more positive than the experiences families shared directly in their own words.

What does the evidence tell us about how integration differs at different levels?

Developing integrated systems is often considered from a horizontal perspective, which is to say between systems and processes, but this must also be considered from a 'vertical' perspective, which is to say the creation of integration at different 'levels' of an agency or organisation, from the individual and team through to organisational, and national levels. Individuals working within or receiving support from these different levels may experience the demands and impacts of integration differently, and in this section we look at the findings in the papers which look at and addresses these different levels, and their interaction. The importance of considering integration from both perspectives is summed up by Toma *et al.* (2022):

> *"A major challenge for the future remains the vertical and horizontal coordination of the role of national organisations and alignment of improvement agendas and resources that move away from the traditional tiered approach to mental health and bring together public and third sector CYP [children and young people's] services through a more extensive whole system approach to change" ([79]Toma et al., 2022: 208)*

A total of 32 papers discussed integration from different perspectives. Twenty-nine papers were from peer-reviewed journals and three were grey literature. All but two peer-reviewed papers discussed primary research, with the remainder being systemic literature reviews. The studies predominantly used qualitative research or used mixed methods with four using quantitative methods only. The studies and literature reviews were undertaken in North America (ten), in Oceania (five), in the UK (four), and in Europe (four). Five papers drew on studies or reviews from across multiple countries where Scotland was one the sites in three and one final study was undertaken in Scotland alone. Where this data was known, in the grey literature, we identified one systematic review undertaken in Europe and one primary research study conducted in the UK. The workforce views expressed were predominantly those of health and social work professionals, with fewer studies including the views of education (four), parents and carers (four) and policy and government colleagues (two).

Many of these papers identified the challenges that are highlighted elsewhere in this review, such as the cultural differences between children and adult services,[46] siloing of service delivery,[66] a lack of common leadership styles between different levels,[20] or a lack of appropriate communication,[13] which prevented values-led integration at a higher level impacting into practice. These differences could also affect the success of service-level integration, due to this integration not being reflected in targets at agency levels,[54] differing understandings of how the integration should work between different managers of services[71] or regulations preventing the effective sharing of information between agencies:

> *"The transformational leadership adopted by the executives nevertheless had little impact on the development of distributed leadership on a strategic level. Our observations also suggest that the post-merger environment and fiscal austerity at the time hindered the emergence of a new leadership model" ([20]Fournier et al., 2022: 9)*

> *"a social agency worker acknowledged his agency (and others) had outcomes targets and focused on one piece of the pie which he contrasted with the more holistic youth development approach YOSSs provided which focused on the journey" ([54]Morgan et al., 2019: 1026)*

One paper from the UK highlighted the importance of service commissioning in the development of multi-level integration. Here, focusing on commissioning contracts which specified outcomes (in terms of benefits for people needing the support of services) as opposed to outputs which describe what services should be provided, was found to be a support to service level integration.[56]

The papers included in the review also provided some indications of how integration between different 'levels' can more effectively achieved. These included:

- conducting 'round table' meetings, where partners could come together and learn about one-another and cooperate to identify needs, clarify resources, and build trust[55]
- developing collaborative 'case studies' which map the system and through the experiences of a hypothetical individual helped to identify where there were challenges, and to develop shared values and vision[53]
- developing knowledge to the extent that staff members are knowledgeable about all parts of the system[51]
- integrated performance management systems which encourage leadership at all levels.[20]
- There was also some evidence from a multi-country review that it may be more important to focus on relationships between staff, emphasising networks rather than hierarchies.[68]

The importance of the role that national and local policy plays in guiding commissioning[46] and supporting integrated work was discussed in a number of the papers we reviewed. However, there was little offered in the way of guidance as to how to best support integration through policy and guidance, with a range of views in the evidence about what was effective in different policy approaches. While some staff appreciated policy that outlined the objectives and the key values, leaving a high degree of latitude to individuals and services in how they achieved these, others found that policies of this type did not provide them with sufficient guidance in how the objective should be achieved. Conversely, where policies were more directive, these could be criticised for not providing the necessary flexibility to allow services to identify solutions to challenges that staff faced working in their specific contexts.[79] Providing high-level policy to promote integration is also found to have risks, where policies which were not appropriately funded could lead to competition between providers. It was also noted by the authors of an Australian study that not recognising the timescales needed to develop relationships and trust was problematic, with the paper finding that "the government should be actively assisting providers to work together at the level of service provision, and not just relying on policy to drive collaboration" (Green *et al.,* 2020 p.395).[24]

A study looking at the integration of services within Canadian provinces suggested that 'political culture' was the biggest obstacle to effective governance.[12] Another Canadian-based paper noted that reform processes typically involved 'reshuffling' management positions, and this resulted in lower levels of clinical support for practitioners and time to dedicate to partnership working.[13]

The benefits of structural integration, however, were highlighted in a third Canadian-based study, where:

> *"…stakeholders indicated that when the wellbeing of women and children falls under the purview of separate ministries, it poses challenges with respect to caring for multiple clients simultaneously. In turn, this can limit service provision, both in terms of type of service and the recipient." ([51]Meixner et al., 2016: 61)*

National level

The majority of papers we reviewed focused on local-level service integration, and not on integration at a national or regional level. However, some papers nonetheless raised issues which highlighted how integration could be effected at a national level.

The impact of changing political culture on effective co-ordination of governance structures for complex systems and structures was highlighted by one paper.[12] The siloed structures of services was identified as impeding collaboration which in turn had a negative impact on access to services for families.[25] This was reported to be particularly acute if there are different approaches to the governance of the different services.[12]

A review of learning from social care in Nordic and Scandinavian countries highlighted the need for appropriate and consistent national legislation to support the aims of integration, with a clear vision for services, and only defining in law those elements considered most critical. Legislative barriers included inconsistent, contradictory and changing legislation, while this review suggested that high-level framework legislation can limit local autonomy when it is used in conjunction with parallel national policies to implement rules and incentives that local social care commissioners and providers are required to follow.[68]

There were various suggestions in the papers we reviewed about navigating a complex policy landscape. One paper reported an intermediary organisation being tasked to navigate a cluttered landscape of a national health and social care organisation, bridge the understanding between national and local narratives, and deliver on policy recommendations, noting:

> *"little guidance had been given on how health and social care, mental and physical health care or the acute and community care sectors could equally contribute to establishing the direction of national transformation, in a coordinated way." ([79]Toma et al., 2022: 208)*

The development of a collaborative culture was identified by the partners involved in the collaboration as important to integration, and this extended to the national level. An example of integration in Manitoba, Canada, described a collaborative culture where each ministerial voice at State level was valued equally.[12] Another study explored this further and discussed a change in public policy to break down silos that isolate providers and public agencies, encouraging communication and collaboration among public and private agencies.[7] Here, the authors noted that "collaboration across agencies to support children and families through the provision of coordinated service delivery and child-focused interventions" (Chao *et al.,* 2014 p.2261) can help to address families' holistic health needs.[7]

In relation to governance and regulation, a review of learning from Nordic and Scandinavian countries identified 18 papers which discussed the role of high-level governance in the design and implementation of integrated social care, with experiences from Sweden, Norway, Denmark, Finland, and three multi-country studies. Important themes that arose here were a clear vision for integrated care and underpinning legislation that is supportive and consistent, the degree of centralisation and formal organisational integration, and regulation and monitoring,[68] issues which were also reflected in a paper looking at mental health policies in practice.[79]

This paper suggested that clear regulatory roles and responsibilities at a national level are needed to ensure effective regulation and monitoring. Governance structures and national monitoring standards need to define responsibilities and boundaries. This review of evidence highlighted the importance of getting the balance right between top-down governance to ensure standardisation and quality of services versus bottom-up flexibility to allow for local context and to meet the needs of people using services. Co-ordination and monitoring of complex care services was particularly important in places where there was both public and private provision and "there to be consistent ways of measuring quality across different care settings to ensure protection of the most vulnerable".[68]

The paper identified that decentralisation can be both a barrier and a facilitator to integrated systems. Decentralisation can lead to fragmentation if there are divisions in health and social care between different institutional levels. On the other hand, it can be an enabler where national legislation provides a clear broad framework for service provision and for regional or local areas to retain responsibility for social care policies. The authors recommended that policy-makers should consider a hybrid top-down and bottom-up approach to support integrated care.[68]

Another paper looking at mental health policies in practice stated that:

> *"Policymakers noted that policy recommendations were developed to set a strategic direction of travel and achieve an overall objective. They*

> *described how they sometimes deliberately offered little guidance around operational implementation in order to enable flexibility from individual services to implement the objectives relevant for their own local populations." ([79]Toma et al., 2022: 206)*

This vagueness allowed policy statements to act as expressions of intention rather than as deliberate courses of specific action. On one hand this was perceived as a positive in driving change nationally and allowing for greater scope for local innovative approaches to developing policy. On the other, it was also perceived that the vagueness meant direction was insufficiently detailed to identify clear pathways for service transformation.[79] In this context, it is also important to note that a Finnish study found that one of the challenges to effective integration was the lack of consistency in policy and guidance, which reduced motivation as professionals did not believe that any changes or initiatives would be sustained.[43]

Funding and commissioning cycles are also important to consider when looking at the national level. NICE guidelines published on working with disabilities in England recommended developing a joint commissioning framework. NICE agreed that mechanisms to achieve effective integrated working would be for commissioners to specify how services should work together in contract requirements.[56]

A multi-review of European systems reported that the evidence on the effect of funding models on cost, health, and service use outcomes was mixed.[68] Key facilitators of financial integration identified included a shared vision among stakeholders, unified structures, co-ordinated funding and consideration of local circumstances. Difficulties of implementing integrated financial systems and commissioning structures were found to be common, with a specific challenge being different payment structures or separate budgets and the transfer of funds between different parts of the system. Many of the recommendations in this multi-agency review emphasised the need for joint working, but the ability of services to implement these would be limited without a framework being established at an organisational level.[68]

A systematic review of integration efforts for people with disabilities in Australia also found that commissioning cycles could also limit the time and flexibility necessary to sustainably implement integration.[25] Some respondents within a study of child health governance in Canada claimed that changing political culture was the biggest challenge to co-ordinating to solve complex problems. The authors argued that the way that government ministries are '"lopped and split" by topic or population into portfolios are proof that solutions to intersectoral challenges remain elusive.' (Cressman *et al.,* 2021 p.9).[12]

Local government level

There was very little information within the papers we reviewed about integration of services at a local government level. One paper focused on paediatric asthma care in the USA and referred to a lack of clarity for practitioners about the impact of different policy initiatives, and that many initiatives may have unintended consequences due to inappropriate/unclear framing or phrasing:

> *"However, the unanimous view was that there was little integration and cohesion between the broad spectrum of national organisations and their activities, leading to an abundance and overlap of implementation support and organisations delivering the same transformations aims but using different approaches." ([34]Janevic et al., 2016: 206)*

Monitoring systems were identified as being able to facilitate social care integration through the inclusion of user outcomes, and not just process outcomes and outputs. One study within a review of evidence from Nordic and Scandinavian countries suggested that policy makers should direct policy development at the level of the individual and local communities, then create mechanisms to support negotiations to achieve the desired outcomes of making care user-centred and shifting care from hospital to community settings.[68] Others found that lack of specificity within policy left too much room for interpretation locally, leading to confusion and ambiguity around the policy aims and objectives, particularly around what the specific policy recommendations mean in relation to service transformation and delivery.[34] A study based in Finland found that without clear guidance professionals will often form their own individual approaches to collaborative working, which are often based on previous experiences of co-operation.[82]

Organisation/agency level

Many of the papers we reviewed highlighted the importance of organisational culture in implementing and sustaining service integration, and these generally related to challenges encountered due to differences in cultures between organisations or teams within an integrated service (See 'What challenges integrated working' for more on this).[44,43,68,54,52,10] However, some papers also clarified the opportunities or situations in which cultural issues may be addressed. It was highlighted in a Finnish paper that it was sometimes necessary for organisations to be more flexible in their perspectives and ways of working in order to make a collaborative process work.[82] Another Norwegian paper highlighted that:

> *"The results of this study can support findings that collaborating activities are more easily managed in smaller municipalities" ([8]Clancy et al., 2013: 666)*

This may relate to the agility and flexibility required to adapt working cultures to support integrated working. A study conducted within Children's Centres in England, which aimed to work in a more integrated manner, found that although it was often challenging for staff to separate out a professional culture from other cultures, such as ethnicity, gender, or family background:

> *"it appears cultural differences that have the potential to be a barrier in collaborative working can be addressed if there are real opportunities for*

> *shared reflection, so that communities of practice as outlined by Wenger (1998) can truly be allowed to develop." ([52]Messenger, 2013: 147)*

This resonates with some of the messages from this review around communication and time with colleagues (this is articulated in the 'What facilitates integrated working' section). An Australian paper identified that both formal and informal roles that linked across agencies and within organisations were key to collaborative working, and that this facilitated the sharing of goals and visions, raising awareness of providers of other available services and enabling pathways for providers to link with one another.[24]

Two other papers highlighted the importance of an organisation's capacity for organisational change. There were two key aspects identified through the evaluation of the Sefton Community Adolescent Service in England: leadership and vision, and the pace of the change. The pressure to become operational as an integrated service fast was found to be counterproductive, leading to poorer service delivery while integration was thought to suffer without strategic level buy-in or leadership during the early stages. In this example the integrated service struggled following the departure of the original strategic lead, in part because there were no clear lines of accountability.[14] A study of a Finnish integrated service also highlighted that leadership needed to be supported by all relevant sectors, not just internally.[57] Although organisational change may be necessary, that does not necessarily mean structural change. Indeed, a Canadian paper using a decision-making ecology framework found no change of structure impacted on decisions to place children in out of home care.[72]

Team level

Many papers we reviewed reported on the challenges of bringing together an integrated team, and often this involved multi-disciplinary working.[14,35,55,7,2,3,43] The studies involved identified that having the relevant professionals with multi-disciplinary teams to achieve the aims of the service, and for senior managers in all services to have processes in place to support inter-agency team working, were both important.[81,56] Furthermore, a systematic review found that meetings which provided face-to-face contact between staff were particularly important for clarifying each other's roles and providing an opportunity for individuals to get to know each other, and enhance trust.[56]

There are also indications that inter-professional hierarchies are a challenge within multi-agency teams. A study across six European countries identified that professional hierarchies, related to professional qualifications, and therefore 'status', presented challenges to working together,[77] a finding which is supported by findings from other qualitative research about inter-professional hierarchies.[55]

Co-location of teams was often addressed in the studies.[14,35,55,63,58] In a study of a youth mental health initiative in Quebec, Canada, statistical analysis indicated that co-location was significantly associated with a positive perception of interprofessional collaboration, improved communication and an improved perception of the organisational culture. This was thought to be due to more frequent contact between the primary team and specialised resources, which allowed mutual appreciation and a common care culture to develop.[63] One further paper concluded effective integration was more than just the co-location of services, and highlighted the values of "client-centeredness", empowerment, non-judgment and holistic care, as a foundation that could support stakeholders in retaining their shared sense of purpose.[51]

Summary

Amongst the papers we reviewed were discussions of integration at different levels, from national and local government to organisation and team levels. The findings related to integration within, as well as between, these levels.

The evidence highlighted the importance of appropriate policy and legislation, at national and local government levels especially. However, professionals' views differed around how legislation and policy might best support integration. The degree to which policies offered specific detail or direction, for example, was thought to influence integration through the extent to which these allowed for flexibility, or were more directive as course of action rather than a statement of intent. The challenge of balancing flexibility with consistency was recognised, and the need for policy and legislation to be clear, consistent and focused was emphasised across the evidence reviewed.

The role of culture was also apparent at the different levels discussed. At a national level, changing political culture could for example influence the governance of complex systems relating to integration. A culture of collaboration was considered important at national as well as organisational level, and organisational culture could also influence integration. This could include flexibility, relationships, and shared organisational goals, as well as the place of leadership and management in driving and supporting change.

The findings around supporting integration at different levels largely reflect the findings on supporting integration more broadly (discussed in the 'How is integration achieved?' section). These include ensuring time and opportunity is available for building trusting relationships and developing shared understandings and cultures.

What does the evidence tell us about the outcomes and impacts of integration?

What the evidence tells us about the impact and outcomes of integration is a key question for the review, but one of the most challenging to answer. It was challenging to attribute change to integration alone and difficult to disentangle the impact of integration from other co-occurring events within organisations,[67,14,18] or from the creation of new or specific roles or services.[14,19] This section first sets out our observations from reviewing the papers about measuring outcomes before describing findings from the papers reviewed.

A total of 44 publications informed the evidence about the outcomes and impact of integration. Thirty-six were peer-reviewed papers and eight were grey literature. Thirty-three peer-reviewed papers were primary research and three were either secondary reviews or systemic literature reviews. Almost all of the studies were qualitative or used mixed methods, with four using quantitative methods only. The studies were mainly spread across the continents included in this review. Where data was available, the peer-reviewed papers were conducted in North America (14), Europe (seven), in the UK (six), in Oceania (five) and three across multiple sites. In the grey literature, we identified three systematic reviews or reports using secondary data, and five studies using primary research. The views expressed were predominantly those of health and social work professionals, with some from children, young people and families.

Some of the data here should be treated with caution as much of the discussion on outcomes or impact relates to integrated services rather than integrated systems or structures. It is also unclear from the evidence reviewed whether the changes or improvements identified are because additional time is often allowed for working with families or there are reductions in caseloads during the early stages of implementing new ways of working, or whether this was an outcome of the new integrated service. Both allow relationships to develop which may impact on positive outcomes.

Measuring ‘outcomes’ in the evidence

There are a number of overarching observations that can be made from the papers providing information on outcomes. The first of these is that there were very few examples of the impact of integration being directly measured. For the most part, impacts were anticipated, expected, or surmised, rather than being measured or directly demonstrable. These papers are most often cover the evaluation studies that focus on service integration, rather than wider system integration, and this therefore focussed the outcome measures on specific objectives which relate to the specific targets of the service. Where there is data available on outcomes, this sometimes reflects self-reported experiences of children and families, but these are outweighed by the large number of studies which reflect professionals’ *perceptions* of the impact which has been achieved.

Where studies have measured impacts or outcomes of integration, these are often clinical medical outcomes such as admissions to hospital; receipt or completion of medical interventions[7,34] or substance abuse interventions.[32] Alongside these clinical outcomes, there are attempts to identify social care impacts for children and young people, but these are limited in scope, focusing on 'easy to measure' metrics which reflect the systems in place, rather than those outcomes or impacts that might be most significant for children and families. Typically, the metrics measured are: being returned to family care;[69,32,59,74,50] permanency for children;[59,50] or reduction in the use of care for children.[19,57]

Other studies included in this review, gathered data on aspects of parental mental health,[5,75] the mental health of young people,[31,30] behavioural improvements in children,[75] and attendance at psychological interventions.[62] Access to services was also an area that was targeted by many of the integration efforts described in the papers.[68,5,44,62,11,16]

Overall, the picture of outcomes and impacts which is created is of a mosaic of small impacts, which may be less notable from a systems perspective but extremely meaningful for individual children, young people and their families. This does not create a consistent picture of changes in outcomes due to integration. It could suggest, however, that these smaller impacts or outcomes are setting out the pathway for some children and families to more sustained long-term outcomes. While there are many papers that demonstrate a positive impact on measured indicators, we also found some papers that demonstrate no improvements,[35,6,16,76,61,1,11] and in one paper, a negative impact from integration.[82]

Another common theme across the papers we reviewed is the challenges the authors face in attributing change to the integrative effort itself as opposed to other co-occurring events,[67,14,18] or to the creation of a specific role or service, rather than the integration element at play.[14,19]

> *"There can be no doubt that [Family Safeguarding Hertfordshire] reduced the use of care for children, though the mechanisms by which this was achieved are less certain." ([2]Bostock et al., 2017: 43)*

This lack of any clear process or causal chain which demonstrates a links between impact and the integration work is particularly challenging in the context of the mosaic of outcome measures and service specific evaluations which constitute the majority of the evidence base. Without a clear theory as to how the impacts are achieved, the disparate integrative processes, objectives, outcomes identified, and impacts demonstrated create a landscape in which there are a range of possibilities, making it almost impossible to determine if *integration*, as opposed to other factors such as additional time or focus on a particular service, for example, is the critical factor in determining positive outcomes.

The short-term nature of the majority of the outcome or impact measures used in these studies further clouds the ability to see what is or isn't contributing to changes in outcomes. Given the learning from implementation science regarding the time it takes to implement meaningful change (Fixsen and Blase, 2016), alongside the time then required to have an impact on people needing the support of services, there is an inherent challenge to being able to demonstrate an impact in the one or two year time periods that the majority of these studies concern themselves with. Additionally, the majority of papers overall used data from a single time-point, presenting further challenges to the measurement of impacts or outcomes.

Authors articulated the challenge of measuring impacts of integration for a range of reasons. In some instances, this related to data integrity issues,[59] lack of a true comparison group,[39] or the differing objectives and expectations between professionals and people needing support, meaning that it is not clear what the right things to measure might even be.[43] It is important to reflect that the limited data on impact and outcomes identified within the papers we reviewed does not mean there is an absence of positive outcomes in the lives of children and families. Rather, the absence reflects the challenges of measuring impact or outcomes and not the impact of support and services on the lives of individuals.

Impacts on the workforce

Efforts to integrate services and agencies inevitably have impacts upon the workforces within those services and agencies. Here, we describe the evidence identified in the papers we reviewed around how the workforce is impacted by integration efforts. The short timeframes of many of these studies means that these impacts are often felt as a result of the *process* of integration, rather than necessarily the integrated ‘end state’. In this section we focus on those impacts which are presented in the studies as having occurred as a result of integration, rather than the process of changing to integrated systems and processes.

Four papers highlighted an improvement in collaboration between services as a result of increased integration.[2,63,71,44] Improved communication across professionals was also linked to increased collaboration and the co-location of professionals.[63] In a study in Quebec, Canada, the authors suggest that co-location, leading to improved communication, could be facilitated through a more “horizontal” or flat hierarchy, that is including specialised professional expertise within a service without an assumed leadership or authority over other professionals.[63] Another Canadian paper suggested that this improved communication might be a predictor or facilitator of integration, and in particular the close working of service leaders, as well as an outcome.[53]

Leadership style is also seen in the evidence to be impacted by integration. In a Norwegian study, it was found that a more passive ‘laissez-faire’ leadership style which was used at an operational level created a disconnect with a transformational leadership style which was being used at a strategic level. However, across a two-year period, the leadership across all levels converged upon a distributed leadership style, supported by democratising approaches to operational activities.[20]

Across several papers, improvements to professionals’ own knowledge, skills and practice as a result of increased collaborative working practices were highlighted. These practice improvements included improved understanding of role and practice in relation to safeguarding,[2] as well as improved skills and practice overall, ultimately allowing for more bespoke services to be offered to children and their families and greater opportunities for accessing and sharing knowledge and expertise.[50,81,5,19] In one systematic review, the authors highlighted that through collaboration professionals were able to build trust between professionals, as well as better meet the needs of the people they were working to support.[81] Changes to practice also meant that professionals were working more directly with people needing support,[19] and that this work was conducted by the most appropriately skilled and informed professional,[19,5,10] which was also acknowledged as being preferred by some of the people they were providing support to.[10] Practice changes highlighted also included a shift towards a more holistic approach to care within integrated services.[83] However, increased workloads stemming from increased interactions between professionals was also acknowledged as an often overlooked consequence of more holistic and collaborative approaches to practice.[21]

A number of papers identified unintended consequences for staff working in services which arose from integration initiatives. These included professional 'passiveness' due to confusion about new and complex roles,[20] delays in anticipated timescales for involving partners effectively,[18] and increased stress among professionals which may be linked fewer supervision opportunities.[19] Further, a UK-based paper questioned the role of the involvement of people needing support in the development of integrated services;[37] while the added burden of evaluation activities for professionals were also a concern in one instance.[18] There were also concerns around the sustainability or ability to scale up pilots of integration work without additional resources.[50]

These unintended consequences were also apparent in the policy and legislative context. Overlapping policy agendas and initiatives were viewed in some studies as having unintended consequences for services, and service integration. Specifically, it was identified that a lack of cohesion across multiple organisations, initiatives and supports had resulted in overlapping efforts to bring about change through different approaches and services.[79]

Evidence on outcomes of integration

It is important to note that the outcomes identified are primarily derived from evaluations or observations of integrated services, rather than integrated systems or structures, and that the timescales of the studies makes it difficult to distinguish whether these impacts are the result of the integration itself, or the time and resource given to support the integration processes involved.

Six papers drew conclusions about the positive impact of co-ordinated services in a general sense, as opposed to specific outcomes. These papers highlighted the challenges that 'fragmented and specialised' services risked entirely excluding individuals who did not within fit tight criteria for at least one service.[82] In a Canadian study, parents noted that services could sometimes 'pass the buck', arguing that they did not have the obligation to support their family, and that the support received was insufficient to the extent that they had to take their own measures without professional help.[76]

An evaluation of Warm Connections in the USA suggested that the integration of the public health initiatives involved reduced barriers for low-income families,[39] while three other studies that looked at research in North America and different parts of the world indicated that integration could improve service access for a) young people who would not otherwise access physical or mental health services;[30] b) adolescent parents and their children;[11] and c) expectant mothers who would not otherwise be connected with services.[83] One study also indicated that integration could lead to improved engagement with services,[65] while another suggested that there was limited or no change in engagement as a result of integration.[16]

Finally, there was a suggestion from a systematic review of inter-agency collaborations in the USA that the impact of integration on outcomes may depend on reaching a certain degree of integration:

> *"Overall, it appears that interagency collaboration between child welfare and substance use agencies leads to positive well-being and permanency outcomes no matter whether a co-ordination or integration level of collaboration. This finding is promising; given collaboration at the co-ordination level may require fewer resources (e.g., time, money, worker capacity) than collaboration at the integration level. However, it is possible that the lower levels of collaboration (communication, co-operation, and co-ordination) do not lead to equally positive outcomes. Future research is needed to understand the bare minimum level of collaboration necessary to achieve positive child welfare outcomes.", ([59]Ogbonnaya & Keeney, 2018: 239)*

Outcomes for children and young people

There is a challenge in distinguishing outcomes for children and families which are due to the integrated services and those which are due to improved relationships with workers. It is also notable that the outcomes identified in the studies are focused on adolescents and young adults, with little being said about the outcomes for younger children.

The study of the Raising Adolescent Families Together programme in Massachusetts state identified an increase in adolescents living independently, being employed, and using condoms,[11] and a systematic review of one-stop shops found that:

> *"Young people also self-reported improvements in their mental health, education and vocational pursuits, confidence and self-esteem, and physical health following involvement with the services." ([30]Hetrick et al., 2017: S15)*

The review also found that young people were highly satisfied with, and valued a range of characteristics of integrated youth health care services, particularly the relationships they were able to form with the staff.[30]

The evaluation of the Sefton Community Adolescent Service in England gathered information from young people which indicated that they experienced increased self-confidence and living more healthily, greater engagement in their education, improved relations with their family members, and an increased ability to remain at home or in suitable independent places to live. Several young people were also reported to have reduced or stopped self-harming as a result of the support they received from the service. A few of the young people expressed concerns that these improvements might reverse when this direct support stopped, but most felt well-equipped to continue developing.[14] Many of the young people reported this as being due to the positive relationship they had with their key worker, and this echoes findings from New Zealand cited in a systematic review which found that adolescents who experienced services as respectful, empowering, and encouraging of their agency, had improved their resilience and wellbeing; while those that reported negative or inconsistent experiences, did not.[44]

Finally, five young people provided responses for the evaluation of the Gloucester Innovation Project in England, identifying positive education and employment outcomes that they attributed to the support received from the project, and indicated that they felt more confident.[18]

Outcomes for families

A range of studies identified that it was professionals' relationships with families that were perceived to make a difference, rather than the integration of services (See the 'Experiences of children and young people' section). The studies highlighted that there was greater positive impact through engaging parents, and approaches that were flexible,[56] and broadly experienced as acceptable to the families themselves,[74] rather than joint working in and of itself.

In some papers, parents compared the positive experiences of support offered through evaluated services to the negative experiences of previous engagements with support professionals.[18,5,19] Staff within a 'facilitating partner' programme in Australia were viewed by parents as having local knowledge, empathy, emotional intelligence, and a capacity to partner with and empower others. Parents needing support considered them to be *of* the community, approachable and trustworthy, and that their understanding of the local community helped them match families to the right services at the right time and identify service delivery gaps and emerging needs.[9]

An evaluation of the 'Healthy Beginnings' programme in the United States of America found that parents strongly agreed with satisfaction measures which considered how respected, responsive the service and how engaged they felt.[7]

Where the studies we reviewed did measure direct outcomes for families, the outcomes tended to be mixed, and relate to a very specific target identified by the services. Evidence in relation to Youth One Stop Shops in Holland identified a reduction in 'parental stress and improvement in behavioural problems' among school aged children, but could not be sure of impacts in relation to family functioning and behavioural problems among pre-school children.[75] An evaluation of an integrated programme for adolescent mothers and families in the USA found that fathers maintained contact with their children, but financial support to their families decreased over time.[11] A systematic review identified six studies measuring the impact of Family Drug Treatment Courts in the USA on wellbeing outcomes which demonstrated an improved chance of caregivers entering treatment and remaining within treatment longer.[59]

The evaluation of the Family Safeguarding Hertfordshire model in England found no difference in the ratings families gave of family life as a result of the intervention, nor the proportion of them and their children experiencing concerning levels of stress or anxiety, social isolation, or school attendance.[19] The guidelines produced by the National Institute for Health and Care Excellence (NICE) on integrated service delivery for disabled children and young people found that there was some evidence that dedicated funding for services, joint budgets and having a designated service manager improved parents' satisfaction and quality of life. However, this evidence was “very limited and was specifically related to the provision of key workers” ([56]National Institute for Health and Care Excellence, 2022: 148).

Many of the papers noted more generalised positive impacts from the integrated services offered, which were often not anticipated in advance by the services but were raised by respondents involved in the studies. These include:

- An empowering approach giving families the tools to improve home routines[14]
- Support to move lives forward through work and training[14]
- Improving resilience and wellbeing[44]
- Reduced stress, improved parenting efficacy, and perceptions of adequate support[39]
- An increased sense of parental competence[65]
- Continued attendance at school[11]
- Higher levels of community pride and enhanced quality of life[9]

Social work and social care outcomes

The papers we reviewed that looked at outcomes in relation to social work and social care had a strong tendency to focus on measuring the processes, such as ‘child in need’ meetings,[19] or referrals to child protection processes[57], rather than outcomes of these for children, young people, or families. The Family Safeguarding Hertfordshire project in England identified a reduction in ‘Child in Need’ meetings, and strongly indicated that support from this programme reduced the need for families to be supported by other services.[19] One community-based approach in Finland, which brought health and social services together as well as other relevant organisations to commit to shared goals and work together to support families, identified a significant reduction in referrals to child protective services due to a preventative approach focused on supporting families at the very earliest stages, before significant concerns were identified. This impact was achieved in context of an overall increase in referrals nationwide.[57]

The Family Safeguarding Hertfordshire evaluation was also one of six studies that reported on the use of care for children and young people. This evaluation identified a reduction in the average number of days spent in "out-of-home placements"[19]. A paper from the USA which evaluated the impact of Sobriety Treatment and Recovery Teams (START) on family outcomes identified a reduced number of children and young people admitted into care,[32]. Another study, based in Kentucky in the USA, identified an increased focus on enabling children to return to live with their families.[69]

A systematic review of cross-system collaborations identified that Family Drug Treatment Courts in the USA improved the chances of children being able to live with their parents, but that there was no reduction in the time taken to do this.[59] A ten-year longitudinal study in England identified higher rates of home and foster care stability as a result of an adolescent multi-agency specialist service.[74]

Health outcomes

Ten papers we reviewed looked at the health impacts of the integration of services. Overall, the evidence in relation to physical and mental health outcomes was both limited and mixed. The papers cover a wide range of outcomes from immunisation rates,[11] to emergency department visits.[61] The evaluation of the SHARE project in England indicated that health services being integrated with other public services meant a broader range of needs were met for families in terms of housing, education and employment.[5] Another paper indicated that a 'care navigator' service in Australia had reduced general stress levels within families, resulting in increased attendance at health appointments improving health conditions for some.[38]

Evidence was provided of improvements in specific outcome measures such as improved attendance at 'well-child visits',[65] and improved immunisation rates.[7] The evidence on emergency department attendance highlights the complexity in understanding outcomes as a fall in emergency department use: this was identified as a result of an integrated health and social care in Scandinavian countries,[68] while a randomised controlled trial of a case management programme found no impact on emergency department attendance.[61] A further study in Alaska highlighted a reported 36% reduction in emergency department visits between 2000 and 2015, but it was unclear what 'client' group this data related to.[67] Other specific outcomes included those in relation to reductions in asthma symptoms,[34], and obesity in children,[65] and increased parental sobriety from substance abuse.[32] However, it should be noted that the follow-up periods for most studies was limited (often 12 months at most), which limits our understanding of the impact of these interventions in the longer-term.

Outcomes in relation to mental health were also identified in three studies. One of these was a systematic review which reviewed four studies.[31] Three of the studies included reported positive impacts on mental health outcomes among children experiencing adversity. The fourth study identified was a randomised controlled trial, which found no significant impacts on mental health.[31] Other studies were more conclusive in the impacts identified, with the following identified in a literature review of 'one stop shop' youth health care:

> *"Across the included service evaluations, between 52% and 68% of young people experienced reductions in symptoms, with some of the most adverse outcomes of mental health problems (suicidal ideation, self-harm and impaired social and vocational functioning) being ameliorated. Young people also self-reported improvements in their mental health, educational and vocational pursuits, confidence and self-esteem, and physical health following involvement with the services."*
> *([30]Hetrick et al., 2017: S15)*

In contrast, the authors of one study reflected on the challenge of increasing demand and complexity of children and young people with mental health needs, suggesting that services did not have capacity to develop future plans due to increasing workloads and referrals, and concerns around staff shortages and burnout.[6] Another study reported mixed findings as to whether integrated health and social care resulted in lower demand for services elsewhere in health care.[68]

Wellbeing was also identified as being impacted, with analysis of wellbeing scores of parents involved in the evaluation of the Family Safeguarding Hertfordshire pilot in England reporting general improvement over time for their psychological health, physical health and quality of life.[19] In another study, the results of the integrated Warm Connections service in the USA was suggested to have had an impact on the well-being of people taking part in the service by reducing distress regarding their identified urgent concern/s while increasing their confidence in addressing that concern/s.[39]

Financial outcomes

Four of the papers we reviewed directly addressed the financial outcomes from integrated services. Challenges identified in achieving financial integration included organising the different budgets involved and transferring budgets between different systems.[68] Two papers identified financial savings as a result of integrated services, but these were often based on limited evidence.[19,53]

Two of the four the studies indicated that there may be a reduction in service demand associated with integrated services, such as a reduction in use of care placements or emergency department visits.[19,67] However, evidence from other papers reviewed provides a more mixed picture, with a rapid review of social care integration finding weak evidence for impacts on service use for those aged 65 and over.[68] Workforces also perceived resourcing as an important factor for successful integration (this is discussed in the 'Experiences of integration' section).

Summary

Overall, very few of the papers we reviewed directly measured the impact of integration; more common was a description of the *anticipated* impact. Outcomes were more frequently reported, but measures tended towards 'process measures' such as number of meetings or referrals, or to focus on clinical or other outcomes specific to the project, including health outcomes such as hospital admissions, and social care outcomes such as referrals to other services. These may not have been the outcomes which were considered most important to the individuals and families intended to benefit from integrated working. While self-report data from young people and families was sometimes evident, there was little from younger children. By contrast, a larger proportion of included papers focused on professional and workforce views of the impacts and outcomes of integration.

Many of the papers reported on evaluation studies focusing on service integration processes, rather than on assessing impacts and outcomes, and often these were conducted over a short time period or used data from a single time point. Furthermore, in many instances, the findings in these papers could not be attributed unequivocally to integration; often, other changes were also taking place at the same time, which might equally have influenced the authors' findings.

For children, young people, and families, flexible and acceptable services, through which good relationships with professionals could be achieved, were a main feature of their experiences, rather than of integration necessarily. Measures of satisfaction with services were generally good. Services were not always experienced as integrated by the individuals and families those services were intended to support, which may have influenced families' responses to such measures.

For the workforce and professionals, relationships and communication were also important, but could be considered a facilitator rather than outcome of integration. Professional learning, changes to practice, and increased direct work with families, could also result from new ways of working, although unintended consequences such as role confusion and reduced supervision were also noted.

Overall, the evidence on impacts and outcomes of integration was limited and mixed. While some papers reported positive impacts and outcomes, others reported no change, or negative findings, and a risk of bias in reported studies. The measures and methods used in these studies did not often lend themselves to definitive conclusions of impacts and outcomes which could be directly attributed to integration.

Discussion

This rapid evidence review provides the first part of the story in addressing the Children's Services Reform Research Study's overarching research question 'What is needed to ensure that children, young people and families receive the support they need when they need it?'. Subsequent reports from this study will continue to build this story, which will be presented in a final report once each strand of work is completed.

The focus of this rapid evidence review has been to answer the following two research questions:

1. What models of integration exist for the delivery of children's social work services with health and/or adult social care services in high income countries?

2. What is the strength of evidence about their effectiveness in improving services, experiences and outcomes for children, young people and their families?

To help us answer these questions, we developed a series of sub-questions, outlined in the methodology, which were designed to help us access the breadth of knowledge required and the depth needed to answer the overarching research questions for this study as a whole as fully as possible.

The sections on findings in this report outline the evidence from the studies included in this review. These focus on four aspects which together address the overarching research questions for this study: definitions of, and rationales for, integration; the process of integration; experiences of integration for children, young people, their families, and the workforce, including the realisation of rights; and what the evidence tells us about outcomes related to integration. The summaries provided at the end of each findings section provide an overview and assessment of the key findings within each.

For our discussion here we have synthesised our findings into several thematic areas which address the two overarching research questions for this rapid evidence review. The research reviewed in this study has also provided first indications about some of things which may be needed to ensure that children, young people and families receive the support they need when they need it, which is the overall focus of the Children's Services Reform Research study.

Lack of evidence of models of systems-level integration

The studies we reviewed were based to a large extent on *service* and *team* integrations, rather than macro-level *system* integrations. This means that whilst the evidence may be strong in relation to what works at service-level integration, it gives little information as to the impacts, benefits, and challenges, that may be encountered in system-level integration. While the evidence we have reviewed may provide information that is of great value in implementing integration within 'frontline' services, it does not allow us to draw any firm conclusions or recommendations in relation to large-scale systems integration.

There also remains a significant challenge to 'scale up' both the positive impacts which can be achieved for children and families, but also our understanding of the impacts of integration efforts at a system or national level. That will require objectives to be translated into meaningful, measurable, long-term outcomes to enable monitoring and assessment of progress for children, young people, and families.

While the issues and factors identified in this review will remain very relevant in systems-level transformational reform, there are doubtless other factors which will arise, producing added complexity to our understandings of integration and its impact. Retaining a complexity-based approach, where we are alert to the fact that changes at any scale can have unpredictable and far-reaching effects on outcomes, can help to navigate this.

Our second report 'Case studies of transformational reform programmes' (McTier et al., 2023) to be published in June 2023 will explore systems level integration in-depth and draws from a different range of material beyond this rapid evidence review's primary focus on peer-reviewed research studies.

Integration should be viewed as an outcome of a range of components

Our study confirmed that 'integration' as a concept is difficult to define and articulate. Authors often spoke of 'integration' without defining what they meant, what the objectives of integration were nor what it aimed to achieve, or how this would be done. This may be because a singular definition of integration is neither straightforward to identify, or perhaps useful, in many contexts.

Through the process of the review, we developed a 'components of integration model' which combines the different perspectives of what integration 'is' across the papers.

Figure 15: Components model of integration

The value of this model lies in allowing a more nuanced understanding of integration, not as a singular process activity, but as an outcome of a broad range of components, the importance or impact of which will vary within different contexts.

Other researchers have taken similar approaches, in terms of creating a continuum (or hierarchy) of activity that leads to 'integration' (Figure 13 Morgan *et al.*, 2019). Each of the 'pre-cursors' to integration in Morgan's study which lie at the bottom of the hierarchy (for example inter-agency information sharing), clearly do not represent the full extent of integration, but it is not immediately apparent why, for instance, shared policies, which lie further along the continuum, are inherently 'more integrated' than inter-agency information sharing. However, the hierarchical approach taken within a continuum approach inevitably suggests this. The approach taken by Audit Scotland (2018) (Figure 1) is closer to our components of integration model, however it represents 'features' of integration, rather than any concrete actions which lead towards or support it, and thus only presents part of the picture.

Our components of an integration approach allows both the 'features' of integration and the 'activities' of integration to be incorporated. This allows integration to be reframed, using complexity theory (Byrne & Callaghan, 2013) to conceptualise it as the complex outcome of the interactions between the different components identified (and likely others). There is still work to be done in the refinement of this model, but in the future, it has the potential to provide support and guidance to integration activities.

The place of shared culture with committed leadership at all levels

Throughout this review, we encountered references to the 'culture' around integration efforts. A supportive culture appears to be a significant facilitator for integration, but it is important to think about what is meant by this term. In the evidence we reviewed 'culture' is used to mean the beliefs and ways of working within services or systems, but is also used to encompass developing a shared vision, shared aims and objectives, shared ideas about what is important, and how their service can be effectively delivered.

When presented in this way, the importance of culture to integration efforts is clear. Without a shared idea of not just 'what' the service is going to do, but how it will do it, and what core values are being embedded and promoted in doing so, there is a greater likelihood that conflict may emerge which have the potential to impact on multi-disciplinary work. This is seen in some of the challenges encountered in identifying who is the central person needing the support of services when a family is involved; approaches to risk; and difficulties due to perceived hierarchies of roles and evidence. This element of culture can also be seen in the value that is placed in some of the studies that looked at services embedded within local communities, which were valued by both parents, carers, and professionals.

The challenges of bringing together different services or systems which have deeply ingrained, and therefore hard to change, cultures, are clear to see from the evidence too. There may be more opportunity in the creation of truly new multi-disciplinary services or systems, rather than simply 're-badging' or moving services into a different or new system wholesale. This allows for the articulation of a clear culture for those involved in shaping and delivering the services.

In developing a shared culture, committed leadership is essential at all levels across shared services and within organisations. Strategically, leaders need to drive change and connect with those implementing change. Operationally, the workforce needs time to build new relationships across different professional peer groups and have the support from and confidence of leaders, including managers, to develop new ways of working. Leadership is also needed horizontally, or across services, to develop joint commissioning arrangements and share resources.

Committed leadership is needed from the early stages of driving change to when integrated structures are more embedded, which take years, not months. It takes time and energy to both drive and sustain change and finding ways through difficult challenges as they arise.

Governments need to support transformational reform programmes involving integration through clear direction, aligning legislative and policy agendas, properly resourcing integrated efforts and providing the necessary context for integration. This supports strategic leaders to drive change locally.

Professionals need appropriate support, resources and time during the process of integration

This review has identified strong evidence on what supports and hinders integration efforts at a service-level from the perspective of individual workers and of workforce teams. Many of the researchers in the studies we reviewed spoke with professionals from a range of services, who were delivering a range of integrated programmes, to a range of people needing these services. Through these studies, common factors emerged which appear to indicate what helps and hinders integration efforts for staff across different settings. We saw these across multiple different studies, not just one or two of the larger studies, which lend weight to applying these within a range of integration efforts.

When integrated services worked well together, there were benefits for practitioners in terms of improved levels of professional skills and knowledge, greater sharing of knowledge and expertise and changes to practice including more time working directly with children, young people, and their families. There were also a range of lessons and challenges which are applicable to workforces across different areas, services, and interventions. These included increased workloads, particularly an increase in ‘unseen’ work such as the time it takes to build and sustain relationships with colleagues from different disciplines, and the importance of clear roles and responsibilities for all team members.

Unfortunately, identifying what works (or needs to be changed) is in some ways the ‘easy bit’. Knowing that staff require the time and support is not the same as being able to provide it. The evidence in this review speaks to the additional time and work that is required to work in an integrative manner. Creating this space within already stretched services will always be a challenge, and there are no easy solutions to identified in these studies. The conclusion to be drawn here is that the implementation of an integrated service or system requires significant, long-term, commitment and resourcing from the highest levels of political and policy leadership if it is to be successful.

Supporting and supportive relationships are vital to integration

It is clear throughout this review that relationships are a key factor in delivering support to the children and families who need this, and the importance of relationships also extends to how integration is experienced and facilitated by and for professionals. The interpersonal, rather than the systemic or organisational, nature of these relationships has been highlighted repeatedly across the studies we reviewed, with the evidence pointing to several key elements regarding what it takes to build and sustain effective relationships. Not enough emphasis can be placed on the importance of relationships to the success of service or system integration.

The two most important elements in terms of supporting relationships may be summarised as time and contact. Throughout this review we have seen the importance of allowing time for relationships to develop. It is not possible to legislate for relationships, or define when, where, or how these will thrive. However, providing the time for trusting relationships to develop is key. This applies equally to the relationship between professional and the person needing the support of a service, as it does to the relationships between professionals. The crucial relationships between professionals and the people needing their support requires time to develop. Time spent together with a consistent professional allows understanding, and the trust that comes with that, to develop.

Young people, parents and carers alike reflected on the importance of a strong relationship with a relevant professional, and it must also be recognised that it is not possible to develop such relationships with multiple professionals from multiple services. Here integration may show its strength: if integrated services and systems are able to be delivered through a professional who has the time to spend building and maintaining a trusting relationship with an individual or family, that integration could contribute to a more effective response and outcome for children and families.

For professionals, there are links to being co-located in where they work, but the evidence indicates that co-location without the additional time needed to meet, discuss, and build and maintain those relationships, is not sufficient.

The central importance of holistic practice with children, young people and families

Across the services, systems, and interventions which are discussed in the papers we reviewed, the central importance of holistic practice has consistently appeared. While only a few services may have explicitly set out to provide holistic support, the importance of seeing the child, young person, parent, carer, and family *in the round*, appears in many. This is especially apparent in the limited information available from the studies on what young people and carers value in services.

In the evidence we reviewed it was often educational, housing and vocational support that the people needing support valued from the services. These are generally not the target objectives of the services themselves, but are the holistic impacts which come from working closely with an individual or family, and meeting the needs that they have. This is also reflected in evidence presented; that it is necessary to see individuals, actions, and families in context, and that support for some of these holistic needs is often a necessary step to enabling people needing support to access and engage with other supports.

While the need and desire for holistic support is reflected by professionals, there is little evidence of services being specifically designed to provide for these holistic needs. The closest to truly holistic supports discussed in the papers appear to be the ‘navigator’ type services, designed to help individuals access a wider suite of services. While these are welcomed, these also encounter challenges in that delivery of each service is by different professionals, which requires a trusting relationship to be developed anew.

Scotland is experiencing rising levels of poverty, a cost-of-living crisis, and ongoing significant inflation. In this context, families require support that addresses these inequalities so that their ability to have the time, energy, and resources to engage substantively with other services is not restricted. Holistic support that looks at the individual or family within their own context and provides the support that they need, where they need it, whether that be health, education, entering the workforce, housing, or anything else, is valued by children, young people, and families. The delivery of such holistic services is a challenge to the way services are established, supported, monitored, financed, and delivered. But this is a challenge that needs to be met if needs are to be addressed and outcomes improved.

More evidence is needed about the impact of integration on rights

Scotland has a clear commitment to incorporating the United Nations Convention on the Rights of the Child (UNCRC) into Scots law as well as existing legal and policy obligations in relation to economic, social, and human rights of parents, carers, and family members living in Scotland. It is therefore critical that efforts are made to understand the impacts that integration of public services might have on the realisation of these rights. The intention is that integration will improve support provided, to further promote children’s rights to family life, health care, and education.

The brief discussions of empowerment within the papers indicates that there is also a hope from children, young people, and families that integration can support rights to participation in society and to be involved in decisions which affect their own lives. However, at this time, given the known limitations about outcomes data relating to integration explored in this review, caution should be applied in either assuming that integration will improve the fulfilment of rights, or indeed assuming that it will not.

There are also risks identified in integrating services, which need to be thoroughly explored in order to ensure that they can be appropriately minimised and mitigated, especially where this may have an impact on rights. One risk which arises in the papers we reviewed is that related to the sharing of information. We saw how integration requires appropriate sharing of information, but that there is also evidence of people needing the support of services being reluctant to have their information shared between professionals. Many of the integration efforts described by the studies involved using new information technology for the sharing of information, and it is right that people would want to be cautious before sharing personal and often highly sensitive information on new platforms or via new methods.

The idea of integration is that the resulting service or system is further reaching than any one service that came before. This offers the potential to address inequalities and empower individuals in their access to services, but this is not guaranteed. In complex systems such as social work and social care, care must be taken to avoid unintended consequences, and/or any assumptions about benefits which may not be realised. It is feasible that without constant attention to what might be the meaningful impacts for people needing the support of services, integrated services or systems may become or appear monolithic and ingrained in an established way of working, potentially creating greater exclusion of already marginalised groups.

From this review there is little evidence of the impact of integration efforts on rights. While it is likely that the realisation of many rights may have been enhanced, it is also possible that others were damaged. It is critical that policy, research, and practice, pays appropriate attention to these potential impacts.

The importance of involving children and families needing the support of services in the design and implementation of integration

The papers in this review paint a picture of extremely limited involvement of the people who need and use the support of services in the research about those services. Understanding the experiences of children, young people, parents and carers, is of vital importance. The Promise of the Independent Care Review in Scotland (ICR, 2020) noted the tendency of services and systems to measure things which are easy to measure (which are predominantly process-based indicators) rather than the things which are meaningful to children and families. We can see this tendency in action in the research we have reviewed too: those who are easiest to involve in research, the professionals, are included in great numbers, while children, young people, parents and carers are only meaningfully represented in a small number of studies.

This is not to dismiss the value of the work that is included in this review, which provides a wealth of information about how integration is designed, experienced, and implemented. However, in the absence of meaningful engagement of the children and families needing and using the support of services, we will only ever have a limited perspective of integration and its potential impact. It is especially important that this evidence gap is addressed.

While it is important that we utilise the information gathered and stored from existing sources such as the Independent Care Review (2020) in Scotland and relevant academic research before we seek out new information, the evaluation of future integration efforts should prioritise the consistent and systematic gathering of feedback from those who use services on their experiences, before and after any change, and how these could be improved.

There’s a complex relationship between integration and outcomes

There were very few longitudinal studies we were able to review, and even fewer which looked beyond a two-year timescale in their assessment of integration efforts. This current lack of research studies completed over a long time period means that the strength of evidence focused on the impact of integration is currently limited. It also takes time to implement meaningful change, which we know needs to be measured in years (Fixen and Blase, 2019). Many of the outcomes which are hoped to be achieved as a result of integrating services are also inherently long-term, often seeking changes to behaviours or experiences for large portions of the population, and are unlikely to be observed within a timescale of months or even two to three years.

Given the limited strength of the evidence reviewed in the study, there is little evidence of a causal link between integration and outcomes.

From the limited evidence in this review which included the voices of children, young people and families, it was clear that they could identify the benefits, to them, of working within an integrated service. An emerging picture of a mosaic of smaller outcomes for children, young people and families over time could be described as part of a pathway to achieving longer-lasting change for them. This speaks to the importance of paying attention to what children, young people and families and the workforce say about their experiences of services and support, and how these should be integrated into consideration about outcomes.

A tension can exist between the need to establish outcomes quickly, often due to funding cycles and policy implementation pressures, and the time it actually takes for change to be properly embedded and evidenced. This is particularly so when considering significant systems change. There is a need to improve the evidence base of what works over longer timelines through longitudinal studies, but this also needs to be matched by stability and consistency in policy support and funding.

The strengths and limitations of the evidence included in this review

We approached the assessment of the evidence regarding the effectiveness of integration on improving services, experiences and outcomes in two ways, firstly assessing the *quality* of the evidence presented in each paper and then considering the *strength* of that evidence in the context of what we found.

We first assessed the quality of each paper included in this review using the Mixed Methods Appraisal Tool (Hong *et al.*, 2018; Hong, 2020). As noted in the Methodology section of this review, our analysis suggested that the *quality* of the studies included in this review was high. The studies were carried out to a high standard, and we are confident that the findings presented are an accurate reflection of the context and experiences studied.

Given the predominance of small-scale qualitative studies and few longitudinal studies providing data over a significant time period, caution must be taken in assessing the *strength* of the evidence presented and in generalising these findings to other populations, systems and processes. Where a body of evidence is either particularly strong or has limitations, we have highlighted this in the findings and discussion sections of the report.

Contribution of this rapid review

This review has set out the evidence from the studies we identified in order that anyone thinking about or undertaking efforts towards integration in the context of services for children and families can learn from what is already known. Through doing this, we have highlighted several important elements for consideration at all levels of service delivery.

This rapid evidence review has brought together evidence on the rationales, process, experiences, and outcomes of integration efforts nationally and internationally, which will be of use both within Scotland, the UK, and further afield. In particular, this has highlighted the lack of voice of children, young people, and families in service design and evaluation. Additionally, the review has contributed to how we might think about and conceptualise ‘integration’. Viewing integration as the complex outcome of a complex system and beginning to articulate the elements that contribute towards it, can help anyone involved in efforts to improve integration to think about how they might proceed.

While the review was undertaken to contribute to decision making around the future delivery of children’s services in Scotland, we have identified issues which are relevant to policy makers, commissioners, service managers, and practitioners outside Scotland. This information can help inform all services that work with children, young people, and their families, whether these are still being designed or are well-established, specialist or universal. This knowledge may impact upon funding, staffing, aims and objectives, measurement of success, management structure, and more.

Finally, this review is the first strand in a series of four, collectively known as the Children’s Services Reform Research Study. The findings of this review have been carried forward into the design and delivery of the other strands of the study and will be combined and synthesised with their findings for the final research report, due to be published later in 2023. Done

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Appendix 1: Research Protocol

Institutional Affiliation	Centre for Excellence for Children’s Care and Protection (CELCIS), University of Strathclyde
PI	Dr Heather Ottaway
Protocol Authors	Dr Robert Porter, CELCIS Dr Leanne McIver, CELCIS Ms Emma Young, CELCIS Dr Alex McTier, CELCIS Dr Nadine Fowler, CELCIS
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Funder	Scottish Government

Part 1: Rationale and Question Formulation

Rationale	In July 2022, CELCIS was asked to conduct research to gather evidence to help inform how best to deliver children's services in the light of the introduction of the National Care Service. The research will take place over the period of one year, and consist of five different strands: 1. Rapid Evidence Review of the published literature 2. ‘Deep Dive’ to examine the approaches to integration and delivery of children’s services taken in a range of high-income countries 3. National scoping and mapping study to explore the different models of integrated service delivery and any potential effects on a range of outcomes. 4. National surveys of the Children’s Services workforce and Children’s Services leaders to build on the emerging findings from the national scoping and mapping study to provide a rich contextual picture. 5. Targeted focus groups/interviews with professionals to explore and better understand the findings from Strands 3 and 4* *Please note that strands 4 & 5 have subsequently been combined. This proposal relates to item No. 1 – a rapid evidence review of the published literature.

	CELCIS has been asked to undertake this work to better understand the evidence associated with different models of integration of children's services with health and/or adult social care services nationally and internationally. Specifically, the work is aimed at informing Scottish Government's decision-making about how best to plan for delivery of children's services in the light of the introduction of the National Care Service (NCS) for Scotland and the ongoing delivery of The Promise. Given the significant impact this decision will have on service provision for children and their families within Scotland, this review aims to synthesise available evidence regarding the rationales behind different approaches to integration; stakeholder experiences and perceived impacts of the process; review all available qualitative and quantitative evidence regarding outcomes; consider to what extent the views and opinions of children, young people and parents about integration were included, and the potential impact of integration on the realisation of children's rights, protection and wellbeing.
Research Questions	Overarching research question: What models of integration exist for the delivery of children's social work services with health and/or adult social care services in high income countries, and what is the strength of evidence about their effectiveness in improving services, experiences and outcomes for children, young people and their families? This review has the following sub-questions to support answering the over-arching research question: What are the evidenced rationales for integration (or not) of children's services within national health and social care contexts? What evidence is available which informs understanding of the challenges, enablers, and experience of integrating children's services with health and/or adult social care? How and in what ways does integration affect the availability, quality, timeliness, cost and relevance of health and social care services for children and their families support, and satisfaction with these services? Can links be drawn between the nature of integration within Children's Services and outcomes for children, young people and their families? How and in what ways do different integrated models of children's services impact on the workforce? Were the views of children, young people and their families/carers sought prior to or during the integration of children's services, and if so, what were these views, and how were they included in design processes? What evidence is there about the impact of integration on the realisation of children's rights?

Part 2: Identifying relevant work

Search Strategy

Electronic databases	Piloting of search strings indicated that evidence relating to integration of social services was spread across a range of journals and publishing houses. We will search SCOPUS which is a large abstract and citation database of peer reviewed literature that contains a large number of social work and

	social policy titles, including key publications relating to: social policy (such as Social Issues and Policy Review, and Policy and Society); public policy and administration (such as Journal of European Public Policy, and Public Administration Review); and Health (such as the International Journal of Health Policy and Management). We will also search ASSIA (Applied Social Science Index and Abstracts) which includes titles related to: social work (such as the British Journal of Social Work and Health and Social Work) and public policy and administration (such as Administration and Society, Behavioural Science & Policy) among others. Between these two databases we would anticipate that all relevant academic journals would be included in our searches.
Other sources	We will also search the Social Care Institute for Excellence (SCIE) online database.
Key search terms	We have created search strings related to three common concepts which will be combined and used for all searches: • Children and young people: ("young people" OR "youth" OR "child" OR "adolescen*") • Social Care: (“social care” OR “health and social care” OR “social services” OR “community care” OR “care in the community”) • Integration/structure: (“integrat*” OR “combin*” OR “coordinat*” OR “co-ordinat*” OR “structure”) We have also created search strings related to four specific concepts that will be appended to the above three concepts to create specific searches relating to: • Rationales for integration: (“rationale” OR “justifi*” OR “reason*” OR “intent*”) • Process of integration: (“process” OR “approach” OR “development”) • Outcomes of integration: (“outcome” OR “achiev*” OR “indicator*” OR “metric* OR “measur*” OR “wellbeing” OR “well-being” OR “safety” OR “protect*”) • Children’s rights: (“children’s rights” OR “UNCRC” OR “united nations convention on the rights of the child” OR “human rights”) Registered date of publication: 2012-2022 Restricted language: English only Restricted Record type: Peer reviewed article
Draft search strategy	We will record the number of publications identified in SCOPUS and ASSIA separately, for each of the four searches conducted (Common concepts + one specific concepts). The full search string for each of the four searches to be conducted is given below: ‘Rationales’: (("young people" OR "youth" OR "child" OR "adolescen*") AND (“social care” OR “health and social care” OR “social services” OR “community care” OR “care in the community”) AND (“integrat*” OR “combin*” OR “coordinat*” OR “co-ordinat*” OR “structure”) AND (“rationale” OR “justifi*” OR “reason*” OR “intent*”)) ‘Process’: (("young people" OR "youth" OR "child" OR "adolescen*") AND (“social care” OR “health and social care” OR “social services” OR “community care” OR “care in the community”) AND (“integrat*” OR

	“combin*” OR “coordinat*” OR “co-ordinat*” OR “structure”) AND (“process” OR “approach” OR “development”)) ‘Outcomes’: (("young people" OR "youth" OR "child" OR "adolescen*") AND (“social care” OR “health and social care” OR “social services” OR “community care” OR “care in the community”) AND (“integrat*” OR “combin*” OR “coordinat*” OR “co-ordinat*” OR “structure”) AND (“outcome” OR “achiev*” OR “indicator*” OR “metric*” OR “measur*” OR “wellbeing” OR “well-being” OR “safety” OR “protect*”))) ‘Rights’: (("young people" OR "youth" OR "child" OR "adolescen*") AND (“social care” OR “health and social care” OR “social services” OR “community care” OR “care in the community”) AND (“integrat*” OR “combin*” OR “coordinat*” OR “co-ordinat*” or “structure”) AND (“children’s rights” OR “UNCRC” OR “united nations convention on the rights of the child” OR “human rights”)) Searches in SCOPUS will be conducted within title/keyword/abstract fields. Searches in ASSIA will be conducted within ‘anywhere except full text’ (this includes searching within title, keywords, abstract as well as other fields such as publication title).

Study selection criteria

Inclusion Criteria	• Studies which focus on the rationales, outcomes, process and rights implications of integration of services (as defined in the research questions) • Based at least in part in High Income Countries (as defined by World Bank) • English language only • Quantitative, qualitative, mixed/multi-methods empirical research and systematic reviews only • Years: Published in 2012-2021 inclusive • Journal Articles
Exclusion Criteria	• Studies that do not include any social care services relating to children and their families • Non-English language texts • Unpublished material • Non-peer reviewed material • Historical accounts. Autobiographies. Non-empirical work Studies published prior to 2012
Process of study selection	The process will begin by using the search strings identified in the databases identified, which will be de-duplicated (using title and author fields) to create a collection of primary papers. We will then exclude papers on the basis of a title, abstract, and keyword review. All titles and abstracts will be double reviewed, blind to other reviewers’ findings. Where disagreements arise, these will be resolved through discussion with a third reviewer. We will then move to reviewing the full texts on the same criteria. This will produce the final list of studies included for synthesis.

Study records

Data collection	One person will extract the relevant lists of studies identified through the search strings on SCOPUS and ASSIA, downloading the data in a RIS format.
Data management process	Search results will be imported into Zotero reference management software for de-duplication. The de-duplicated list will then be split into groups and exported to Excel to allow for reviewing of title and abstract. Studies included as a result of this process will be identified and placed in a specific collection within Zotero, and full texts will be sourced. Data from the full text review and data extraction will be recorded in shared excel sheets.
Data items	The following data will be extracted from each study: • DOI • Authors • Journal • Publication year • Country/location being studied/reported on • Study Design • Methods of data collection and analysis • Sample, and any reasons given for exclusion • Ethical issues • Identified strengths and limitations Findings in relation to overarching research question and all sub-questions. A separate proforma form will be used specifically relating to the research questions to inform thematic synthesis. We anticipate that the majority of data collected in this review will be qualitative. However, quantitative data may be available regarding a range of outcomes of integration for children, their families and the workforce and the impact of integration on service provision. Where outcome measures or indicators are used or referred to, we will also capture also these as they may inform subsequent strands of the research.
Outcomes and prioritisation	The review will deliver a clear articulation of what evidence is available relating to the rationales, process, and outcomes of integration of children's social services, as well as how integration relates to the rights of children and young people.

Part 3: Risk of bias assessment

Risk of bias assessment criteria	As the review will include qualitative, mixed-methods, and quantitative empirical studies, the Mixed Methods Appraisal Tool (MMAT) will be used. This tool provides an algorithm for selecting the study categories to rate within the MMAT for different study designs. This will provide the reviewer with at least 5 appraisal items to rate the study on. The results of this appraisal will be recorded in a descriptive section highlighting the relative strengths and weaknesses of the included literature, as well as detailed alongside each study in a table included as an appendix.
Purpose of risk of bias assessment	The risk of bias assessment will be used to assess the strength of inferences and make recommendations for future research.

Part 4: Summarising the evidence

Data synthesis	An overview of the literature returned during exploratory searches, as well as the nature of the research questions indicates that there will be few studies with experimental or quasi-experimental research designs, and as such meta-analysis will not be possible or appropriate. Following Biesty et al.'s (2020) article reflecting on their approach to a rapid Qualitative Evidence Synthesis on COVID-19 interventions, the summary will be in the form of a thematic synthesis using a 'best fit' framework approach. This synthesis method is recommended for tight timeframes, and has been used in a variety of prior rapid reviews. The method involves the preliminary identification of important themes or concepts against which to map findings from included studies, potentially from a pre-existing model identified from the literature. As the study develops, more themes can be added, building on the existing framework. These themes are used to analyse and synthesise the included research by identifying and extracting findings in each study which fall under these themes (analysis), and then synthesising the evidence in the text body of the review and in table format. Data to be extracted can take the form of verbatim quotes from the literature, or summaries of findings relevant to the research questions created by the reviewer during full-text review where the relevant information is too disperse within the paper and quotation would be excessively long (>200 words). Synthesis will be conducted simultaneously, and iteratively, with the review and data extraction process. The main body of the synthesis will be in the form of written text synthesising the findings under each theme, the range and quality of evidence, and commenting on the quality of the body of evidence. A table will also be included citing the studies that supported the findings under each research question and theme.
Meta-bias(es)	We do not anticipate conducting any assessment of publication bias.
Confidence in cumulative evidence	We will assess the confidence in the evidence collated through this review using the Confidence in Evidence from Reviews of Qualitative research (GRADE-CERQual), which examines the methodological limitations, coherence, adequacy of data, and relevance and assesses overall confidence in the findings.
Reporting	The final report will include: a brief overview of the context; outline the methodology; provide an in-depth results section focusing on the rationale, process, outcomes, and rights implications of integration; discuss the strengths and limitations of the review process; and include a discussion of the implications of the findings for policy, practice and future research in Scotland. We will also publish a shorter summary report which will be designed for a range of non-specialist audiences.

Personnel

Dr Heather Ottaway and Dr Robert Porter will be leading the work, with support from Emma Young, Kate Mackinnon, Dr Leanne McIver and Dr Nadine Fowler. The review will further be supported by a steering group led by Prof. Brigid Daniel, Professor Emerita at Queen Margaret University, Edinburgh.

References

This protocol was created with reference to the following:

Atun, R., de Jongh, T., Secci, F., Ohiri, K., & Adeyi, O. (2010). ‘A systematic review of the evidence on integration of targeted health interventions into health systems’, *Health Policy and Planning*, 25(1): 1–14. https://doi.org/10.1093/heapol/czp053

Biesty, L., Meskell, P., Glenton, C., Delaney, H., Smalle, M., Booth, A., ... & Houghton, C. (2020). ‘A QuESt for speed: rapid qualitative evidence syntheses as a response to the COVID-19 pandemic’, *Systematic reviews*, 9(1): 1-6.

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Hong, Q. N., Pluye, P., Fabregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M.-P., Griffiths, F., Nicolau, B., O’Cathain, A., Rousseau, M.-C., & Vedel, I. (2018). *Mixed Methods Appraisal Tool (MMAT)*. http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf

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Appendix 2: Data Extraction Tool

Section 1: About the Paper

Question 1

Who is completing this review?

- ☐ Emma
- ☐ Heather
- ☐ Kate
- ☐ Leanne
- ☐ Nadine
- ☐ Robert

Question 2

Authors (you may copy and paste from the original paper)

Question 3

Paper title

Question 4

Is the paper published in a peer-reviewed journal?

- ☐ Yes
- ☐ No

Question 5

Year of publication (YYYY)

[If the year of publication is less than 2012, skip to Question 31]

Question 6

Is the paper based on:

- ☐ Primary Research
- ☐ Secondary data analysis
- ☐ Systematic Literature Review
- ☐ Secondary review (not using systematic review methodology)
- ☐ Descriptive account/Opinion piece
- ☐ Other

[If the answer to Question 6 is 'Primary Research', display MMAT questions after Question 9]

Question 7

Does/is the paper:

Written in English
AND
Full text available
AND
Have a focus on the rationales, outcomes, process, and rights implications of integration of services
AND
Based at least in part on a high income country
AND
An empirical study (qualitative, quantitative, or mixed methods) OR a systematic review OR other published literature review (scoping review, etc.)?

- ☐ Yes
- ☐ No

[If the answer to Question 7 is 'No', skip to Question 31]

Question 8

Does the paper include a discussion of at least one of the following areas of integration?

Rationale: Reasoning, motivation, expected outcomes, cost rationales, relevance
Outcomes: Availability of services, quality of services, timeliness of services, cost of services, relevance of services, user satisfaction, child & family wellbeing, child safety, child protection
Process: How was integration organised, how was the process of integration experienced.
Rights: Impact, implications, or changes to children's rights

- ☐ Yes
- ☐ No

[If the answer to Question 8 is 'No', skip to Question 31]

Question 9

Which high-income country geographical regions is the research conducted in?

- ☐ SCOTLAND
- ☐ UK (Other)
- ☐ AFRICA (Seychelles)
- ☐ ASIA (Bahrain, Brunei Darussalam, Guam, Hong Kong, Japan, Kuwait, South Korea, Macao, Oman, Qatar, Saudi Arabia, Singapore, Taiwan, United Arab Emirates)
- ☐ EUROPE (Non-UK) (Andorra, Austria, Belgium, Channel Islands, Croatia; Cyprus, Czech Republic, Denmark, Estonia, Faroe Islands, Finland, France, Germany, Gibraltar, Greece, Hungary, Iceland, Ireland, Isle of Man, Israel, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland)
- ☐ LATIN AMERICA AND THE CARIBBEAN (Antigua and Barbuda, Aruba, The Bahamas, Barbados, Bermuda, British virgin Islands, Cayman Islands, Chile, Curacao, Puerto Rico, Sint Maarten/St. Martin, St Kitts & Nevis, Trinidad and Tobago, Turks and Caicos Islands, Uruguay, Virgin Islands)
- ☐ NORTHERN AMERICA (Canada, Greenland, United States)
- ☐ OCEANIA (Australia, French Polynesia, Guam, Nauru, New Caledonia, New Zealand, Northern Mariana Islands)
- ☐ None of the above

[After Question 9, researchers were directed to answer the MMAT questions if (a) the paper they were reviewing was based on 'Primary Research' (as per Question 6) and, (b) the paper met the criteria for inclusion. They then resumed extracting data from the included papers from Question 10 onwards]

Section 2: Findings

Question 10

In your own words, using bullet points, please provide **a summary of the key focus/findings/arguments/discussions/conclusions**, and their relevance to our research questions.

Please provide specific, direct, and short responses here to help with reviewing this information at a later stage.

Question 11

Where primary or secondary data was gathered, what data collection methods have been used? (select all that apply)

- ☐ Interview
- ☐ Focus Group
- ☐ Survey
- ☐ Observation
- ☐ Documentary Review
- ☐ Systematic or Secondary Literature Review
- ☐ Other
- ☐ N/A

Question 12

What groups were included within the research (please select all that apply)

- ☐ Infants (0-2 years)
- ☐ Young Children (3-7 years)
- ☐ Older Children (8-12 years)
- ☐ Young People (13-18 years)
- ☐ Parents/Carers
- ☐ Other Family Members
- ☐ Education Practitioners
- ☐ Health Practitioners
- ☐ Social Work Practitioners
- ☐ Policy/Government Officials
- ☐ Other (please describe)
- ☐ N/A

Question 13

Please describe, in detail, the **methods and methodology** used by the authors of this paper.

Include, where appropriate, sample size, demographics, recruitment techniques and any inclusion/exclusion criteria that had to be met.

Question 14

What child and/or young person needs or circumstances were identified?

- ☐ Maltreatment (neglect and/or abuse)
- ☐ Child/Adolescent physical health need
- ☐ Child/Adolescent mental health need
- ☐ Homelessness
- ☐ Learning disability and/or difficulty
- ☐ Asylum seeking or refugee
- ☐ Parental physical health need
- ☐ Parental mental health need
- ☐ Not specified
- ☐ Other (please describe)

Question 15

Is 'social care' specifically defined in the paper?

Consider social care for children and for adults.

- ☐ Yes
- ☐ No

Question 16

Please describe how 'social care' is defined or interpreted in the paper?

Please use the terminology of the authors, where possible, and/or your own description.

Question 17

What services or types of services are discussed in the paper?

You can include high-level descriptions (such as education, health, social work, etc.) and/or more specific descriptions (such as youth clubs, FASD support, obesity management, CAMHS, etc.).

This question will help us to establish a definition of 'social care' services in our review.

Question 18

Were any of the following relating to health and social care integration discussed in this paper (select all that apply)

- ☐ Rationales for integration
- ☐ Service quality
- ☐ Service cost
- ☐ Service user satisfaction
- ☐ Child and/or young person safety and/or protection
- ☐ Outcomes for children and young people
- ☐ Challenges and/or enablers of integration
- ☐ Impact of integration of workforce (i.e. resources, skills, training, retainment, costs etc.)
- ☐ Service user participation in process of integration
- ☐ Children and/or young people's experiences of integration
- ☐ Parents and/or carers experiences of integration
- ☐ Practitioner and/or service providers experiences of integration
- ☐ Models of integration

Question 19

Is 'integration' specifically defined in the paper?

- ☐ Yes
- ☐ No

Question 20

Please describe how 'integration' is defined or interpreted in the paper?

Please use the terminology of the authors, where possible, and/or your own description.

Question 21

To what extent does this paper contribute to answering the research questions on **Rationale**?

Research Question (a) What are the evidenced rationales for integration (or not) of children's services within national health and social care contexts?

- ☐ A lot
- ☐ Somewhat
- ☐ Not at all

Question 22

Please describe what the authors have written about **Rationale**, and reflect on how the paper answers the research questions on **Rationale**.

Question 23

To what extent does this paper contribute to answering the research questions on **Outcomes**?

Research Question (c) How and in what ways does integration affect the availability, quality, timeliness, cost and relevance of health and social care services for children and their families support, and satisfaction with these services?
Research Question (d) Do integrated children's services improve outcomes for children, young people and their families?
Research Question (e) How and in what ways do different integrated models of children's services impact on the workforce?
Research Question (g) What evidence is there about the impact of integration on the realisation of children's rights.

- ☐ A lot
- ☐ Somewhat
- ☐ Not at all

Question 24

Please describe what the authors have written about **Outcomes**, and reflect on how the paper answers the research questions on **Outcomes**.

Question 25

To what extent does this paper contribute to answering the research questions on **Process**?

Research Question (b) What evidence is available which informs understanding of the challenges, enablers, and experience of integrating children's services with health and/or adult social care?
Research Question (e) How and in what ways do different integrated models of children's services impact on the workforce?
Research Question (f) Were the views of children, young people and their families/carers sought prior to or during the integration of children's services, and if so, how were their views included in the design process?

- ☐ A lot
- ☐ Somewhat
- ☐ Not at all

Question 26

Please describe what the authors have written about **Process**, and reflect on how the paper answers the research questions on **Process**.

Question 27

To what extent does this paper contribute to answering the research questions on **Rights**?

- ☐ A lot
- ☐ Somewhat
- ☐ Not at all

Question 28

Please describe what the authors have written about **Rights**, and reflect on how the paper answers the research questions on **Rights**.

Research Question (f) Were the views of children, young people and their families/carers sought prior to or during the integration of children's services, and if so, how were their views included in the design process?
Research Question (g) What evidence is there about the impact of integration on the realisation of children's rights.

Question 29

Please summarise the **strengths and weaknesses** of this paper, as highlighted by the authors themselves.

You may want to focus on how the authors describe their unique contribution to this field of study, or the limitations of their research.

Question 30

Please note any findings which are of relevance to the review but have not been included elsewhere.

[End of survey]

[Only papers that were excluded from the review because they did not meet the inclusion criteria (based on answers to Question 5, 7 and 8), were shown Question 31]

Question 31

Please provide any reflections about why this paper does not meet the inclusion criteria here.

[End of survey]

Appendix 3: MMAT Questionnaire

Section 1: MMAT Screening Questions

Question 1.1

Are there clear research questions?

- ☐ Yes
- ☐ No
- ☐ Can't Tell
- ☐ Comments

Question 1.2

Do the collected data allow to address the research question?

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comments

Question 1.3

What category of research does the study fall into?

- ☐ Qualitative (Case study, ethnography, grounded theory, interpretive description, narrative research, phenomenology, qualitative description)
- ☐ Quantitative
- ☐ Mixed methods

[The answer to Question 3 directed researchers to the appropriate MMAT sections. For instance, if the answer to Question 3 was 'Qualitative', researchers progressed to Section 2: Qualitative Questions, and did not answer questions related to Sections 3, 4, 5 or 6. If the answer to Question 3 was 'Quantitative', researchers progressed to Question 1.4, before progressing to Section 3, 4 or 5]

Question 1.4

Does the study have a comparison of outcomes between interventions/exposures?

- ☐ Yes
- ☐ No

[If the answer to Question 1.4 is 'No', display Section 5. If the answer to Question 1.4 is 'Yes', progress to Question 1.5]

Question 1.5

Do researchers assign interventions/exposures?

- ☐ Yes
- ☐ No

[If the answer to Question 1.5 is 'No', display Section 4. If the answer to Question 1.5 is 'Yes', progress to Question 1.6]

Question 1.6

Is more than one group studied?

- ☐ Yes
- ☐ No

[If the answer to Question 1.6 is 'No', display Section 4. If the answer to Question 1.6 is 'Yes', progress to Question 1.7]

Question 1.7

Is there random allocation?

- ☐ Yes
- ☐ No

[If the answer to Question 1.7 is 'No', display Section 4. If the answer to Question 1.7 is 'Yes', display Section 3]

Section 2: Qualitative Questions

Question 2.1

Is the qualitative approach appropriate to answer the research question?

The qualitative approach used in a study should be appropriate for the research question and problem. For example, the use of a grounded theory approach should address the development of a theory and ethnography should study human cultures and societies.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 2.2

Are the qualitative data collection methods adequate to address the research?

This criterion is related to data collection method, including data sources (e.g., archives, documents), used to address the research question. To judge this criterion, consider whether the method of data collection (e.g., in depth interviews and/or group interviews, and/or observations) and the form of the data (e.g., tape recording, video material, diary, photo, and/or field notes) are adequate. Also, clear justifications are needed when data collection methods are modified during the study.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 2.3

Are the findings adequately derived from the data?

This criterion is related to the data analysis used. Several data analysis methods have been developed and their use depends on the research question and qualitative approach. For example, open, axial and selective coding is often associated with grounded theory, and within- and cross-case analysis is often seen in case study.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 2.4

Is the interpretation of results sufficiently substantiated by data?

The interpretation of results should be supported by the data collected. For example, the quotes provided to justify the themes should be adequate.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 2.5

Is there coherence between qualitative data sources, collection, analysis and interpretation?

There should be clear links between data sources, collection, analysis and interpretation.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Section 3: Quantitative Randomised Control Trial

Question 3.1

Is randomisation appropriately performed?

In a randomized controlled trial, the allocation of a participant (or a data collection unit, e.g., a school) into the intervention or control group is based solely on chance. Researchers should describe how the randomization schedule was generated. A simple statement such as 'we randomly allocated' or 'using a randomized design' is insufficient to judge if randomization was appropriately performed. Also, assignment that is predictable such as using odd and even record numbers or dates is not appropriate. At minimum, a simple allocation (or unrestricted allocation) should be performed by following a predetermined plan/sequence. It is usually achieved by referring to a published list of random numbers, or to a list of random assignments generated by a computer.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 3.2

Are the groups comparable at baseline?

Baseline imbalance between groups suggests that there are problems with the randomization. Indicators from baseline imbalance include: "(1) unusually large differences between intervention group sizes; (2) a substantial excess in statistically significant differences in baseline characteristics than would be expected by chance alone; (3) imbalance in key prognostic factors (or baseline measures of outcome variables) that are unlikely to be due to chance; (4) excessive similarity in baseline characteristics that is not compatible with chance; (5) surprising absence of one or more key characteristics that would be expected to be reported" (Higgins et al., 2016, p. 10).

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 3.3

Are there complete outcome data?

Almost all the participants contributed to almost all measures. There is no absolute and standard cut-off value for acceptable complete outcome data. Agree among your team what is considered complete outcome data in your field and apply this uniformly across all the included studies. For instance, in the literature, acceptable complete data value ranged from 80% (Thomas et al., 2004; Zaza et al., 2000) to 95% (Higgins et al., 2016). Similarly, different acceptable withdrawal/dropouts rates have been suggested: 5% (de Vet et al., 1997; MacLehose et al., 2000), 20% (Sindhu et al., 1997; Van Tulder et al., 2003) and 30% for a follow-up of more than one year (Viswanathan and Berkman, 2012).

☐ Yes
☐ No
☐ Can't tell
☐ Comment

Question 3.4

Are outcome assessors blinded to the intervention provided?

Outcome assessors should be unaware of who is receiving which interventions. The assessors can be the participants if using participant reported outcome (e.g., pain), the intervention provider (e.g., clinical exam), or other persons not involved in the intervention (Higgins et al., 2016).

☐ Yes
☐ No
☐ Can't tell
☐ Comment

Question 3.5

Did the participants adhere to the assigned intervention?

To judge this criterion, consider the proportion of participants who continued with their assigned intervention throughout follow-up. “Lack of adherence includes imperfect compliance, cessation of intervention, crossovers to the comparator intervention and switches to another active intervention.” (Higgins et al., 2016, p. 25).

☐ Yes
☐ No
☐ Can't tell
☐ Comment

Section 4: Quantitative Non-randomised

Question 4.1

Are the participants representative of the target population?

Indicators of representativeness include: clear description of the target population and of the sample (inclusion and exclusion criteria), reasons why certain eligible individuals chose not to participate, and any attempts to achieve a sample of participants that represents the target population.

☐ Yes
☐ No
☐ Can't tell
☐ Comment

Question 4.2

Are measurements appropriate regarding both the outcome and intervention (or exposure)?

Indicators of appropriate measurements include: the variables are clearly defined and accurately measured; the measurements are justified and appropriate for answering the research question; the measurements reflect what they are supposed to measure; validated and reliability tested measures of the intervention/exposure and outcome of interest are used, or variables are measured using ‘gold standard’.

☐ Yes
☐ No
☐ Can't tell
☐ Comment

Question 4.3

Are there complete outcome data?

Almost all the participants contributed to almost all measures. There is no absolute and standard cut-off value for acceptable complete outcome data. Agree among your team what is considered complete outcome data in your field (and based on the targeted journal) and apply this uniformly across all the included studies. For example, in the literature, acceptable complete data value ranged from 80% (Thomas et al., 2004; Zaza et al., 2000) to 95% (Higgins et al., 2016). Similarly, different acceptable withdrawal/dropouts rates have been suggested: 5% (de Vet et al., 1997; MacLehose et al., 2000), 20% (Sindhu et al., 1997; Van Tulder et al., 2003) and 30% for follow-up of more than one year (Viswanathan and Berkman, 2012).

☐ Yes
☐ No
☐ Can't tell
☐ Comment

Question 4.4

Are the confounders accounted for in the design and analysis?

Confounders are factors that predict both the outcome of interest and the intervention received/exposure at baseline. They can distort the interpretation of findings and need to be considered in the design and analysis of a non-randomized study. Confounding bias is low if there is no confounding expected, or appropriate methods to control for confounders are used (such as stratification, regression, matching, standardization, and inverse probability weighting).

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 4.5

During the study period, is the intervention administered (or exposure occurred) as intended?

For intervention studies, consider whether the participants were treated in a way that is consistent with the planned intervention. Since the intervention is assigned by researchers, consider whether there was a presence of contamination (e.g., the control group may be indirectly exposed to the intervention) or whether unplanned co-interventions were present in one group (Sterne et al., 2016). For observational studies, consider whether changes occurred in the exposure status among the participants. If yes, check if these changes are likely to influence the outcome of interest, were adjusted for, or whether unplanned co-exposures were present in one group (Morgan et al., 2020).

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Section 5: Quantitative Descriptive

[Section 5 was completed for any paper that employed quantitative methods, including those that met the criteria for either Section 3, 4 or 6]

Question 5.1

Is the sampling strategy relevant to address the research question?

Sampling strategy refers to the way the sample was selected. There are two main categories of sampling strategies: probability sampling (involve random selection) and non-probability sampling. Depending on the research question, probability sampling might be preferable. Non- probability sampling does not provide equal chance of being selected. To judge this criterion, consider whether the source of sample is relevant to the target population; a clear justification of the sample frame used is provided; or the sampling procedure is adequate.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 5.2

Is the sample representative of the target population?

There should be a match between respondents and the target population. Indicators of representativeness include: clear description of the target population and of the sample (such as respective sizes and inclusion and exclusion criteria), reasons why certain eligible individuals chose not to participate, and any attempts to achieve a sample of participants that represents the target population.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 5.3

Are the measurements appropriate?

Indicators of appropriate measurements include: the variables are clearly defined and accurately measured, the measurements are justified and appropriate for answering the research question; the measurements reflect what they are supposed to measure; validated and reliability tested measures of the outcome of interest are used, variables are measured using ‘gold standard’, or questionnaires are pre-tested prior to data collection.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 5.4

Is the risk of nonresponse bias low?

Nonresponse bias consists of “an error of non-observation reflecting an unsuccessful attempt to obtain the desired information from an eligible unit.” (Federal Committee on Statistical Methodology, 2001, p. 6). To judge this criterion, consider whether the respondents and non- respondents are different on the variable of interest. This information might not always be reported in a paper. Some indicators of low nonresponse bias can be considered such as a low nonresponse rate, reasons for nonresponse (e.g., noncontacts vs. refusals), and statistical compensation for nonresponse (e.g., imputation). The nonresponse bias is might not be pertinent for case series and case report.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 5.5

Is the statistical analysis appropriate to answer the research question?

The statistical analyses used should be clearly stated and justified in order to judge if they are appropriate for the design and research question, and if any problems with data analysis limited the interpretation of the results.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Section 6: Mixed Methods

Question 6.1

Is there an adequate rationale for using a mixed methods design to address the research question?

The reasons for conducting a mixed methods study should be clearly explained. Several reasons can be invoked such as to enhance or build upon qualitative findings with quantitative results and vice versa; to provide a comprehensive and complete understanding of a phenomenon or to develop and test instruments (Bryman, 2006).

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 6.2

Are the different components of the study effectively integrated to answer the research question?

Integration is a core component of mixed methods research and is defined as the "explicit interrelating of the quantitative and qualitative component in a mixed methods study" (Plano Clark and Ivankova, 2015, p. 40). Look for information on how qualitative and quantitative phases, results, and data were integrated (Pluye et al., 2018). For instance, how data gathered by both research methods was brought together to form a complete picture (e.g., joint displays) and when integration occurred (e.g., during the data collection-analysis or/and during the interpretation of qualitative and quantitative results).

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 6.3

Are the outputs of the integration of qualitative and quantitative components adequately interpreted?

This criterion is related to meta-inference, which is defined as the overall interpretations derived from integrating qualitative and quantitative findings (Teddlie and Tashakkori, 2009). Meta-inference occurs during the interpretation of the findings from the integration of the qualitative and quantitative components, and shows the added value of conducting a mixed methods study rather than having two separate studies.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 6.4

Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?

When integrating the findings from the qualitative and quantitative components, divergences and inconsistencies (also called conflicts, contradictions, discordances, discrepancies, and dissonances) can be found. It is not sufficient to only report the divergences; they need to be explained. Different strategies to address the divergences have been suggested such as reconciliation, initiation, bracketing and exclusion (Pluye et al., 2009b). Rate this criterion 'Yes' if there is no divergence.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

Question 6.5

Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?

The quality of the qualitative and quantitative components should be individually appraised to ensure that no important threats to trustworthiness are present. The quality of both components should be high for the mixed methods study to be considered of good quality. The premise is that the overall quality of a mixed methods study cannot exceed the quality of its weakest component. For example, if the quantitative component is rated high quality and the qualitative component is rated low quality, the overall rating for this criterion will be of low quality.

- ☐ Yes
- ☐ No
- ☐ Can't tell
- ☐ Comment

[After answering Questions 6.1 to 6.5, researchers were directed to answer the qualitative questions in Section 2. Upon completing the qualitative questions in Section 2, researchers were asked Question 6.6 to determine the appropriate quantitative questions to be displayed]

Question 6.6

What is the quantitative element of the mixed methods?

- ☐ Randomised controlled trial
- ☐ Non-randomised study
- ☐ Quantitative descriptive study

[The answer to Question 6.6 directed researchers to the appropriate quantitative questions. If the answer to Question 6.6 was 'Randomised controlled trial', Section 3 was displayed. If the answer to Question 6.6 was 'Non-randomised study', Section 4 was displayed. If the answer to Question 6.6 was 'Quantitative descriptive study', Section 5 was displayed]

[End of survey]

The MMAT Questionnaire presented here was adapted from the *Mixed Methods Appraisal Tool (MMAT) Version 2018: User guide* (Hong et al., 2018), available here.

Appendix 4: Coding Structure

A total of seven high-level codes and 89 sub-codes were developed in NVivo to aid the analysis of the data captured using Appendix 2: Data Extraction Tool.

High-level codes	Sub-codes
Experiences of integration	Children and young people's perspectives Culture clashes between organisations or services Experienced or perceived barriers and facilitators How families experience integration How the workforce experiences integration
How integration is done	Lead agencies Models of integration Settings Timings Training What is involved AND/OR Principles of integration in practice Who is involved • Coordinator OR Broker OR Trusted person role
Impact of integration	Facilitators of impact Impact on workforce • Negative impacts • Positive impacts Limiters of impact Measured or achieved outcomes for children and families
Impact of integration on rights	Inclusive approaches Inequalities Empowering families Rights - Children Rights - General Rights - Parental
Integration at different levels	Impacts of service exclusion Individuals Influence of structural integration on outcomes Integration at different levels - Individual Integration at different levels - National Integration at different levels - Organisational Integration at different levels - Teams

High-level codes	Sub-codes
	Links between integration at different levels
Outcomes	Access to services Change in service demand or delivery Children and young peoples' experiences Experience of families Financial savings Improved collaboration or co-location Leadership Measuring service outcomes Practice Quality of service delivery Service users Timeliness of service delivery
Rationales for integration	Cost Evidence base Importing models Lack of rational Service improvement Access to services Improving lives • Improving lives • Meeting needs • Improving communities
What works in integration	Systemic barriers Systemic facilitators Group specificity Locations What works at different levels

Appendix 5: MMAT scores for all papers

Complete MMAT Scores: Papers 1-15

	Paper Codes														
Questions	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Overall Rating	80%	100%	80%	20%	100%	80%	60%	100%	40%	100%	100%	100%	100%	100%	100%
Q2.1	1	1	1	3	1	1	1		1	1		1	1	1	1
Q2.2	1	1	1	3	1	1	1		1	1		1	1	1	1
Q2.3	1	1	1	3	1	1	3		3	1		1	1	1	1
Q2.4	1	1	3	3	1	1	3		3	1		1	1	1	1
Q2.5	1	1	1	1	1	1	1		3	1		1	1	1	1
Q3.1															
Q3.2															
Q3.3															
Q3.4															
Q3.5															
Q4.1	1				1	1	1	1	1						
Q4.2	1				1	1	1	1	1						
Q4.3	1				1	1	1	1	3						
Q4.4	0				1	1	1	0	3						
Q4.5	1				1	1	3	1	3						
Q5.1	1				1	1	1		1					1	
Q5.2	1				1	1	1		3					1	
Q5.3	1				1	1	1		3					1	
Q5.4	1				1	3	1		3					1	
Q5.5	1				1	1	1		1					1	
Q6.1											1			1	
Q6.2											1			1	
Q6.3											1			1	
Q6.4											1			1	
Q6.5											1			1	

Complete MMAT Scores: Papers 16-32

	Paper Codes																
Questions	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Overall Rating	40%	100%	100	20%	100%	60%	100%	60%	40%	N/A	20%	60%	40%	60%	N/A	N/A	100%
Q2.1			1	3	1	3	1		1		3	1	1	1			
Q2.2			1	3	1	1	1	1	1		3	1	1	1			
Q2.3			1	3	1	1	1	1	3		3	1	3	3			
Q2.4			1	1	1	1	1	3	3		0	1	3	3			
Q2.5			1	3	1	3	1	1	3		1	1	3	1			
Q3.1	1																
Q3.2	1																
Q3.3	0																
Q3.4	3																
Q3.5	3																
Q4.1		1	1					1			0						
Q4.2		1	1					3			3						
Q4.3		1	1					1			0						
Q4.4		1	1					3			3						
Q4.5		1	1					1			3						
Q5.1			1					1			1	1					
Q5.2			1					1			3	3					
Q5.3			1					1			3	1					
Q5.4			1					1			3	1					
Q5.5			1					1			3	1					
Q6.1												1					1
Q6.2												1					1
Q6.3												1					1
Q6.4												0					1
Q6.5												0					1

Complete MMAT Scores: Papers 33-49

	Paper Codes																
Questions	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49
Overall Rating	N/A	40%	100%	0%	80%	100%	100	100%	100%	100%	100	N/A	N/A	80%	60%	60%	60%
Q2.1			1	1	1	1		1	1	1	1			3			
Q2.2			1	1	1	1		1	1	1	1			1			
Q2.3			1	3	1	1		1	1	1	1			1			
Q2.4			1	3	1	1		1	1	1	1			1			
Q2.5			1	3	1	1		1	1	1	1			1			
Q3.1																	
Q3.2																	
Q3.3																	
Q3.4																	
Q3.5																	
Q4.1				3	1										1	1	1
Q4.2				3	1										3	3	3
Q4.3				3	1										1	1	1
Q4.4				3	3										3	3	3
Q4.5				3	1										1	1	1
Q5.1				3	1												
Q5.2				1	1												
Q5.3				3	1												
Q5.4				1	1												
Q5.5				3	1												
Q6.1		3					1										
Q6.2		1					1										
Q6.3		0					1										
Q6.4		0					1										
Q6.5		1					1										

Complete MMAT Scores: Papers 50-65

	Paper Codes															
Questions	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65
Overall Rating	60%	80%	100%	100%	100%	80%	N/A	100%	N/A	N/A	100%	60%	100%	100%	N/A	20%
Q2.1	1	1	1	1	1	1					1					1
Q2.2	1	1	1	1	1	1					1					3
Q2.3	1	3	1	1	1	1					1					3
Q2.4	1	1	1	1	1	3					0					3
Q2.5	1	1	1	1	1	1					1					3
Q3.1												3	1			
Q3.2												1	1			
Q3.3												1	1			
Q3.4												1	0			
Q3.5												0	1			
Q4.1	1							1						1		
Q4.2	1							1						1		
Q4.3	1							1						1		
Q4.4	3							1						1		
Q4.5	1							1						1		
Q5.1	1															1
Q5.2	1															0
Q5.3	0															0
Q5.4	3															3
Q5.5	1															3
Q6.1																1
Q6.2																1
Q6.3																1
Q6.4																0
Q6.5																1

Complete MMAT Scores: Papers 66-81

	Paper Codes															
Questions	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81
Overall Rating	60%	N/A	N/A	100%	N/A	20%	N/A	N/A	40%	80%	100%	80%	100%	100%	100%	N/A
Q2.1	3			1		3					1	1	1	1	1	
Q2.2	3			1		1					1	1	1	1	1	
Q2.3	1			1		3					1	1	1	1	1	
Q2.4	1			1		3					1	3	1	1	0	
Q2.5	1			1		3					1	1	1	1	0	
Q3.1																
Q3.2																
Q3.3																
Q3.4																
Q3.5																
Q4.1									3	1						
Q4.2									3	1						
Q4.3									1	1						
Q4.4									3	3						
Q4.5									1	1						
Q5.1																
Q5.2																
Q5.3																
Q5.4																
Q5.5																
Q6.1																
Q6.2																
Q6.3																
Q6.4																
Q6.5																

Complete MMAT Scores: Papers 82-87

	Paper Codes					
Questions	82	83	84	85	86	87
Overall Rating	100%	100%	100%	100%	40%	80%
Q2.1	1		1	1	1	
Q2.2	1		1	1	1	
Q2.3	1		1	1	1	
Q2.4	1		1	1	3	
Q2.5	1		1	1	3	
Q3.1						
Q3.2						
Q3.3						
Q3.4						
Q3.5						
Q4.1		1	1			
Q4.2		1	1			
Q4.3		1	1			
Q4.4		1	1			
Q4.5		1	1			
Q5.1			1		1	
Q5.2			1		3	
Q5.3			1		3	
Q5.4			1		3	
Q5.5			1		1	
Q6.1						1
Q6.2						1
Q6.3						1
Q6.4						3
Q6.5						1

Appendix 6: Data table for included sources

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
1	Peer Reviewed	Primary Research	Interview Survey	Education practitioners Health practitioners Social work practitioners	202	0	UK (Other)	Rationales Processes Experiences Outcomes
2	Peer Reviewed	Primary Research	Interview	Health practitioners Social work practitioners Other	61	0	UK (Other)	Processes Experiences Levels Outcomes
3	Peer Reviewed	Primary Research	Interview Other	Health practitioners Social work practitioners Policy / government officials	Not stated	0	Scotland North America	Experiences Levels
4	Peer Reviewed	Primary Research	Other	Young people	0	2 Young people	North America	Processes Experiences
5	Grey Literature	Primary Research	Interview Focus Group Observation	Young people Parents / carers Health practitioners	17	10 Young people 12 Parents	UK (Other)	Experiences Outcomes

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
				Social work practitioners Other				
6	Grey Literature	Primary Research	Interview Focus Group Survey Documentary Review	Young people Health practitioners	Not stated	90 Young people (focus groups) 1624 Young people (survey)	UK (Other)	Processes Experiences Outcomes
7	Peer Reviewed	Primary Research	Survey	Parents / carers	0	148 Parents	North America	Rationales Processes Experiences Levels Outcomes Rights
8	Peer Reviewed	Primary Research	Survey	Health practitioners Social work practitioners	1596	0	Europe (Non-UK)	Processes Levels
9	Peer Reviewed	Primary Research	Interview Focus Group Survey Documentary Review	Policy / government officials Other	52	0	Oceania	Rationales Processes Experiences Outcomes Rights

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
10	Peer Reviewed	Primary Research	Interview Focus Group	Health practitioner Social work practitioners	38	0	Oceania	Rationales Processes Experiences Levels Outcomes
11	Peer Reviewed	Primary Research	Secondary Data Analysis		N/A	N/A	North America	Rationales Processes Outcomes
12	Peer Reviewed	Primary Research	Interview Documentary Review	Health practitioners	40	0	North America	Rationales Processes Experiences Levels
13	Peer Reviewed	Primary Research	Interview Focus Group	Health practitioners Social work practitioners	20	0	North America	Rationales Processes Levels
14	Grey Literature	Primary Research	Interview Survey Observation Documentary Review Other	Parents / carers Other	45 (interview) 52 (survey)	20 Young people 5 Parents / carers	UK (Other)	Processes Experiences Levels Outcomes
15	Peer Reviewed	Primary Research	Interview Observation	Health practitioners	36	0	Europe (non-UK)	Processes

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
			Documentary Review	Social work practitioners				
16	Peer Reviewed	Primary Research	Other	N/A	N/A	N/A	North America	Processes Outcomes
17	Peer Reviewed	Primary Research	Survey	Health practitioners Social work practitioners	797	0	Europe (non-UK)	Experiences
18	Grey Literature	Primary Research	Interview Survey Other	Young people Health practitioners Social work practitioners	19 (interviews) 156 (survey)	5 Young people (interview) 10 Young people (advisory group)	UK (Other)	Rationales Processes Experiences Outcomes
19	Grey Literature	Primary Research	Interview Focus Group Survey Observation Documentary Review Other	Young people Parents / carers Social work practitioners	439 (survey) 61 (interview)	78 Parents (survey) 11 Young people	UK (Other)	Processes Experiences Outcomes
20	Peer Reviewed	Primary Research	Interview Focus Group Observation	Other	15 (interviews) 3 focus groups (number of staff at each	0	North America	Experiences Levels Outcomes

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
					focus group is not stated)			
21	Peer Reviewed	Primary Research	Observation	Health practitioners Social work practitioners Education practitioners	0	0	Oceania	Processes Experiences Outcomes
22	Peer Reviewed	Primary Research	Interview Focus Group	Young people Parents / carers Education practitioners Health practitioners Social work practitioners Other	31	14 Young people 7 parents	UK (Other)	Rationales Experiences Rights
23	Peer Reviewed	Primary Research	Focus Group Survey	Education practitioners Health practitioners Social work practitioners Other	7 (survey part 1) 71 (survey part 2) 7 (focus group)	0	Oceania	Processes Experiences
24	Peer Reviewed	Primary Research	Interview	Education practitioners	24	0	Oceania	Rationales Processes

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
				Health practitioners Social work practitioners				Experiences Levels
25	Peer Reviewed	Systematic Literature Review	Systematic or Secondary Literature Review	N/A	N/A	N/A	Oceania	Processes Experiences Levels
26	Peer Reviewed	Primary Research	Survey Documentary Review	Health practitioners Social work practitioners	Not stated	0	North America	Processes
27	Peer Reviewed	Primary Research	Interview Survey	Parents / carers Health practitioners Social work practitioners	4	99 Parents	North America	Processes Experiences
28	Peer Reviewed	Primary Research	Other	N/A	0	0	Europe (non-UK)	Experiences
29	Peer Reviewed	Primary Research	Interview	Other	25	0	Europe (non-UK)	Rationales Processes Experiences

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
30	Peer Reviewed	Systematic Literature Review	Systematic or Secondary Literature Review	N/A	N/A	N/A	UK (other) Asia Europe (non-UK)	Rationales Processes Outcomes
31	Peer Reviewed	Systematic Literature Review	Systematic or Secondary Literature Review	N/A	N/A	N/A	Europe (non-UK)	Outcomes
32	Peer Reviewed	Primary Research	Observation	N/A	0	0	North America	Outcomes
33	Peer Reviewed	Secondary Review (not using systematic review methodology)	Systematic or Secondary Literature Review	N/A	N/A	N/A	North America	Rationales Processes Experiences
34	Peer Reviewed	Primary Research	Survey	Parents	0	1223 Parents	Latin America and the Caribbean North America	Experiences Levels Outcomes
35	Peer Reviewed	Primary Research	Interview Observation	Parents / carers Health practitioners Social work practitioners	45	39 Parents	Oceania	Rationales Processes Experiences Levels Outcomes
36	Peer Reviewed	Primary Research	Interview Survey	Education practitioners	12 (interviews) 120 (survey)	0	UK (Other)	Processes Experiences

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
				Health practitioners Social work practitioners				
37	Peer Reviewed	Primary Research	Interview Survey	Parents / carers	0	3 Parents (interviews) 49 parents (survey)	UK (Other)	Experiences Outcomes Rights
38	Peer Reviewed	Primary Research	Interview Observation Documentary Review	Parents / carers Other	9	4 Parents	Oceania	Processes Experiences Outcomes
39	Peer Reviewed	Primary Research	Interview Observation Documentary Review	Parents / carers	0	68 (survey)	North America	Outcomes
40	Peer Reviewed	Primary Research	Survey	Social work practitioners Other	54	0	Oceania	Processes
41	Peer Reviewed	Primary Research	Focus Group	Social work practitioners Other	28	0	Europe (Non-UK)	Rationales Processes Experiences
42	Peer Reviewed	Primary Research	Interview Focus Group	Education practitioners	26	0	North America	Processes Experiences

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
				Health practitioners Social work practitioners				
43	Peer Reviewed	Primary Research	Focus Group	Education practitioners Health practitioners Social work practitioners Other	23	0	Europe (non-UK)	Rationales Processes Experiences Levels Outcomes Rights
44	Peer Reviewed	Systematic Literature Review	Systematic or Secondary Literature Review	N/A	N/A	N/A	Europe (non-UK) North America Oceania	Processes Experiences Levels Outcomes Rights
45	Peer Reviewed	Systematic Literature Review	Systematic or Secondary Literature Review	N/A	N/A	N/A	UK (other) North America Oceania	Processes Experiences
46	Peer Reviewed	Primary Research	Interview	Other	29	0	UK (other)	Rationales Processes Experiences Levels
47	Peer Reviewed	Primary Research	Interview	Health practitioners	122	0	Europe (non-UK)	

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
				Social work practitioners Policy / government officials				
48	Peer Reviewed	Primary Research	Survey	Health practitioners Social work practitioners	339	0	North America	Processes Experiences
49	Peer Reviewed	Primary Research	Survey	Other	55	0	North America	Experiences
50	Peer Reviewed	Primary Research	Interview Focus Group Documentary Review	Health practitioners	24 (interview) 7 (focus group)	0	UK (Other)	Rationales Processes Experiences Outcomes
51	Peer Reviewed	Primary Research	Interview Focus Group Other	Health practitioners Social work practitioners	30	0	North America	Processes Experiences Levels
52	Peer Reviewed	Primary Research	Interview	Health practitioners Social work practitioners	25	0	UK (Other)	Processes Experiences Levels

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
				Policy / government officials				
53	Peer Reviewed	Primary Research	Interview Observation	Education practitioners Health practitioners Social work practitioners	15 (interview)	0	North America	Processes Experiences Levels Outcomes
54	Peer Reviewed	Primary Research	Interview Focus Group Observation Documentary Review Other	Health practitioners Other	20	0	Oceania	Processes Experiences Levels
55	Peer Reviewed	Primary Research	Interview Focus Group	Education practitioners Health practitioners Social work practitioners	30 (interview) 10 (focus groups)	0	North America	Processes Experiences Levels
56	Grey literature	Other	N/A	N/A	N/A	N/A		Rationales Processes Experiences Levels Outcomes

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
57	Peer Reviewed	Primary Research	Secondary Data Analysis	N/A	N/A	N/A	Europe (non-UK)	Rationales Levels Outcomes
58	Peer Reviewed	Systematic Literature Review	Systematic or Secondary Literature Review	N/A	N/A	N/A	Scotland UK (Other) Africa Europe (non-UK) Latin America and the Caribbean North America Oceania Asia	Processes Experiences Levels
59	Peer Reviewed	Systematic Literature Review	Systematic or Secondary Literature Review	N/A	N/A	N/A	North America	Rationales Experiences Outcomes
60	Peer Reviewed	Primary Research	Interviews	Other	30	0	Oceania	Rationales Processes Experiences
61	Peer Reviewed	Primary Research	Observation	N/A	0	0	North America	Outcomes
62	Peer Reviewed	Primary Research	Observation	N/A	0	0	Europe (non-UK)	Rationales Experiences

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
								Outcomes Rights
63	Peer Reviewed	Primary Research	Survey	Health practitioners Social work practitioners Other	104	0	North America	Rationales Processes Experiences Levels Outcomes
64	Peer Reviewed	Systematic Literature Review	Systematic or Secondary Literature Review	N/A	N/A	N/A	UK (other) Europe (non-UK) North America	Processes Experiences
65	Peer Reviewed	Primary Research	Observation	N/A	0	0	North America	Processes Experiences Outcomes
66	Peer Reviewed	Primary Research	Interview	Health practitioners	23	0	North America	Rationales Processes Experiences Levels
67	Grey Literature	Secondary Review (not using systematic methodology)	Systematic or Secondary Literature Review	N/A	N/A	N/A	Oceania	Rationales Processes Experiences Outcomes

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
68	Grey literature	Systematic Literature Review	Systematic or Secondary Literature Review	N/A	N/A	N/A	Europe (non-UK)	Processes Experiences Levels Outcomes Rights
69	Peer Reviewed	Primary Research	Interview	Social work practitioners Other	22	0	North America	Processes Experiences Outcomes
70	Peer Reviewed	Secondary Review (not using systematic review methodology)	Systematic or Secondary Literature Review	N/A	N/A	N/A	UK (Other) North America Oceania	Processes Experiences
71	Peer Reviewed	Primary Research	Interview	Education practitioners Health practitioners Social work practitioners Other	23	0	UK (Other)	Rationales Processes Experiences Levels Outcomes
72	Peer Reviewed	Secondary Review (not using systematic review methodology)	Systematic or Secondary Literature Review	N/A	N/A	N/A	North America	Levels

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
73	Grey Literature	Primary Research	Interview Other	Education practitioners Health practitioners Social work practitioners Other	Not stated	0	UK (Other)	Processes
74	Peer Reviewed	Primary Research	Documentary Review Other	N/A	N/A	N/A	UK (Other)	Rationales Processes Outcomes
75	Peer Reviewed	Primary Research	Administrative Data	N/A	N/A	N/A	Europe (non-UK)	Outcomes
76	Peer Reviewed	Primary Research	Interview	Parents / carers	0	56 Parents	North America	Rationales Processes Experiences Outcomes
77	Peer Reviewed	Primary Research	Interview Documentary Review	Health practitioners Social work practitioners Other	61	0	Scotland Europe (non-UK)	Processes Experiences Levels
78	Peer Reviewed	Primary Research	Focus Group	Health practitioners Social work practitioners	17	0	Europe (non-UK)	Rationales Processes Experiences

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
				Other				
79	Peer Reviewed	Primary Research	Interview Focus Group	Health practitioners Social work practitioners	22	0	Scotland	Processes Experiences Levels Outcomes
80	Peer Reviewed	Primary Research	Interview	Health practitioners Other	30	0	Oceania	Experiences Rights
81	Peer Reviewed	Primary Research	Survey Interview	Not defined	Not stated	0	Europe (non-UK)	Rationales Processes Experiences Outcomes
82	Peer Reviewed	Primary Research	Interview	Education practitioners Health practitioners Social work practitioners Other	Not stated	0	Europe (non-UK)	Rationales Processes Experiences Levels Outcomes
83	Peer Reviewed	Primary Research	Interview	Health practitioners	35	0	North America	Processes Outcomes
84	Grey Literature	Primary Research	Survey Other	Policy / government officials	50	0	Scotland UK (other)	Experiences

Paper Code	Source Type	Study Type	Data Collection Methods Used	Groups Included in data collection	Number of staff involved	No. children, young people & parents involved	Geographical regions covered	Sections of the report referenced
							Europe (non-UK)	
85	Peer Reviewed	Primary Research	Interview Focus Group Other	Young People Parents / carers Health practitioners Social work practitioners	44 (focus groups)	9 Young people 12 Parents	Europe (non-UK)	Processes Experiences Rights
86	Peer Reviewed	Primary Research	Interview Systematic or Secondary Literature Review	Health practitioners	18	0	North America	Rationales Processes Experiences
87	Peer Reviewed	Primary Research	Survey	Health practitioners Other	263	0	North America	Rationales Processes Experiences

CELCIS Centre for excellence for Children's Care and Protection

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