Table of integrated primary health and employment services included in this review

NEW ZEALAND SERVICES								
Initiative	**Aim of service**	**Target population**	**Infrastructure / funding**	**Setting of service**	**Type of integration model**	**Evaluation methods**	**Outcomes**	**Information Source**
Navigator Models								
Here Toitū - Oranga Mahi programme	To assist participants to achieve their wellbeing and employment goals, with the overall aim of improving individual and whānau wellbeing, quality of life, and financial stability	Working-aged clients on a main benefit with a medical deferral for a health condition, injury or disability	Funded by MSD and co-designed in partnership with three PHOs - the National Hauora Coalition, ProCare Network Limited, and Pegasus Health in Canterbury	Primary care practices - Auckland, Whanganui, and Canterbury	Navigator Model - support from a dedicated Health Navigator and a dedicated Work and Income case manager, access to a flexible fund to pay for health-related supports or services not covered elsewhere, and flexible end dates on Work Capacity Medical Certificates	In progress	TBD	
Step Up (now a Here Toitū service)	To improve the health and wellbeing of people in receipt of a main benefit to enable them to start or return to work	Individuals in receipt of a main benefit (including Jobseeker Support, Sole Parent Support and Supported Living Payment) with any health-related issues resulting in medical deferral from work	Funded by MSD and contracted through Canterbury DHB, co-designed with Pegasus Health PHO	General practices in Canterbury (excluding Ashburton)	Navigator Model - health navigators (such as social workers and/or registered nurses) help to develop a return to work and health management plan and connect people with different support services they need to implement the plan (weekly meetings during intensive phase and monthly during less intensive phase), Work and Income case manager support and connection of clients with work opportunities, and up to 4 free health practitioner	Descriptive baseline data from 51 Step Up clients; Interviews with 35 Step Up clients and a range of staff (e.g. health navigators, case managers, employment coordinators, GPs)	Small number of WHOQOL assessments completed pre- and post participation. Baseline data showed Step Up clients scored lower in physical, social and psychological domains compared to New Zealand norms. During interviews, clients reported improvements in self-confidence, increased motivation, increased independence/autonomy and reduced anxiety and stress because of support from health navigators.	Malatest International. (August 2019). Step Up Evaluation.

					consultations over one year			
Case Management/Coordination Models								
<u>Māori</u>								
Rakau Rangatira - Oranga Mahi programme	To integrate health and social services (and improve health and employment outcomes) for whānau residing in and around Otangarei, who are currently receiving a benefit, have experienced minor-moderate difficulties with alcohol and drugs and/or mental health, and would like support to gain employment	Whānau residing in and around Otangarei, who are currently receiving a benefit, have experienced minor-moderate difficulties with alcohol and drugs and/or mental health, and would like support to gain employment	Funded by MSD, delivered in partnership with Northland DHB, Te Hau Āwhiowhio ō Otangarei Trust and Manaia Health PHO	Kaupapa Māori organisation - Te Hau Āwhiowhio ō Otangarei Trust	Coordination/Case Management Model - coaching and mentoring support from a Kairaranga Rākau Rangatira (Programme Co-ordinator) and a Kairaranga Whānau Whaiora (Peer Support Worker) to increase access to health and social services in the community, completion of a PATH plan (Planning Alternative Tomorrows with Hope) and development of skills to achieve PATH goals, support customised to suit the needs of each individual	Kaupapa Māori strengths-based approach involving a review of programme documentation; interviews with 3 managers, 3 programme staff, 1 Kainga Ora member, 2 MSD staff, and 1 Manaia PHO member; 2 focus groups with participating whānau from 2 cohorts (14 of 55 cohort 1 members and 8 of 40 cohort 2 members); and review of administrative data	94% of participants registered with PHO; 100% participated in structured peer support programme; 75% of participants actively participating in community; 12% of participants found full time employment, 6% found part-time employment, 4% entered training programmes, 4% obtained voluntary work; 6% successful in finding alternative accommodation during programme participation; reported health and wellbeing outcomes included increased confidence, decreased social anxiety and increased socialisation; 75% of members actively working through mental health/substance use issues with support staff; 75% of members who participated in the exercise group reported improved physical health and fitness; 53% of members had achieved a PATH plan.	FEM 2006 Ltd. (March 2018). Rākau Rangatira Evaluation Report.
<u>Mainstream</u>								
Jobs Jolt including Enhanced Service and Case Management for Sickness and Invalid Clients	To identify employment opportunities and provide individualised	Working-age population receiving an invalid's benefit or a sickness benefit for	Funded by MSD	Work and Income 'concept' sites	Case Management Model - specialist case management with target caseload ratios of 1:160, specialist case	Implementation across 14 'concept' sites	Just under half of all clients in the concept sites had journal entries made for them by case managers focused on	Lunt. (March 2006). Sickness and invalid's benefits: new

	employment support for sickness and invalid's benefit recipients	health conditions and/or disabilities			managers work with medical practitioners and job brokers to devise return-to-work strategies		employment aspirations and moves towards employment, compared with 10.7% in the non-concept sites. The change in proportions moving off sickness and/or invalid's benefits, compared to the previous 12 months, was 1.2% for concept sites compared to 0.1% for non-concept sites.	developments and continuing challenges. Social Policy Journal of New Zealand, 27, 77-99.
Providing Access to Health Solutions (PATHS)	To bring together public health, community mental health and welfare agencies to provide a coordinated employment service for people unable to work due to one or more health or disability issues	People receiving Sickness (SB) or Invalid's Benefit (IB) with a desire to work but cannot due to one or more health or disability issues	Work and Income worked in partnership with community mental health agencies, DHBs and/or PHOs to provide PATHS	Work and Income sites (with referrals from case managers, GPs, and community agencies) - initially Counties Manukau, Wellington, Bay of Plenty, Canterbury and Taranaki with subsequent expansion to 9 other regions	Coordination Model - support from a Health Intervention team; in addition to a GP or medical advisor, each team included a Work and Income coordinator, a health coordinator, and a community mental health coordinator; access to a wide range of funded health interventions including medical specialist assessments, healthy lifestyle packages, and physiotherapy	Quantitaive and qualitative evaluation of PATHS operation in Counties Manukau, Wellington, Bay of Plenty, Canterbury and Taranaki 2004-2007; MSD admin data and regional programme monitoring records, interviews with participants and staff in each region, and workshop with Health Intervention team staff	1211 people participated in PATHS. 29% of PATHS participants were off benefit after 18 months from commencement in PATHS, mostly because they obtained work (15%) - comparable to those in a similar cohort of those in receipt of benefit but not taking part in PATHS. Across the PATHS evaluation regions, the proportion of participants who remained on benefit but had declared earnings increased slightly following their participation in PATHS.	Centre for Social Research and Evaluation. (January 2009). PATHS Evaluation: Overview report. Ministry of Social Development.
Providing Access to Health Solutions (PATHS)						Impact - propensity-matched comparison group using MSD data	Mixed effectiveness rating - statistically significant positive impact on 'any employment', no statistical difference in impact on 'all income', and statistically significant negative impact on independence from welfare.	Effectiveness of MSD employment assistance - Summary report for 2014/2015 financial year.

Mild to Moderate Mental Health (MMMH) Pilot	Unclear - To assist people receiving Sickness (SB) or Invalid's Benefit (IB) due to mental health conditions (such as stress and depression) into employment?	People receiving Sickness (SB) or Invalid's Benefit (IB) with mild-moderate mental health problems	Service purchased by MSD through the Health and Disability Innovation Fund	Unspecified - Primary Health Organisation, DHB or independent provider	Coordination/Case Mangement Model - Work and Income case managers refer clients to a service coordinator who assesses clients mental health needs and arranges appropriate support services (delivered by one or more providers); at completion of the support period, the service co-ordinator provides Work and Income with a summary of the client's progress and identifies further actions necessary to assist the client into employment	Comparison of pilot participants (n=926) with comparison group (n=703) matched to participants based on observed characteristics at programme start	MMMH resulted in increased part-time work whilst on benefit, movement onto unemployment-related benefits and staircasing onto further Work and Income programmes (non-significant). Over the same period, participants also spent longer receiving main benefits (lock-in effect). After the first year, the off-benefit outcomes of participants were similar to those of the comparison group.	Centre for Social Research and Evaluation. (May 2010). Impact of Mild to Moderate Mental Health service on participants' outcomes: Technical Report.
Mental Health Employment Service (replaced with Work to Wellness)	To support clients with common mental health conditions to gain work and achieve sustainable employment	Job seekers registered with Work and Income who were willing to undertake full-time employment but were limited in their capacity to look for or be available to work because of common mental health issues such as anxiety, stress or depression	Funded by MSD	Auckland, Canterbury, Southern, and Waikato regions - "delivery of service in an environment that is positive, respectful and encourages the client to take responsibility for their actions"	Case Management Model - contracted case management providers tailoring activities to the individual needs of clients to support achievement of employment outcomes; sharing of client information between the provider, MSD and the client's health and support providers; identification of barriers to employment and support to overcome these; development of a plan in partnership with client and actively assisting the client to find work quickly (e.g. brokering appropriate employment through employment networks); ongoing support to the client and employer once employment has been obtained	RCT comparing case management services through a contracted provider (n=1785) with normal statutory entitlement and MSD-delivered case management service (n=878)	No statistically significant differences between intervention and control groups	Insights MSD. (July 2018). Effectiveness of contracted case management services - Sole Parent Employment Service and Mental Health Employment Service Trials Evaluation: Final Report.

Work to Wellness	To support clients who have a diagnosed mental health condition to find and maintain employment	Clients with any diagnosed mental health condition (primary, secondary and/or tertiary diagnosis) of working age in receipt of a main benefit and who have a willingness to work	Three service providers contracted by MSD; providers were responsible for generating referrals which could come from Work and Income (whereby case managers identify and refer eligible clients), health services, or directly	Five regions: Auckland, Waikato, Central, Canterbury and Southern	Case Management Model - contracted case management service providing clients with the support of a dedicated employment consultant; providers were able to support clients however they felt was suitable in order to move clients into employment but core functions included employment-related activities (e.g. preparing a CV, identifying and applying for jobs, preparing for interviews); providers could also support clients with their mental health, including support to deal with anxiety, low self-confidence, resilience and stress; another aim of the service was to build relationships with healthcare providers to generate suitable referrals and to improve client retention	Interviews and focus groups with 20 MSD frontline and regional staff, 18 contracted service providers and 13 clients	Support required was of a higher density than MSD case management could provide. There was significant variation in the method of service delivery between and within providers (e.g. group sessions versus one-to-one support).	Bence-Wilkins & Conlon. (2018). Work to Wellness Qualitative Evaluation 2018.
Realising Employment through Active Coordinated Healthcare (REACH) - Oranga Mahi programme	To support participants to improve the management of their health and achieve their employment goals	Working-aged clients on a main benefit with a medical deferral for a health condition, injury or disability	Funded by MSD	Waikato DHB general practices	Case Management Model - support to set and achieve goals from a Key Worker and Living Well Coach using cognitive behavioural techniques, support from a dedicated Work and Income case manager who works in collaboration with the rest of the client's support team to help them make progress on their plan, particularly on employment goals,	Clustered randomised controlled trial of 12 week REACH (55 intervention group clients and 44 control group clients), 15 month evaluation period	Small decline in benefit receipt among REACH participants - of the 55 people who received REACH, 36 had either no change or more benefit days (65.5%) and 19 had a reduction from pre to post (34.5%). For the control group, a higher percentage had the same or more days on benefit from pre- to post trial (69.6%) and slightly less demonstrated a	Cameron. (May 2019). REACH evaluation, preliminary analysis.

					and availability of a 'programme fund'		reduction in benefit days (30.4%).	
Mana Taimahi (now a Here Toitū service)	To support people to stay in work or return to work that is appropriate for their capacity, benefiting whānau and reducing the costs associated with benefits for Work and Income	18–65-year-olds with health issues challenging their ability to maintain or seek work and: on JS or JS-HCID, and/or considered for a work capacity medical certificate (WCMC), and/or transferring from ACC	Funded by MSD and co-designed in partnership with the National Hauora Coalition (NHC)	4 general practices in Auckland and 3 in Whanganui	Coordination/Distributed Model - an education module for GPs, intensive patient management with a GP through up to 4 additional free consultations to allow for work-focused conversations and improved management of conditions (with the GP making referrals to alternative work-focused or other health/social services as necessary), and strengthening of relationships between GPs and Work and Income through regular meetings and information sharing	Process evaluation involving interviews with 46 stakeholders and operational data from MSD and NHC	Uptake of additional consultations was low (7 out of 49 were additional consultations at GP A and 14 out of 50 at GP B). Target of '90% of intensive patient management conversations incorporate work-focused conversations' nearly met, with 86% of consultations at GP A incorporating a work-focused conversation and 84% at GP B.	Moss, King, & Pipi. (2017). Evaluation of Mana Taimahi prepared for National Hauora Coalition.
Mana Taimahi (now a Here Toitū service)	To support people to stay in work or return to work that is appropriate for their capacity, benefiting whānau and reducing the costs associated with benefits for Work and Income	18–65-year-olds with health issues challenging their ability to maintain or seek work and: on JS or JS-HCID, and/or considered for a work capacity medical certificate (WCMC), and/or transferring from ACC	Funded by MSD and co-designed in partnership with the National Hauora Coalition (NHC)	4 general practices in Auckland and 3 in Whanganui	Coordination/Distributed Model - an education module for GPs, intensive patient management with a GP through up to 4 additional free consultations to allow for work-focused conversations and improved management of conditions (with the GP making referrals to alternative work-focused or other health/social services as necessary), and strengthening of relationships between GPs and Work and Income through regular meetings and information sharing	Process evaluation involving interviews with GPs at 5 practices, 2 in Whanganui and 3 in Auckland, 5 MSD case managers at 4 sites, and 3 Health and Disability Coordinators (HDCs)	Take up of free GP visits was low	Mana Taimahi - Process Evaluation Memo - 12 November 2018.

Well Plan (now a Here Toitūservice)	To increase wellbeing and social and economic independence among people who have spent time on the JS-HCD, enhance primary health and Work and Income service collaboration, and improve integrity and efficiency in WCMC systems and practice	Working-age clients with a health condition, an injury or a disability who received Jobseeker Support – Health Condition and Disability	Funded by MSD and co-designed in partnership with ProCare Network Limited	Three general practices within the ProCare network	Case Management/Distributed Model - development of a client-led shared employment and wellbeing plan, access to a flexible fund, Work and Income case management, flexible medical certificate expiry dates, and service training and education	No evaluation completed	Not available	
IPS Adaptations								
Take Charge	To support young benefit recipients with mild-to-moderate mental health and/or substance use issues to improve their wellbeing and find sustainable employment	Young benefit recipients (Jobseeker Support benefit with a medical deferral) aged 18-19 years with a medical certificate indicating they had mild or moderate mental health problems e.g. stress-related disorder, depression, another psychological or psychiatric condition and/or an alcohol or drug disorder	Funded by MSD, co-designed by MSD, Odyssey House Trust, and the Work and Income Canterbury Youth Shop	Community youth mental health service (Odyssey House) in Christchurch	IPS Model Adaptation - a service based on principles of IPS (an evidence-based, integrated approach to supporting people with serious mental illness into employment) providing: pastoral care (mentoring and counselling) from a Take Charge coordinator who also helped young people access other mental health and addiction services and access to an Employment Consultant, group-based motivational workshops at programme entry, a flexi-fund for purchases supporting work attainment, and a 'positive youth development' approach	Formative evaluation of Take Charge prototype involving best practice evidence review, 29 semi-structured interviews with young people involved in the prototype (14 immediately after workshop participation and 15 three months or more after workshops), 3 interviews with whānau or family members supporting participants, 12 interviews with relevant staff, practice observations of full workshop	26 of 44 young people who participated in the prototype participated in at least one interview. Many participants reported that the supportive environment of Take Charge helped them see a way towards managing their mental health and embarking on an employment search. Māori participants responded positively when asked about inclusivity and respect in relation to their culture. All those interviewed were supportive of the group workshops. Participants reported improved understanding of their mental health as a result of pastoral care and workshops.	Higgins et al. (February 2019). Formative Evaluation of 'Take Charge', a Prototype Individual Placement and Support Adaptation for Young Benefit Recipients

						content, and document review		
Take Charge	To support young benefit recipients with mild-to-moderate mental health and/or substance use issues to improve their wellbeing and find sustainable employment	Young benefit recipients (Jobseeker Support benefit with a medical deferral) aged 18-19 years with a medical certificate indicating they had mild or moderate mental health problems e.g. stress-related disorder, depression, another psychological or psychiatric condition and/or an alcohol or drug disorder	Funded by MSD, co-designed by MSD, Odyssey House Trust, and the Work and Income Canterbury Youth Shop	Community youth mental health service (Odyssey House) in Christchurch	IPS Model Adaptation - a service based on principles of IPS (an evidence-based, integrated approach to supporting people with serious mental illness into employment) providing: pastoral care (mentoring and counselling) from a Take Charge coordinator who also helped young people access other mental health and addiction services and access to an Employment Consultant, group-based motivational workshops at programme entry, a flexi-fund for purchases supporting work attainment, and a 'positive youth development' approach	Process evaluation of Take Charge prototype	44 young people consented to take part, and 1/4 were Māori. The rate of retaining participants in the service was high (89 percent of participants were still engaged at three months), although there were considerable gaps in contact with the service for some participants. Group workshops were relatively well attended, with 80 percent (35/44) of enrolled participants attending at least three sessions. There was considerable variation in participants' monthly engagement with the Employment Consultant and Co-ordinator. Of the 25 participants able to be followed for six months from enrolment, 16 (64%) had commenced employment within the six month window. Over the course of the prototype, 10 participants went on to receive care from District Health Board services. This primarily involved referrals to psychiatric emergency services.	Wilson, Painuthara, Henshaw, Conlon, & Anderson. (September 2019). Implementation study of 'Take Charge', a prototype Individual Placement and Support adaptation for young benefit recipients.
Hamilton primary care employment support demonstration programme	To provide employment support to people with mental health conditions who	People whose key barrier to employment was a mild-to-moderate mental health condition and people	Partnership between Workwise (NGO provider of employment services) and	A group of urban Hamilton general practices (sites were selected based on the practices'	IPS Model Adaptation - employment consultants integrated into general practice teams who: assessed psycho-social fitness to work; carried	Formative evaluation involving a brief literature review, in-depth interviews,	The evaluation found it is possible to integrate an employment support programme in general practice clinics within a six month period.	Te Pou. (April 2013). A demonstration of integrated employment support in

	are receiving treatment through primary care, to obtain, return to, or keep their existing employment	at risk of losing their employment because of a mild-to-moderate mental health condition (initially the target group was also required to be receiving a Sickness or Invalid's Benefit)	Midlands Health Network PHO, along with Waikato Work and Income	extended general practice team ethos which enabled co-location of other service providers)	out back to work planning in consultation with the GP including development of a return-to-work plan; provided benefit advice, guidance and liaised with Work and Income; liaised with GPs about emerging health issues; communicated with employers and actively developed job opportunities; and provided ongoing support	review of routine programme data, stakeholder consultation and an initial quality review (semi-structured interviews were conducted with 8 GPs, 3 representatives from the Midlands Health Network, 2 senior managers from Workwise, two employment consultants and 2 representatives from Waikato Work and Income)	Employment consultants established good working relationships with the practice staff. GPs described the project as meeting patients' needs which they could not otherwise fully respond to or support. The programme raised stakeholder awareness regarding the role of employment in improving health and increased the frequency of employment-related conversations in general practice.	primary care. Formative evaluation report.
Employment support in Wellington general practices	To address system barriers experienced by clients with mental health issues wishing to pursue competitive employment	People with a mental health condition including depression, anxiety, bipolar disorder and schizophrenia) wishing to pursue competitive employment; a key criteria for MSD was clients' long-term benefit status (52 weeks continuous)	Workwise and Compass Health PHO formed a partnership with two volunteer general practices in Wellington (owner-operated); Work and Income subsequently became a partner, developing a cohort trial involving some of Workwise's eligible clients	Newtown Medical Centre and Waitangirua Health Centre	IPS Model Adaptation - GPs provided a consultation room for an employment consultant to provide employment support services at their practices; the employment consultant's role was to bridge clients with Work and Income through communication and providing support to help the client navigate the Work and Income system; Workwise had a critical role in communicating with the GPs, which was facilitated through regular co-location of the employment consultant at each practice	Process evaluation exploring evolution of the partnership model and early impacts on individuals involved in the service, including literature review, in-depth interviews, a review of routine programme data, and two relationship surveys targeted to Work and Income frontline staff and GPs (interview	34 clients enrolled in Workwise services through the programme at their GP. By the end of July 2013, the programme had reached capacity and Workwise created a waitlist for new referrals. After enrolling in the programme, clients reported they felt more hopeful, confident, motivated and supported to achieve their goals. They were regularly engaging in employment-related activities such as developing their CV, writing cover letters, training in interviews, and searching and applying for jobs. Of the 34 clients accepted into	Te Pou. (September 2013). Process evaluation of employment support in Wellington general practices.

						participants included 2 GPs, 5 representatives from Workwise, and 13 from Work and Income, and 5 clients)	the service over 9 months, 5 had gained employment and 6 had enrolled in accredited study. GPs remarked that their patients were more confident and motivated to manage their health issues.	
INTERNATIONAL SERVICES								
Initiative	**Aim of service**	**Target population (demographic characteristics)**	**Infrastructure / funding**	**Setting of service**	**Integration model**	**Evaluation methods**	**Outcomes**	**Source**
Navigator Models								
Stay Well, Stay Working (SWSW)	To prevent or delay disability among people currently in employment and managing a mental illness	Individuals working at least 40 hours a month with a diagnosis of mental illness as determined by a clinical assessment, and not eligible for other sponsored public programmes	Funded by the Centers for Medicare and Medicaid Services, implemented through a public-private partnership between the Minnesota Department of Human Services and a provider network, administered by Medica (a non-profit managed care organisation)	Minnesota - non-profit community-based organisation	Navigator Model - assignment of a Wellness and Employment Navigator responsible for the coordination of a comprehensive set of health, behavioural health, and employment services; development of a Wellness and Employment Success Plan (WESP) with navigator upon enrolment; employment supports included job placement, intensive employment needs assessment, career counselling, worker support/coaching, and Workforce Center referrals	Experimental design with stratified random sample - 1257 intervention group participants (1157 analysed) and 300 participants receiving standard care	Compared to the control group, intervention participants had significantly more health and behavioral health care service claims (99% vs. 49%) in the year post-enrollment than in the year prior to enrollment. After the first year of enrolment almost 78% of control group participants reported delaying care due to cost compared with 38% of intervention group participants. Control group participants had more ADL limitations than intervention group participants after 12 months, controlling for the count of baseline ADL limitations (b = 0.2744, p< 0.05).(b = 0.9777, p< 0.05). No significant differences in average number of hours worked per month or change in earnings between the	Linkins et al. (2011). Influencing the disability trajectory for workers with serious mental illness: Lessons from Minnesota's Demonstration to Maintain Independence and Employment.

							intervention and control groups.	
Case Management/Coordination Models								
Fit for Work Service (FFWS)	To support employees in ill health to stay in or return to work after a period of sickness absence	Focus on people in the early stage of sickness absence working within small and medium-sized workplaces. Any health condition.	Partnerships or partnership organisations which included local health organisations, local authorities, employment service providers (such as Jobcentre Plus) and other community organisations with differences across regions of implementation	United Kingdom (Birmingham area, Kent, Dundee, Greater Manchester, Kensington and Chelsea, Leicestershire, North Staffordshire, Nottinghamshire, Rhyl, Scotland, Wakefield)	Case Management Model - biopsychosocial assessments of need and case-managed support (with RTW plan development) to aid a quick return to work in a variety of locally designed delivery models, as well as access to additional clinical or non-clinical services (either through in-house provision, external partnerships or referrals to existing services)	Mixed methods evaluation involving review of routinely collected management information, 200 semi-structured qualitative interviews with stakeholders and providers across all pilot areas, the first wave of a 2-wave quantitative telephone survey of over 300 clients, interviews with 64 FFWS clients from 4 pilot areas, and semi-structured qualitative interviews with 30 GPs across all pilots	40% of the anticipated take up of the services (because the size of the core client population of long-term sickness absentees may have been overestimated and there were difficulties generating the expected level of referrals from GPs and employers). In the first year, nearly all FFWS clients were employed and two-thirds were 'presentees' rather than absentees who were the original policy focus. The most common way of accessing the FFWS was by self-referral or GP referral. There was some evidence that most clients would not have received the interventions they had without the support of the FFWS and that the service helped people get back to work more quickly or more easily than they would otherwise have done.	Department for Work and Pensions. (2012). Evaluation of the Fit for Work Service pilots: first year report.
Fit for Work Service (FFWS)	To support employees in ill health to stay in or return to work after a period of sickness absence	Focus on people in the early stage of sickness absence working within small and medium-sized workplaces. Any health condition.	Partnerships or partnership organisations which included local health organisations, local authorities, employment service providers (such as Jobcentre Plus) and other	United Kingdom (Greater Manchester, Kensington and Chelsea, Leicester, North Staffs, Nottingham, Rhyl, Scotland) - some pilots located within	Case Management Model - biopsychosocial assessments of need and case-managed support (with RTW plan development) to aid a quick return to work in a variety of locally designed delivery models, as well as access to additional clinical or non-clinical services (either through	Qualitative evaluation for 7 proof of concept pilots (5300 supported clients) and impact evaluation using fit note data for 3 pilot areas compared with 'control' fit note data collected	72 per cent of clients who were absent from work on entry to the pilots had returned to work by the time of their discharge. Employment outcomes varied between the pilots, from 92% being back at work in one location to only 46% in another. In 2 out of the 3 pilots involved in the	Department for Work and Pensions. (2015). Evaluation of the 2010–13 Fit for Work Service pilots: final report.

			community organisations with differences across regions of implementation	primary care services	in-house provision, external partnerships or referrals to existing services)	from 4 general practices	impact study, clients had shorter certified sickness absence periods than their equivalent local average. However, this may have partly been due to differences between pilot clients and the local employed population. Clients with musculoskeletal conditions were significantly more likely to return to work sooner than the local adjusted norm. Specifically, the odds of returning to work sooner than the local average was twice as high for clients with musculoskeletal conditions compared with clients with common mental health conditions.The average cost of providing the pilots was around £1,000 per client, but costs varied from around £500 to over £2,000, depending on the mode of assessment and the extent of in-house support.	
GP and case-managed support	To promote better work retention and enable a quicker, more sustained RTW for individuals on sick leave through GP support combined with support from workplace	Sickness absentees, or presentees in employment with work-related health problems. Any health condition.	Sponsored by Liverpool Primary Care Trust	United Kingdom - general practice	Case Management Model - support from GP plus workplace health advisers (no further detail)	Feasibility-controlled trial comparing individuals supported by their GP (n=3) and those supported by their GP and workplace health advisers (n=60 at baseline, 29 at follow-up)	At 3 months, there were no GP referrals to either arm of the trial. It was unclear whether GPs had distributed packs to patients, or if patients had received the packs but had declined to take part. Because of the lack of GP engagement with the trial, no comparison between case-managed support with GP support for workplace sickness	Rannard et al. (2014). Feasibility trial of GP and case-managed support for workplace sickness absence.

	health advisers (WHA)						absence completed. The majority of participants in the case managed group returned to work within one month.	
Intensive Case Management (ICM)	To improve healthcare treatment and support the rehabilitation process of people involved in serious accidents, thereby facilitating return to work and reducing uptake of disability pensions	Victims of severe accidents insured at the Swiss National Accident Insurance Fund (Suva), estimated to benefit from ICM due to medical complexity, difficulties with RTW and risk of permanent disability	Launched by Suva	Switzerland - 'local agencies' and case manager field visits to patients, employers and care providers	Case Management Model - intensive and individually tailored coaching by specially trained case managers with a typical caseload of 35 cases, with responsibilities including assessing the patient's needs, developing a care plan, providing personal assistance in all aspects of the rehabilitation process, including coordination of healthcare treatment, monitoring the patient's progress, and finding new work arrangements or helping to adapt existing ones	Prospective RCT-type study comparing ICM with standard case management (case management provided by claims specialists with a typical caseload of 100, focused on handling acute problems), 3863 analysed under ICM and 4187 analysed under SCM	Average work incapacity over the 6-year follow-up was 21.3% under SCM and 21.6% under ICM (p = 0.44). The percentage of patients receiving permanent disability pensions at the end of the 6-year study period was 20.1% under SCM and 21.3% under ICM (p= 0.16). Average treatment costs per case were higher under ICM than under SCM - at the end of the 6-year follow-up period, cumulative treatment costs were 39,800 swiss francs under SCM and 43,500 under ICM (p= 0.01).	Scholz et al. (2016). Work Incapacity and Treatment Costs After Severe Accidents: Standard Versus Intensive Case Management in a 6-Year Randomized Controlled Trial.
Danish return-to-work (RTW) program based on a Coordinated, Tailored and Multidisciplinary (CTM) approach	To reduce sickness absence and improve labor market participation among a broad group of sick-listed persons, including sick-listed beneficiaries with both somatic and mental health problems and with all types of employment status	"Sick-listed beneficiaries of working age assessed to be unlikely to return to work within 3 months but able to participate in RTW activities (like gradual return to work); beneficiaries who were	Danish National Research Centre for the Working Environment (NRCWE) developed the intervention, all 98 Danish municipalities invited to apply for participation in the program by the Danish National Prevention Fund with 21 municipalities selected	Denmark - sickness benefit management offices	Coordination Model - multi-disciplinary RTW teams established within the municipalities consisting of 2 RTW coordinators (sickness benefit officers), a psychologist, physical therapist, psychiatrist and physician; work accommodation by healthcare providers when appropriate; upper limit to RTW team caseload of 170 beneficiaries per team; RTW coordinators responsible for conducting regular follow-up (at least every 4th week) and coordinating RTW	NRCWE-designed RCT involving 3 municipalities - 1948 participants assigned to the CTM intervention group and 1157 participants assigned to ordinary sickness benefit management	"Could not estimate overall effect of the intervention due to differences in effect across municipalities (p=0.00005). In one municipality the intervention resulted in a statistically significant increased rate of recovery from long-term sickness	NRCWE-designed RCT involving 3 municipalities - 1948 participants assigned to the CTM intervention group and 1157 participants assigned to ordinary sickness benefit management

					initiatives with other members of the team; use of a standardised RTW assessment tool based on a biopsychosocial understanding of health and disability			
Danish return-to-work (RTW) program based on a Coordinated, Tailored and Multidisciplinary (CTM) approach	To reduce sickness absence and improve labor market participation among a broad group of sick-listed persons, including sick-listed beneficiaries with both somatic and mental health problems and with all types of employment status	"Sick-listed beneficiaries of working age assessed to be unlikely to return to work within 3 months but able to participate in RTW activities (like gradual return to work); beneficiaries who were	Danish National Research Centre for the Working Environment (NRCWE) developed the intervention, all 98 Danish municipalities invited to apply for participation in the program by the Danish National Prevention Fund with 21 municipalities selected	Denmark - sickness benefit management offices	Coordination Model - multi-disciplinary RTW teams established within the municipalities consisting of 2 RTW coordinators (sickness benefit officers), a psychologist, physical therapist, psychiatrist and physician; work accommodation by healthcare providers when appropriate; upper limit to RTW team caseload of 170 beneficiaries per team; RTW coordinators responsible for conducting regular follow-up (at least every 4th week) and coordinating RTW initiatives with other members of the team; use of a standardised RTW assessment tool based on a biopsychosocial understanding of health and disability	Qualitative and quantitative evaluation of data from administrative records, interviews, field notes, and questionnaires according to 29 implementation criteria	Implementation varied considerably between the municipalities, particularly with respect to fidelity. Five municipalities had high and eight had low fidelity scores. Similar large differences were found with regard to dose-delivered, particularly in the quality of cooperation with beneficiaries, employers, and general practitioners.	Aust et al. (2015). Implementation of the Danish return-to-work program: process evaluation of a trial in 21 Danish municipalities.
Co-location models								
Study of Work and Pain (SWAP)	To reduce work absence among people with musculoskeletal pain by implementing a vocational advice (VA)	Patients consulting with a GP about musculoskeletal pain, aged 18 to 70 years, currently in paid employment or with current sickness absence due to musculoskeletal pain	Clinical governance of the VA service from Staffordshire and Stoke-on-Trent Partnership Trust; Research	United Kingdom - 6 general practices	Co-location/Case Management Model - general practices could refer patients to a vocational advisor within the practice (physiotherapist recruited to deliver the service) who provided a case-managed stepwise	Pragmatic, cluster randomised controlled trial with 2 parallel arms (158 participants in the VA group compared with 180 in control	Participants in the intervention arm had fewer days work absence over 4 months compared with the control arm (mean 9.3 [SD 21·7] vs 14·4 [SD 27·7]) days, incidence rate ratio 0·51 (95% confidence interval	Wynne-Jones et al. (2018). Effectiveness and costs of a vocational advice service to improve work outcomes in patients with musculoskeletal

	service into primary care	of less than 6 months duration	funded by the National Institute for Health Research (NIHR), under its Programme Grants for Applied Research funding scheme		intervention addressing obstacles to working; initial contact was by telephone (step 1), with 1 or more face-to-face meetings (step 2) and contact with employers (step 3); VAs focused discussions on 3 main areas - psychological or behavioural obstacles to working, work perceptions, and context factors; VAs ensured that the patient's GP was linked into communications	group - best current work-focussed primary care), an economic evaluation, and linked qualitative interviews	0·26, 0·99), p=0·048). By 12 months, there was no overall statistically significant difference in the cumulated number of days of work absence between arms. However, the intervention arm reported fewer days off work certified by the GP at a mean of 16.4 (SD 34.2) days compared with 22.9 (SD 50.5) days in the control arm (p=0.018).Work-related measures demonstrated statistically significant differences between arms, in favour of the intervention arm, at both 4 and 12 months in return-to-work self-efficacy and performance at work, and a significant difference in presenteeism at 4 months. Few statistically significant differences in other outcome measures.	pain in primary care: a cluster randomised trial.
Convergence Dialogue Meeting (CDM)	To increase work ability by adding a workplace dialogue according to Convergence Dialogue Meeting (CDM) in physiotherapy practice for patients with pain in ordinary primary care	Adult patients with acute/sub-acute neck and back pain, worked at least 4 weeks in the past year and not currently on sick leave or no more than 60 days of sick leave and considered at-risk of sick leave	Funded by "The Scientific Committee of Region Kronoberg" Sweden, the REHSAM project Sweden, and the county councils in Skane, Kronoberg, and Blekinge	Sweden - 32 primary care centers corresponding to 20 primary care rehabilitation units	Co-location/CDM Model - CDM is a model aimed at helping the patient, the caregiver, and the employer to support work ability and RTW; step 1 - individual interview between physiotherapist and patient where the patient gave his/her consent regarding contacting employer, step 2 - in-person or phone contact between physiotherapist and employer, step 3 -	Prospective pairwise cluster randomised controlled trial with 1-year follow-up comparing structured physiotherapy care (n=206) with structured physiotherapy care plus CDM (n=146)	Work ability was reached by significantly more patients in the intervention group (108/127, 85%) compared with the reference group (127/171, 74%) (p=0.02). The intervention increased the odds of having work ability at 1-year follow-up, also after adjustment for baseline health-related quality of life (odds ratio 1.85, confidence interval	Sennehed et al. (2018). Early workplace dialogue in physiotherapy practice improved work ability at 1-year follow-up—WorkUp, a randomised controlled trial in primary care.

					patient and employer invited to meet together with physiotherapist to develop a plan of action and written record of workplace improvements and changes in patient's daily life		1.01-3.38). A strict intention-to-treat analysis showed the same result for work ability at 1-year follow-up (119/146, 82% vs 147/206, 72%, p=0.02).	
IPS adaptions								
IPS for autism spectrum disorder	To help young adults with autism spectrum disorder (ASD) gain competitive employment	Young adults with moderate to severe symptoms of ASD	Program started with the support of a private grant, which enabled planning, networking, advertising, and establishing relationships with employers and providers; participants also paid a monthly fee of $400 per month for IPS services	USA - academic medical center	IPS Model Adaptation - IPS delivered by an employment specialist working 20 hours per week and receiving weekly supervision from experienced ASD clinicians and an IPS trainer	Pilot study (descriptive) with 5 participants	During 1 year of IPS, all participants gained competitive employment. Participants also improved in hygiene, self-esteem, social relationships, employment satisfaction, work hours, and pay. Parents observed gains in independence, self-confidence, and family relationships. Both parents and clinicians reported improvements in the participants' mental health and reduction of symptom severity of their comorbid psychiatric diagnosis.	McLaren et al. (2017). Individual placement and support for people with autism spectrum disorders: a pilot program.
IPS for youth with developmental and/or psychiatric disabilities	To promote competitive employment for youth with developmental and/or psychiatric disabilities	Transition age youth with developmental and/or psychiatric disabilities	U.S. federal Centers for Medicare and Medicaid awarded the state of Illinois $90 million through the Balancing Incentives Program (BIP) to increase access to non-institutional, long-term services and	USA - community rehabilitation centers (5 in rural, 2 in suburban, and 3 in urban regions)	IPS Model Adaptation - 10 IPS programs implemented with slightly different populations (4 of the 10 served exclusively youth with mental illness, 4 served exclusively youth with developmental disorders, and 2 served youth with developmental disabilities and youth with mental illness)	Descriptive study of 10 of the 20 Illinois BIP programs that implemented IPS services	Over a 12-month follow-up period, most programs increased quarterly employment rates, reaching a mean employment rate of 36% (SD = 14%) by the fourth quarter, approaching the national benchmark for good employment outcome.	Noel et al. (2018). A preliminary evaluation of individual placement and support for youth with developmental and psychiatric disabilities.

			supports; the Illinois Department of Human Services Division of Rehabilitation Services funded 20 community-based BIP teams to pilot vocational programs during a 20-month period (required to be either IPS or customised employment)					
Adapted IPS Model	To assist homeless young adults with mental illness to obtain and maintain competitve employment using an adapted evidence-based intervention (IPS)	Homeless young adults (aged 18-24) with a diagnosed mental illness in the past year (assessed with the Mini International Neuropsychiatric Interview) and a desire to work	Funding provided by the Columbia University Center for Homelessness Prevention Studies (CHPS) Scholars' Program	USA - non-profit multi-service organisation that offers homeless, runaway and at-risk young people a comprehensive system of care including health care, mental health counseling, educational and employment services, and basic subsistence items	IPS Model Adaptation - adaptation of the 7 principles; zero exclusion - all young adults meeting criteria eligible; integration of vocational and mental health treatment services - weekly meetings between host-agency employment specialist, case managers and clinicians; competitive employment - assistance to obtain competitive work and wages and supported education; benefits counselling - education on goverment assistance; rapid job search - job-search process initiated within 1 month of vocational assessment; follow-along supports - individualised assistance throughout study; preferences - vocational	Pre-post, self-comparison quasi-experimental design, 20 participants in IPS group and 16 receiving standard agency services (including vocational services)	IPS young adults were more likely than the control group to have worked at some point during the 10-month study (X2 = 8.69, p = 0.003, OR = 9.4). While only significant at the p = 0.10 level, the IPS group had 7.83 greater odds of working at follow up than the control group (p = 0.06, OR = 7.83) using logistic regression with adjustment for baseline working status and agency site. For the monthly work rate, IPS young adults worked a significantly greater number of months over the 10-month study (t = -2.83, p= .008, d = 0.95). No significant differences in weekly working hours or weekly income. Regarding weekly income at follow up, the IPS group averaged $263.57 (SD = $147.61), whereas	"Ferguson et al. (2012). Adapting the Individual Placement and Support model

					assessment guided nature of support		the control group averaged $192.50 (SD = $116.67). The effect size of Cohen's d for weekly income was 0.53.	
IPS adapted for headspace	To improve the vocational education and employment outcomes of young people who require mental health support	Young people with Mild-moderate mental illness aged up to 25 (no formal diagnosis required) facing barriers to achieving employment, education or training goals	Funding from 2015-2016 Federal Budget; trial managed by the Disability and Carer Policy Branch of the Department of Social Services, with responsibility for contract management undertaken by the Delivery Network, with a Funding Arrangement Manager in each state/territory	Australia - headspace centres (which act as a one-stop-shop for young people who need help with mental health, physical health, alcohol and other drugs, or work and study support)	IPS Model Adaptation - individually tailored and specialist vocational support in tandem with existing clinical mental health supports and other non-vocational assistance; support from 2 Vocational Specialists who delivered IPS services in accordance with IPS principles and formed partnerships with a range of local networks including employers and employment services	Four domains - implementation, efficiency, appropriateness, and effectiveness (n = 1558) through document review, literature review, analysis of program data, stakeholder interviews with participants, Vocational Specialists, other headspace staff and employers, and a case study analysis	676 participants (43%) achieved an education and/or employment outcome during the trial (33% achieved employment, 9% acehived an education outcome and 3% had both an education and employment outcome). Young people felt that their experience was guided by their own preferences, goals and interest and emphasised the time-unlimited nature and tailored supports as contributing factors to engagement and the achievement of positive outcomes. 15% of trial participants identified as Aboriginal or Torres Stait Islander. The representation of Aboriginal and Torres Strait Islander young people across sites varied. A lower proportion of Indigenous participants than non-Indigenous participants had either an education or employment outcome.	KPMG, Department of Social Services. (June 2019). Final Report for the Evaluation of the Individual Placement and Support Trial.

At Work and Coping (AWaC) programme	To increase the work participation of people with common mental disorders	People aged 18-60 years struggling with work participation due to common mental disorders and sub-threshold symptoms of anxiety and depression disorders (including people on and at risk of sick leave as well as people on long-term benefits)	Commissioned by the Norwegian Ministry of Health and Ministry of Labour, financed through the National Strategy on Work and Mental Health (2007-2012)	Norway - 6 centres organised by Norwegian Labor and Welfare Administration (NAV)	Adapted IPS + CBT - combined individual CBT and job support with mini-teams of therapists and employment specialists at each centre to ensure integration between CBT and the explicit work focus; individual job support was based on principles of the IPS model and offered to those in need (primarily participants on long-term disability) to facilitate workplace adaptations or identification of appropriate employment	Multi-centre RCT comparing AWaC (n=630) with standard treatment from GP, NAV or other health professionals (n=563)	A larger proportion of participants in the intervention group had increased or maintained their work participation at follow-up compared to the control group (44.2% vs 37.2%, p=0.015). The difference remained significant after 18 months (difference 7.8%, p=0.018), and was even stronger for those on long-term benefits (difference 12.2%, p=0.007). The intervention also reduced depression (t=3.23, p≤0.001) and anxiety symptoms (t=2.52, p 0.012) and increased health-related quality of life (t=2.24, p=0.026) more than usual care.	Reme et al. (2015). Work-focused cognitive-behavioural therapy and individual job support to increase work participation in common mental disorders: a randomised controlled multicentre trial.
At Work and Coping (AWaC) programme	To increase the work participation of people with common mental disorders	People aged 18-60 years struggling with work participation due to common mental disorders and sub-threshold symptoms of anxiety and depression disorders (including people on and at risk of sick leave as well as people on long-term benefits)	Commissioned by the Norwegian Ministry of Health and Ministry of Labour, financed through the National Strategy on Work and Mental Health (2007-2012)	Norway - 6 centres organised by Norwegian Labor and Welfare Administration (NAV)	Adapted IPS + CBT - combined individual CBT and job support with mini-teams of therapists and employment specialists at each centre to ensure integration between CBT and the explicit work focus; individual job support was based on principles of the IPS model and offered to those in need (primarily participants on long-term disability) to facilitate workplace adaptations or identification of appropriate employment	Multi-centre RCT comparing AWaC (n=630) with standard treatment from GP, NAV or other health professionals (n=563)	Intervention group had higher income, higher work participation and more months without receiving benefits over the 10-month to 46-month long-term follow-up period after end of treatment, but differences were not statistically significant. For the group on long-term benefits at inclusion, effect sizes were larger and statistically significant.	Overland et al. (2018). Long-term effects on income and sickness benefits after work-focused cognitive-behavioural therapy and individual job support: a pragmatic, multicentre, randomised controlled trial.
IPS adapted for veterans with PTSD	To help veterans with PTSD obtain	Veterans with a diagnosis of PTSD, aged 19-60, with a	Funded by VA Rehabilitation Research and	USA - Tuscaloosa VA Medical Center	IPS Model - IPS specialist integrated into the clinical mental	Prospective randomised comparison of	76% of IPS participants gained competitive employment, compared	Davis et al. (2012). A randomized

	and maintain competitive employment	medical clearance to work, currently unemployed and interested in competitive employment	Development grant with support from Tuscaloosa VAMC's Research and Development Services	(provides primary care, long-term health care and mental health care services to eligible veterans)	health or PTSD treatment team who carried out all phases of the vocational services, provided predominantly community-based services, provided assertive engagement and outreach in community-based employment, had a caseload of no more than 25 clients, and provided continuous, time-unlimited, follow-along supports for vocational services; IPS involved rapid job search and individualised placement in diverse competitive jobs, with ongoing work-based vocational assessment and assistance in finding subsequent jobs	IPS (n=42) with standard VA Vocational Rehabilitation Program (VRP) (n=43)	with 28% of VRP participants (number needed to treat=2.07; $\chi 2=19.84$, df=1, p <.001). Veterans assigned to IPS also worked substantially more weeks than those assigned to VRP (42% versus 16% of the eligible weeks, respectively; p <.001) and earned higher 12-month income (mean±SD income of \$9,264±\$13,294 for IPS versus \$2,601± \$6,009 for VRP; p<.001) during the 12-month period.	controlled trial of supported employment among veterans with posttraumatic stress disorder.
Veterans Individual Placement and Support Toward Advancing Recovery (VIP-STAR)	To assist veterans to rapidly obtain competitive work in the community that aligns with their preferences, skills, and abilities	Veterans with a lifetime diagnosis of PTSD according to DSM-IV criteria who were aged 65 years or younger, currently unemployed, interested in seeking competitive employment, eligible for transitionalwork (based on local programmatic restrictions), likely tocomplete the study (based on participant's plans to remain in the catchment area for 18 months), and willing to be randomised	Supported by Cooperative Studies Program, Department of Veterans Affairs Office of Research and Development	USA - 12 Veterans Affairs medical centers	IPS Model - IPS specialist co-located within the PTSD or mental health clinic to provide integrated services to an active caseload of 25 veterans; IPS specialist person-centred support includes individualised job search consistent with the participant's preferences, skills, and abilities; job coaching and advocacy; care coordination within the treatment team; disability benefits counseling; and open-ended follow-along supports; IPS model focuses on rapidly searching and finding competitive employment	Prospective, multisite, randomised clinical trial comparing IPS (n=271) with transitional work (n=270) using intention to treat analysis	More participants in the IPS group achieved steady employment than in the transitional work group (105 [38.7%] vs 63 [23.3%]; odds ratio, 2.14; 95%CI, 1.46-3.14). A higher proportion of IPS participants attained any competitive job (186 [68.6%] vs 154 [57.0%]; p =.005) and had higher cumulative earnings from competitive jobs (median [interquartile range] \$7290 [\$23 174] in IPS vs \$1886 [\$17 167] in transitional work; p =.004).	Davis et al. (2018). Effect of evidence-based supported employment vs transitional work on achieving steady work among veterans with posttraumatic stress disorder - a randomized clinical trial. Mueller et al. (2019). Positive impact of IPS supported employment on PTSD-related occupational-

					in the community setting for each participant with specialists spending most of their time in job development activities			psychosocial functional outcomes: results from a VA randomized-controlled trial
Spinal Cord Injury Vocational Integration Program (SCI-VIP)	To help veterans with spinal cord injury (SCI) obtain and maintain community-based competitive employment in their chosen occupation	Veterans with SCI between the ages of 18 and 65 years	Supported by VA Rehabilitation Research and Development Service	USA - Veterans Affairs (VA) SCI centers - services are primarily provided in the community, rather than in mental health treatment or rehabilitation settings	IPS Model Adaptation - sought to follow the evidence-based principles as closely as possible including integrated vocational and medical rehabilitation treatment, rapid engagement in job finding, competitive employment, inclusion regardless of severity or type of disability, ongoing job support, and focus on participant preferences; services were primarily provided in the community and access to personalised benefits counseling was included; provision of these services was by a vocational rehabilitation counselor who was trained in the model and integrated as a provider among the SCI interdisciplinary care team	Prospective, randomised, controlled, multisite trial; in interventional sites, subjects were randomly assigned to the supported employment condition (n=81) or the treatment as usual condition (n=76) and in observational sites where the intervention was not available, 44 subjects were enrolled in a non-randomized treatment as usual (TAU) condition (treatment as usual involved referrals to traditional vocational rehabilitation outside of and apart from VA spinal cord injury health care)	The rate of employment for intervention subjects was significantly greater (29.6%; 95% CI, 20.8–40.4) than that of either the TAU group (11.8%; 95% CI, 4.6–19.1; p<.003) or the TAU-observational site group (4.8%; 95% CI, 0.5–16.7; p<.002). When employment was restricted to competitive employment only, intervention subjects significantly accounted for 50 (69.4%) of 72 jobs and were significantly more likely to achieve employment (25.9%; 95% CI, 17.6 – 36.5) compared with either TAU subjects (10.5%; 95% CI, 3.6 – 17.4; p<.008) or TAU-observational site subjects (2.3%; 95% CI, 0.0 –12.9; p<.002).	Ottomanelli et al. (2009). Methods of a multisite randomized clinical trial of supported employment among veterans with spinal cord injury; Ottomanelli et al. (2012). Effectiveness of supported employment for veterans with spinal cord injuries: results from a randomized multisite study; Ottomanelli et al. (2014). Individual Placement and Support (IPS) in physical rehabilitation and medicine: the VA spinal cord injury experience.
Predictive Outcome Model Over Time for Employment (PrOMOTE) (extension of SCI-VIP)	To help veterans with spinal cord injury find meaningul employment in	Veterans with SCI between the ages of 18 and 65 years who expressed a desire to be employed	Supported by the Department of Veterans Affairs, Veterans Health Administration,	USA - 7 VAMC SCI Centers	IPS Model Adaptation - as above (includes integrated treatment, rapid engagement in job searches based on the individual's preferences,	Mixed method, longitudinal study; semi-structured interviews (n=151) and	"At 12 months, participants who obtained competitive employment (CE) and those who did not (no-CE) showed	Predictive Outcome Model Over Time for Employment (PrOMOTE)

	their community, thereby increasing quality of life, overall health and financial independence		Office of Research and Development, and the Rehabilitation Research and Development Service		while providing community-based services with personalized benefits counseling regardless of the severity of injury or type of disability)	surveys (n=213)	improvement on most measures. In months 12-24, the CE group showed improvements on all study measures while the no-CE group declined on many indices. Improvements in HRQOL as measured by QALYs were less for veterans without social support at one year of follow-up but by the end of the second year of follow-up there were no differences in QALYs between these groups.	(extension of SCI-VIP)
IPS for young adults at risk of early work disability	To improve competitive employment as well as physical and mental health and wellbeing for young people not in employment, education, or training (NEET)	Young adults (18-29) with Social and health-related problems, not in employment or education receiving temporary benefits from the Norwegian Labor and Welfare Service (NAV)	Funded by The Research Council of Norway	Norway - vocational rehabilitation organisations overseen by the NAV	IPS Model Adaptation - 2 trained job specialists sought to follow the IPS principles although because the study population had various social and health-related challenges that did not necessarily involve mental illness, the principle of integrating services with mental health treatment was not implemented; instead, job specialists contacted health personnel involved in the treatment of individual participants in cases where this was applicable and accepted by the participant	RCT comparing IPS (n=50) with traditional vocational rehabilitation (n=46)	Significantly more IPS participants obtained competitive employment compared to traditional vocational rehabilitation participants during 12-months follow-up (48% versus 8%; odds ratio 10.39, 95% confidence interval 2.79–38.68). The IPS group reported significantly better outcomes than the comparison group in subjective health complaints, helplessness, and hopelessness. In post hoc analyses adjusted for baseline and missing data, the IPS group reported significantly better outcomes on these measures in addition to level of disability, optimism about future well-being, and drug use.	Sveinsdottir et al. (2016). Protocol for the SEED-trial: Supported employment and preventing early disability; Sveinsdottir et al. (2020). Individual placement and support for young adults at risk of early work disability (the SEED trial). A Randomized controlled trial.
Multi-Component/Distributed Models								

Integrated care programme	To restore occupational functioning and achieve lasting return to work for patients with work disability due to chronic low back pain through a combined patient-directed and workplace-directed integrated care programme	Adults aged 18-65 sick listed for at least 12 weeks owing to chronic low back pain	"Funding from VU University Medical Center, TNO Work & Employment, Dutch Health Insurance Executive Council, Stichting Instituut GAK, and the Netherlands Organisation for Health Research and Development; costs of interventions (graded			Integrated care programme	To restore occupational functioning and achieve lasting return to work for patients with work disability due to chronic low back pain through a combined patient-directed and workplace-directed integrated care programme	Adults aged 18-65 sick listed for at least 12 weeks owing to chronic low back pain