**International Models of Support Coordination and Local Area Coordination: Evidence Review Report**

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## Title Page for Research Paper International Models of Support Coordination and Local Area CoordinationAbout the Research and Evaluation Branch

The Research and Evaluation Branch is responsible for ensuring that NDIA policies, practices and priorities are informed by trustworthy and robust evidence so decisions can be based on an understanding of what works, what doesn’t and the benefit to participants and the Agency.

### This document

This report summarises the background, methods and findings for a rapid systematic evidence review of published reports of contemporary (2010-2020) Support Coordination and Local Area Coordination models.

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**Abbreviations**

| LAC | Local Area Coordinator |
| --- | --- |
| LCC | Local Community Coordination |
| NDIA | National Disability Insurance Agency |
| NDIS | National Disability Insurance Scheme |
| SC | Support Coordination |

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## Executive summary

### The Problem:

Support Coordination (SC) is an intervention funded by NDIS as an intermediary service to assist participants to understand and implement their plan, connect them to community or mainstream services, anticipate, mitigate and manage crises, and build the participant’s capacity for self-direction. It is currently funded at 3 levels (Support connection, Coordination of supports, and Specialist support Coordination) depending on the intensity of support and expertise the participant requires.

It isunclear if this 3-level model is ‘fit for purpose’ to facilitate intended plan implementation outcomes for NDIS participants. Critical issues include:

* + inconsistent application of “reasonable and necessary” criteria when including SC in plans;
  + unclear guidelines for determining what level of SC is required;
  + conflicts of interest where providers of other funded services also provide SC; and
  + service duplication particularly for level one (Support connection) which overlaps considerably with Local Area Coordination (LAC) roles.

#### Our methods:

We undertook a rapid evidence review using systematic methods to retrieve and critically appraise published reports of contemporary (2010-) SC and LAC models.

We also sought published data comparing the effectiveness and cost-effectiveness of different SC-equivalent interventions.

#### Key Findings:

Key components of SC models (as described in published journal articles) are summarised in Appendix 2.

Key components of LAC models (as described in published journal articles or reports to government) are summarised in Appendix 3.

**What do we know about the effectiveness or cost-effectiveness of SC interventions?**

There were no studies directly comparing SC-equivalent intervention/s to “no service” or an alternative model, thus the effectiveness (and cost-effectiveness) of these interventions is uncertain.

There is qualitative evidence from the perspective of disability planners and workers that SC-equivalent interventions are important enablers of successful plan implementation. This is likely to be particularly important for people with more complex needs, circumstances or support environments.

There is also qualitative evidence from the perspective of consumers and their families that:

* external support is required to successfully navigate self-directed systems; and
* strong, trusting and collaborative relationships with both paid and unpaid individuals in the person's support network were facilitators of successful plan implementation.

There was evidence of disabling practices and attitudes among some support agencies, evidenced by staff being very risk averse in order to safeguard their clients.

**What do we know about the effectiveness or cost-effectiveness of LAC services?**

There were no reports directly comparing interventions delivered by LAC to “no service” or an alternative service model, thus their effectiveness is uncertain. Several reports attempted to estimate the cost-effectiveness of LAC using the Social Return on Investment (SROI) method which attempts to quantify extra-financial values like social or environmental impacts which are not reflected in conventional financial accounts. The accepted estimate was that for each unit invested there was a four-fold return into the local system.

#### Where to next:

For Support Coordination:

* SC interventions are implemented differently internationally but seldom described in detail or evaluated. Although they have not been tested experimentally, extensive qualitative research suggests they are valued by consumers and are a major facilitator of successful plan implementation, providing support agencies avoid overly risk-averse attitudes.
* They are likely to be crucial for people with complex needs i.e. those with a range of different, often interrelated, needs that are serious, intense, severe, or profound and likely to require support from different services, such as social, health and housing services. Populations who experience difficulty accessing information and recruiting personal assistance workers are also likely to benefit from SC.
* Eligibility criteria and levels of service for proposed new models should be developed in consultation with groups representing those with complex needs and LACs to ensure clarity of provider roles/scope and service priorities.
* A website similar to the “Connect to Support” platform used in the United Kingdom is recommended to provide participants with information and advice tailored to reflect the local area’s service market including links related to education, health or social care, mental wellbeing, or logistical support.
* Advice and information should remain independent of service providers as well as the initial assessment process. Core characteristics of conflict-free intermediary services have been articulated by the Centers for Medicare and Medicaid Services (USA) and might be a useful template for future NDIS models.
* Testing of proposed models may be unethical or unfeasible using randomised trial designs, but is possible using Comparative Effectiveness Research (CER) or Realist Evaluation methods which allow for real world evaluations of complex interventions within complex systems.

For Local Area Coordination:

* International models of LAC deliver positive outcomes for participants from all walks of life and their families, providing a sense of agency and control over their health, and supporting their vision of ‘good life.’ Socially isolated, older people, and people with disabilities are likely to benefit from LAC service.
* LAC services act as a social glue for the communities they work with. Communities are supported to become more accepting of marginalised people and people with disabilities, and have higher rates of volunteering.
* Communities should be involved in the recruitment process because that increases community’s ownership of LAC service, gives them agency, embeds Coordinators in the community and decreases staff turnover.

## Introduction

Individualised plans aim to facilitate empowerment, independence, and self‐determination by providing access for people with disabilities to services and equipment that increase independence, participation and quality of life. Some individuals may require an intermediary service to assist them to understand and implement their plan, connect them to community or mainstream services, and build their capacity for self-direction and independence.

It is currently unclear which populations are likely to benefit most from this type of intervention, and whether any evidence exists regarding its effectiveness. It is also unclear how to best structure this service in a way that avoids conflicts of interest with providers of other funded services and service duplication with services such as Local Area Coordination (LAC).

### Objectives and Research Questions:

This report aims to locate and critically summarise international contemporary models of Support Coordination (SC) and Local Area Coordination (LAC).

Our questions were:

1. How are equivalent support coordination and local area coordination services provided elsewhere?
2. What evidence exists regarding the effectiveness and cost-effectiveness of these service models?

Specifically:

* What support coordination/LAC models are currently under development, have been implemented or evaluated in other countries?
* How are these funded, and how is eligibility determined?
* What is known about the effectiveness of these in terms of outcomes for people with disabilities? These may include Quality of Life, Client Satisfaction, Independent Living or participation scales, goal achievement
* What is known about process outcomes such as reach, access, connection to services?
* What is known about system outcomes such as resource use, redirection/reallocation of services or funding?
* What is known about their cost-effectiveness in comparison to other models?

### Methods:

We undertook a rapid evidence review using systematic methods to retrieve and critically appraise published reports of contemporary SC and LAC models. Rapid reviews use the same methods used for systematic reviews, but with simplified processes to produce information in a timely manner (Tricco et al., 2015.). Our project methodology is summarised in Figure 1.

Diagram showing systemmatic methods 
fo rapid revidence review

Figure 1: Overall Project Methodology

### Limitations:

As the results of this rapid evidence review were required within three weeks, we restricted our search to records published in English between 2010 and March 2020, and only one person screened titles and abstracts, which may have resulted in the omission of some key evidence. Rapid reviews, by their nature, can lack the detail that traditional systematic reviews and a more comprehensive review might yield differing results.

### Flowchart for finding key evidence

The process used is presented in the preferred Reporting Items for Systematic Reviews and Meta Analysis(PRISMA) format.

| Steps in retrieval and analysis of relevant evidence are summarized below and in Figure 2. |
| --- |
|  |
| Step 1:. Relevant documents were located via academic databases as well as grey literature, |
| search engines and websites |
|  |
| Step 2: Documents were uploaded to Covidence, an online platform for streamlining systematic reviews, which identified and removed duplicates |
| Step 3: One reviewer screened titles and abstracts against inclusion/exclusion criteria |
|  |
|  |
| Step 4: Two reviewers conducted full text review and excluded ineligible documents |
|  |
|  |
| Step 5: With 22 included documents, reviewers extracted data separately for SC (2 systematic reviews of quantitative and qualitative studies, 4 studies with original data) and LAC (15 evaluation reports and 1 evidence review) and summarised the results separately |

This diagram showing the PRISMA decision making process

.

Figure 2: PRISMA Flowchart

For a full description of methodology please refer to the Appendix 1 Review Methodology

## Findings

Excluding the three reviews, the location of SC or LAC models described in included records was mostly England (15), United States (2), Australia (1) and New Zealand (1) (Figure 3: Number of reports/studies per country).

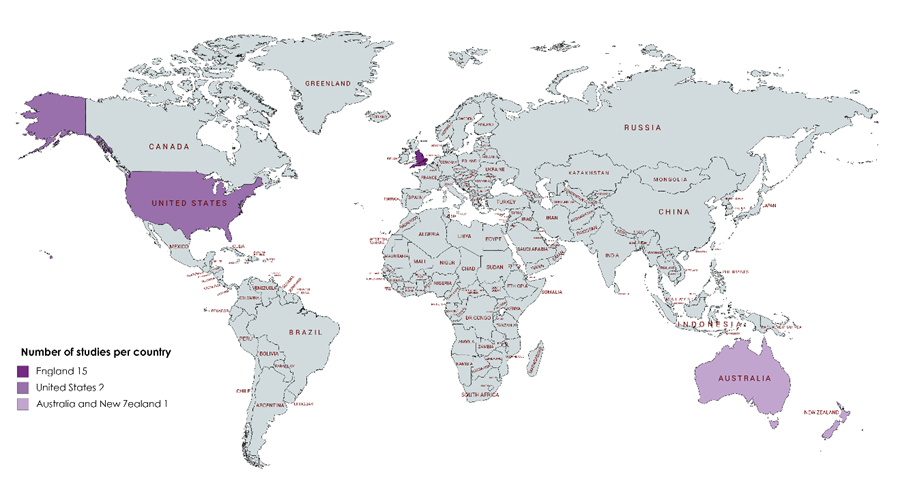


Figure 3: Number of studies per country

As all LAC records were mostly descriptive of their service model (i.e. did not include any outcome or effectiveness data) we have presented our findings in summary tables and a narrative review.

Records relating to Support Coordination-equivalent interventions provided some data regarding perceived benefits and harms from the perspective of consumers and disability planners / coordinators, so were included in a separate rapid systematic review report.

### Support Coordination (Intermediary) Models

#### Key components of equivalent models

Of the six records relevant to SC, four peer reviewed studies described either the structure of models or the key activities performed by SC-equivalent services (described as “intermediary” services in the international literature) which provided useful insights into how they had been implemented. Of these, two (Harry et al. 2017; Mahoney et al. 2019) described the US ‘Cash and Counseling’ model, one (Bogenschutz et al. 2019) described Case Management services for people with intellectual and developmental disabilities, and one (Collings et al. 2018) explored planning supports for people with complex support needs across disability, mental health, alcohol and other drugs, housing and criminal justice.

Common to all models was the provision of information about how to manage the self-directed plan, and referral or direct linkage to services in the community. All highlighted the need for the intermediary to know about or find the *right* service, as people with complex needs may have had negative past experiences when attempting to access services. All except one (Collings et al. 2018) specifically included ongoing monitoring as part of the role. Assistance with financial management was not mentioned in two of the studies, but was explicit in the ‘Cash and Counseling’ studies. This model includes services delivered by a Fiscal intermediary who helped manage the budget, wrote checks for hired support workers, and took responsibility for other payroll duties, such as withholding taxes.

The manner in which intermediary services were delivered was most important, with participants in one of the Cash and Counseling studies (Mahoney et al. 2019) valuing familiarity, proactivity, cultural friendliness, responsiveness, and supportive relationships with their broker. This was echoed from the provider’s perspective, with building rapport, avoiding shortcuts and rushed approaches to decision making, and supporting the person to learn being key priorities (Collings et al. 2018). Appendix 2 (Support Coordination equivalent models) presents summary data regarding each model.

Two systematic reviews, one focusing on facilitators of service users’ engagement and choice-making**,** and the other on the effectiveness of individualised funding interventions (but not specifically intermediary services) were included as both provided syntheses of qualitative data relating to either consumer/family and/or staff perspectives of intermediary services.

We found no studies that directly compared “consumer-directed plan plus intermediary services” to “consumer-directed plan with no/alternative intermediary”, and we found no comparative studies published after theincluded reviews.

#### Quality of the evidence

One of the two systematic reviews by Fleming et al (2019) was exceptionally rigorous and comprehensive. The review by Lakhani (2019) however had a weaker and narrower search strategy and unclear assessment of the quality of included articles.

The one randomised controlled trial by Harry (2017) presented secondary data analysis of data collected between 1999 to 2003 during the Cash and Counseling Demonstration and Evaluation (CCDE) randomized control trial in the USA which compared “Cash and Counseling” to “agency-based care as usual”. They specifically focused on a subgroup of participants aged between 18 and 30 years, however there were significant dropouts in the intervention group (25% in one state) which was not explained and no blinding of data collectors. The qualitative studies included were generally of good quality, although none provided clear statements regarding the relationship between researcher and participants.

Tables describing the characteristics and quality appraisal of included studies for this part of the review are included in Appendix 5: Characteristics and Quality Appraisal of included studies for Support Coordination Systematic Review

**NB A full draft manuscript: “*Intermediary services to assist people with disabilities to implement individualised funding plans: A rapid systematic review*” is available on request**

#### Effectiveness of Intermediary Models

Table 1: Summary of Evidence, Intermediary Services

| Types of findings | Direction of Effect | Comment |
| --- | --- | --- |
| Effectiveness | Unknown | No studies provided quantitative data that compared an SC-equivalent intervention to “no service” or an alternative model. |
| Perceived  benefits | Postive | There is qualitative data from the perspective of disability planners and workers that the provision of support and other human resources (including intermediary services, community integration, and innovative/creative supporters) was a facilitator of successful plan implementation (Fleming et al 2019 – review of 66 qualitative and 3 mixed methods papers). |
| Harms | Negative | There was evidence of disabling practices and attitudes among some funding bodies and support agencies, resulting in planners/coordinators being very risk averse in order to safeguard their clients. |
| Costs and cost-effectiveness | Unknown | Our search retrieved no published data regarding costs or cost-effectiveness of support coordination. |
| Stakeholders' views and experiences | Postive | There is qualitative data from consumer and family perspectives that external support is required to successfully navigate self-directed systems and that strong, trusting and collaborative relationships with both paid and unpaid individuals in the person's support network were facilitators of successful plan implementation (Lakhani et al 2018 – review of 18 studies; Fleming et al 2019 – review of 66 qualitative and 3 mixed methods papers) |

### Local Area Coordination models

Data for Local Area Coordination models was extracted from 15 evaluation reports and one evidence review paper. To describe contemporary models and report any evaluations effectiveness and/or cost-effectiveness, data were extracted under 12 categories (Name of the service, Key functions, Participants engagement with LAC, Life events associated with accessing LAC, LAC role, Participants per LAC ratio, Admin tasks, Service funding, Cost-effectiveness, Eligibility criteria, Service providers, and Summary of strengths and weaknesses). Not all reports addressed all categories (see Appendices 3 & 4).

#### Name of the service

The most common name was Local Area Coordination service specified for a location. For instance, LAC New Zealand (Pike et al. 2016), Waltham Forest (Gamsu & Rippon 2018), Leicestershire (Forshaw et al. 2016;) Haringey (Gamsu & Rippon 2019;) Derby[[1]](#footnote-1) (Kingfishers 2016; Marsh 2016) City of York (Lunt & Bainbridge 2019; Lunt et al. 2018) Isle of Wight (Mason et al. 2019; Darnton et al. 2018; Oatley 2016) and Thurrock (Sitch 2014; Kingfishers 2015; Kingfishers 2016). There were reports on LAC pilot programs in Suffolk (Yannitell & Chatsiou 2018) and Middlesbrough (Peter Fletcher Associates Ltd 2011). One study reported on Local Area Coordination and Local Community Coordination (LCC) as two separate services within the same locality, Western Bay, England (Swansea University 2016).

#### Key functions

Key functions of the LAC service were listed or described in all studies, but with varying quality of reporting. Ten studies reported in depth about LAC services, including vision and levels of service (Yannitell & Chatsiou 2018; Gamsu & Rippon 2018; Peter Fletcher Associates Ltd 2011; Darnton et al. 2018; Sitch 2014; Oatley 2016; Forshaw et al. 2016; Kingfishers 2016 Gamsu & Rippon 2019;Lunt et al. 2018), however six reports lacked comprehensive elaboration of models.

In England, LACs “walk alongside” individuals and families helping them build their strengths and develop resilience. LAC is available to anyone in the community, and the approach is person centered and tailored to individual needs.

The majority of reports described two levels of support available through LAC (Figure 4: LAC support levels).

Level 1 – anyone can access this level of support from LACs and there are no assessments or intake processes. This level offers provision of information, advice, or signposting to other services. Level 1 is defined as limited support however there was no data about the duration of this provision.

Level 2 – is support for people, children and adults, who are vulnerable “due to physical, intellectual, cognitive and/or sensory disability, mental health needs, age or frailty” (Sitch 2014; Oatley 2016; Gamsu & Rippon 2019; Marsh 2016; Peter Fletcher Associates Ltd 2011). Level 2 participants require ongoing assistance to “to build relationships, nurture control, choice and self-sufficiency, plan for the future, and find practical solutions to problems” (Sitch 2014; Oatley 2016; Marsh 2016). This is a longer-term relationship, however there was no data about the duration of support.

Another level of LAC support was reported in the City of York (Lunt & Bainbridge 2019) and Derby (Marsh 2016) aimed at community groups. This level supports existing or new groups, and assistance can be brief or ongoing. Support includes connecting community groups, giving advice on funding, and identifying delivery locations.

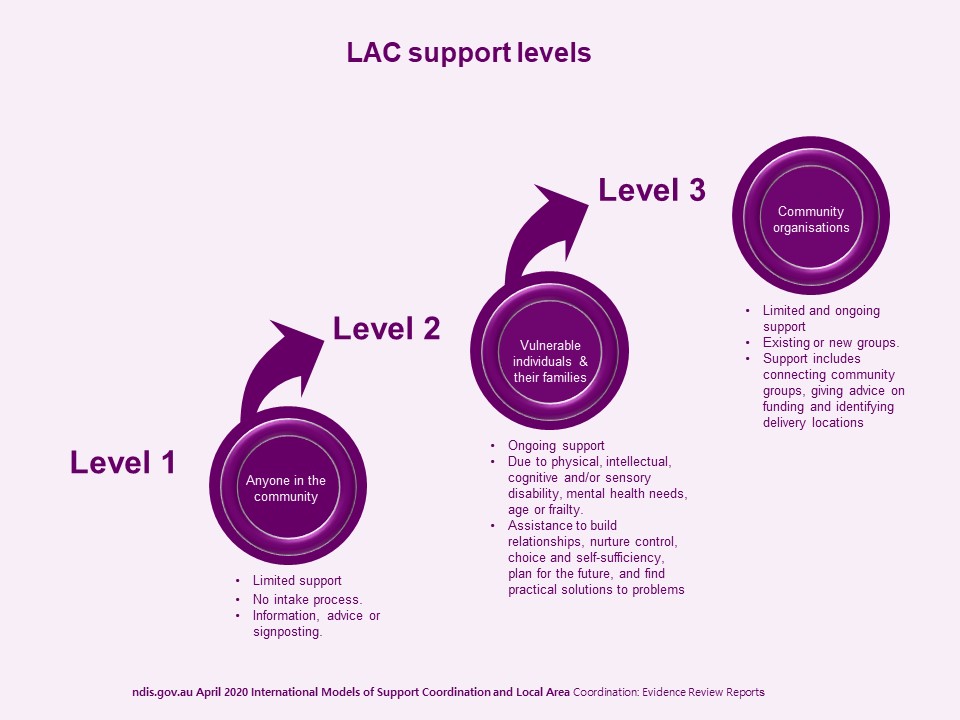


Figure 4: LAC support levels

Alongside LAC, another type of support was reported for Western Bay, England (Swansea University 2016). Local Community Coordination (LCC) was based on LAC components with an emerging framework build from the ground up. LCC is driven by the context in which it operates, does not have a dedicated leadership group, but instead allows Coordinator autonomy in shaping and developing the working model. LCC offers the same levels of support as LAC.

In New Zealand, LACs were trialed as part of Enhanced Individualised Funding (Pike et al. 2016). The LAC supports people with disabilities, their families and/or carers to strengthen connections with communities they live in. The service also works with communities supporting them to become more inclusive of people with disabilities.

In this model, the LAC offers two levels of support. For level 1, participants have initial contact with the LACs and they are provided with information they need. This is a limited support, however no data was found about the duration of provision. There is no formal intake process or assessment. Level 2 focuses on participants who meet the Ministry of Health’s definition of people with disabilities

#### Participants’ engagement with LAC

LAC does not work through referrals or waiting lists but rather utilizes the principle of ‘introductions’ to engage with participants (Marsh 2016). The focus is on voluntary relationships and connecting with participants (Marsh 2016; Lunt & Bainbridge 2019). Data about introductions was extracted from ten studies (Mason et al. 2019; Yannitell & Chatsiou 2018; Gamsu & Rippon 2018; Darnton et al. 2018; Sitch 2014; Lunt & Bainbridge 2019; Oatley 2016; Gamsu & Rippon 2019; Marsh 2016; Pike et al. 2016). The majority of studies reported on ‘who introduces’ participants to LAC service. Figure 5 shows methods of introduction as reported in the studies[[2]](#footnote-2).

Figure 5: LAC Methods of introduction

#### Life event associated with accessing LAC

Data on life events associated with accessing LAC could not be found in any report. However, proxy data that potentially might give the answer was found in reasons for introductions. Of 18 studies, seven reported on reasons for introductions (Gamsu & Rippon 2018; Darnton et al. 2018; Forshaw et al. 2016; Kingfishers 2016; Kingfishers 2015; Swansea University 2016; Marsh 2016). Table 2 illustrates the reasons for accessing LAC.

Table 2: Reasons for accessing LAC

| # | Reason category | Number of records |
| --- | --- | --- |
|  | Social isolation and/or loneliness | 7 |
|  | Mental health | 7 |
|  | Complex needs | 4 |
|  | Hoarding | 4 |
|  | Old age | 3 |
|  | Frequent GP visits | 3 |
|  | Housing | 3 |
|  | Learning/health disabilities | 2 |
|  | Mobility | 2 |
|  | Homelessness | 2 |
|  | Finances | 2 |
|  | Job, training, volunteering | 2 |
|  | Child protection/drugs/anger/school | 1 |
|  | Personal abuse | 1 |
|  | Police involvement | 1 |
|  | Not managing at home/separation | 1 |
|  | Home adaptations | 1 |
|  | Carer struggling and respite | 1 |

#### LAC role

Reports acknowledge that the role of Coordinators is at the heart of the LAC approach (Lunt & Bainbridge 2019). LACs walk alongside people of all ages and their families, respecting their different lived experiences in regard to disability, mental health, and caring (Oatley 2016). Lunt et al. (2018) argue that “Local Area Coordination is as strong as the Local Area Coordinators appointed.”

Several characteristics were deemed as important for the LAC role - traits and skills of coordinator, knowledge of local community, time, and involvement of community in recruitment of LACs. The skills deemed most important are illustrated in Figure 6: LAC role.

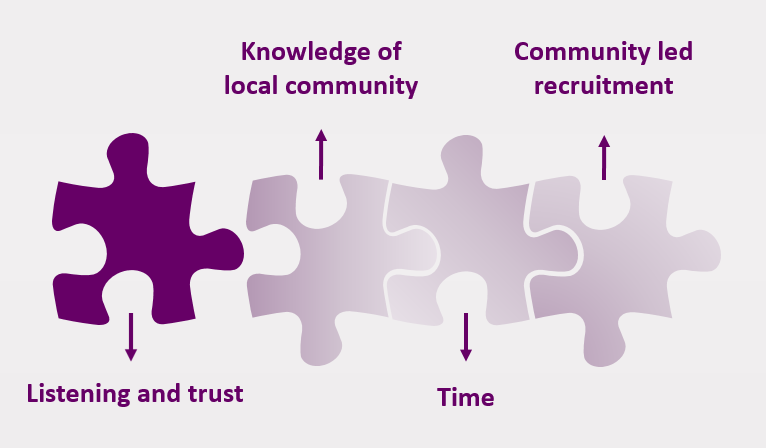


Figure 6: LAC Role

Listening and developing trust were listed as the most important skills for the LAC role. Coordinators were seen as someone who has the ability to listen to those who are often left on the margins of society, understand their needs, and provide a platform for achieving outcomes for a ‘good life’(Mason et al. 2019). Nurturing trust and developing positive relationships with participants and their families was seen to help build resilience and supportive connections to reduce the risk of future crisis (Swansea University 2016).

Several studies emphasised the importance of knowledge about local community and services available (Kingfishers 2016; Gamsu and Rippon 2018; Gamsu and Rippon 2019; Mason et al. 2019). Coordinators formed connections with local libraries, community clubs, sector professionals, other agencies including health, social care, housing and community policing. They were also present at local events and activities (Gamsu and Rippon 2018; Mason et al. 2019). By making themselves visible, LACs were seen as a ‘familiar face’ in the community encouraging ‘harder to reach’ residents to approach them (Gamsu and Rippon 2019).

Mason et al. (2019) argue that the time that Coordinators spend with each participant is the most important element of the service. LACs take time to get to know each participant, understand their problems and their vision of a better life, and support them with local based solutions (Oatley 2016). This allowed participants to build resilience and stay focused on the future.

Involvement of the community in recruitment was another important mechanism. Sitch (2014) reported that LACs in Thurrock were recruited by local communities through an inclusive process. Oatley (2016) argues that recruitment by the community increases community ownership of the LAC service, but also makes LACs accountable to communities they work with. Darnton et al (2018) reported that embedding a new LAC in the community through inclusive recruitment process contributed to low staff turnover.

#### Participants per LAC ratio

We found no data to support the optimal ratio of participants to LAC. One study stated that each LAC should support a given number of participants drawing on an example from Australia where the reported ratio was 60:1 (Peter Fletcher Associates Ltd 2011). However, there was no reference to the original study or explanation about how that number was determined.

Studies reported a growing concern over increased caseload (Lunt & Bainbridge 2019) and the need for mapping and maintaining ‘human sized units’ (Oatley 2016). One of the recommendations was to avoid program overstretching and working across large areas or supporting too many people (Oatley 2016).

#### Admin tasks

There was no data found about administrative tasks burdening LACs. One report stated that the growth of caseload might cause difficulties in data collection and management. The authors recommended developing software and/or smart device “Apps” to allow LACs to log visits in an easy and timely fashion (Oatley 2016).

#### Service funding

LAC service funding was only reported in 11 reports. Figure 7 illustrates LAC funding source.

Figure 7: LAC Funding

#### Cost-effectiveness

Data of cost-effectiveness was reported in nine reports (Gamsu & Rippon 2018; Peter Fletcher Associates Ltd 2011; Sitch 2014; Forshaw et al. 2016; Kingfishers 2015; Kingfishers 2016; Swansea University 2016; Gamsu & Rippon 2019; Marsh 2016).

Eight reports utilised the Social Return on Investment (SROI), a method used to help organisations measure and quantify extra-financial values, like social or environmental value they are creating, but which are not reflected in conventional financial accounts (Social Change 2020; Investopedia 2019). They showed a consistent benefit attached to LAC, concluding that for each £1 invested there was a £4 return into the local system (Sitch 2014; Forshaw et al. 2016; Kingfishers 2015; Kingfishers 2016; Swansea University 2016; Gamsu & Rippon 2019; Marsh 2016; Peter Fletcher Associates Ltd 2011) (Figure 8: LAC cost-effectiveness). The highest returns were seen in the local authority system and local health economy (Gamsu & Rippon 2018). Gamsu and Rippon (2018) reported that the scope of their evaluation and resources available did not allow them to perform a full financial and cost-benefit analysis.

Figure 8: LAC cost-effectiveness

#### Adding value to wider service system

The reports noted that aside of providing service to local community LACs were also adding a value to the local service system. That was seen on two levels – by addressing participants’ underlying issues and by collaborating with other services.

LACs were addressing participants’ underlying ongoing issues, such as loneliness, isolation, hoarding, and living in unsafe houses by helping them to participate in skills sharing and finding volunteering opportunities. By doing so, LACs were acting as prevention which relieved other services, notably GPs, fire brigade, mental health services, employment services, local non profit organisations or services like local libraries (Oatley 2016; Marsh 2016).

Through collaboration with other services, helping participants navigate local councils and services, making timely referrals to avoid crises, and bringing in volunteers (Oatley 2016; Marsh 2016) LACs were reducing demands on other services. Oatley (2016) also reports that LAC were working with a range of partners including children’s services, housing providers, police, GPs and District Nursing to help address participants’ needs. A report by Yannitell Reinhardt and Chatsiou (2018) stated that 5% of participants had reduced inappropriate visits to GP or other health teams due to the LAC program.

#### Eligibility criteria

Eligibility criteria were stated in five reports. As a service embedded in the community, LAC is available to anyone for the Level 1 support (Gamsu & Rippon 2018; Peter Fletcher Associates Ltd 2011). Level 2 support is an ongoing support available to vulnerable individuals and their families (Gamsu & Rippon 2018; Peter Fletcher Associates Ltd 2011; Oatley 2016; Gamsu & Rippon 2019; Pike et al. 2016).

A report regarding the Middleborough LAC pilot (Peter Fletcher Associates Ltd 2011) stated that opened eligibility criteria enables the service to work with people who have low-level needs. This means that participants can receive support before their problem escalates (Level 1 support). The authors point out that LACs are supporting individuals, their families and carers through direct contact and not via a third party. In addition, Middleborough LAC works with people who might ‘slip through the net’ because they do not meet criteria of statutory services.

In New Zealand (Pike et al. 2016), Level 1 support is open to everyone in the community. Level 2 is for the people who meet the Ministry of Health’s definition of people with disabilities. They may choose to receive ongoing support from a LAC, even if they are receiving other support funded by Disability Support Services in the Ministry.

#### Service providers

Service providers were addressed in nine reports, however there was no extensive data. Six reports stated that LAC is a part of Local Authority – in Suffolk (Yannitell & Chatsiou 2018), London’s Borough of Waltham Forest (Gamsu & Rippon 2018), City of York (Lunt et al. 2018; Lunt & Bainbridge 2019), Western Bay (Swansea University 2016) and City of Derby (Marsh 2016). Two reports stated that LAC is embedded in the Clinical Commissioning Group however both were referring to the Isle of Wight (Oatley 2016; Darnton et al. 2018). Lastly, one study referred to the New Zealand Government as a service provider (Pike et al. 2016).

#### Summary of strengths and weaknesses

Reports selected for this part of the review showed that participants were the primary beneficiaries of LAC services. Participants were supported to overcome social isolation and build new relationships or re-connect with their community, family, and friends. Participants were supported to leave their homes and undertake tasks outside which led to an increased sense of independence. Further, participants reported increased social capital and were feeling self-reliant, more connected and willing to share their knowledge with the community through volunteering (Darnton et al. 2018; Kingfishers 2015; Kingfishers 2016; Lunt & Bainbridge 2019; Mason et al. 2019; Oatley 2016; Marsh 2016).

LAC have supported participants through providing information and advocacy, helping them navigate local councils and other social services, take control of their life and work towards the fulfilment of their idea of good life (Marsh 2016; Kingfishers 2015; Darnton et al. 2018; Oatley 2016). Participants reported that engaging with LAC made them feel more in control.

Further, participants were supported in managing their health, overcoming crises, or acting before crises emerged (Peter Fletcher Associates Ltd 2011; Darnton et al. 2018; Kingfishers 2016). LAC had helped with connecting participants with the right services in the right moment while reducing demand on health care sector, police, education and council supports (Yannitell & Chatsiou 2018).

Other areas of life where participants have benefited from engaging with LAC were employment, training, financial advice, housing, fire hazards, and hoarding.

Communities benefited from the work of LACs through preventative interventions, building resilience and increasing social capital. LAC supported community and community organisations through engaging participants in volunteering and skill sharing, and by bringing attendees to events (Oatley 2016; Marsh 2016). LAC was also supporting families in navigating complex needs and challenging circumstances (Lunt & Bainbridge 2019).

Lastly, LACs provided positive outcomes for other services through good collaboration, facilitation of access to services, timely referrals to avoid crises, and reducing demands on other services (Marsh 2016; Swansea University 2016;).

Few reports identified weaknesses of LAC services. The most prominent unintended negative outcome was participants’ dependency on LAC services. Marsh (2016) reported that about 5% Level 2 participants were dependent on LACs. Kingfisher’s report for Thurrock and Derby (2016) reported that dependency was found in both LAC services. Dependency occurred in a small number of cases and was seen as a product of the close relationship that LACs build with participants. Recommendations for improvement accentuated sharing knowledge and skills between LACs on mitigating dependency and increasing the number of LACs per area to avoid strong personal relationships while still maintaining trust (Kingfishers 2016; Kingfishers 2015).

Reports highlighted the need to focus on certain groups of participants that were not getting enough attention. Kingfishers (2016) argue that LACs should try and engage young people, especially those with learning disabilities, to aid their transition into adulthood, as well as people looking to return to work. Similarly, Mason et al. (2019) emphasized the need for LACs to try and engage more with young people.

There was evidence of LAC’s limited availability. Two reports recommended a rescoping of LAC service boundaries, due to requests that were just outside an LAC area or restricted availability to only a few wards (Swansea University 2016; Peter Fletcher Associates Ltd 2011). The report from Swansea University (2016) argued for scoping of LAC areas based on need assessment.

Another concern was a future growth of LAC service and need to maintain ‘human sized units’ to avoid overstretching of the service (Oatley 2016). In relation to this concern, the need to better manage caseloads was voiced (Lunt & Bainbridge 2019; Gamsu & Rippon 2019).

Evaluations have reported on need for LAC’s purpose and role in the community to be understood by other services (Gamsu & Rippon 2018; Lunt & Bainbridge 2019; Forshaw et al. 2016). Gamsu & Rippon (2018) argue that it should not be assumed that other services understand or readily accept the approach endorsed by LACs. This is because LAC works in a way that is significantly different to other services and some work should be done to assure alignment and cooperation.

Lastly, Peter Fletcher Associates Ltd (2011) argued that LACs in Middlesbrough need to do more work on building communities and developing their abilities to be more inclusive and supportive of people with disabilities and vulnerable members of community.

## Conclusion

### Support Coordination equivalents

Intermediary interventions equivalent to NDIS’s Support Coordination are implemented differently internationally but rarely described in detail. Common to all models included in this review was the provision of information about how to manage the self-directed plan, and referral or direct linkage to services in the community. Many people with complex needs have had negative past experiences when attempting to access services, and the intermediary must be able to link participants to the *right* service.

This review has highlighted the lack of robust effectiveness data on what is a complex social intervention. This is due to the inherent ethical and logistical challenges associated with collecting quantitative data via controlled comparative methods. There is, however, extensive qualitative evidence that they are valued by consumers and are seen by planners and consumers as a major facilitator of successful plan implementation. There is the risk of harm if providers of intermediary services hold overly risk-averse attitudes which constrain consumers’ choice and control.

Whilst some individuals may be “consummate consumers”, others will need greater assistance in implementing their plan due to isolation from their local community, lack of experience in navigating the funding system, or the ability to effectively procure and manage their own services. Ideally, the level of support provided should be flexible and informed by the consumer’s current needs and access to family or peer support. They are likely to be crucial for people with complex needs i.e. those with a range of different, often interrelated, needs that are serious, intense, severe, or profound and likely to require support from different services, such as social, health and housing services.

Eligibility criteria and levels of service for proposed new models should be developed in consultation with groups representing those with complex needs and LACs to ensure clarity of provider roles/scope and service priorities.

A clearer understanding of their effectiveness for different populations would require carefully planned and methodologically robust comparative trial designs, clear description and consistent delivery of interventions, and long-term evaluation of impact

Finally, advice and information should remain independent of service providers as well as the initial assessment process. In the USA, the Centers for Medicare and Medicaid Services have articulated the following core characteristics of conflict-free intermediary services[[3]](#footnote-3) (referred to as case management):

* Responsibility for providing case management services is separated from responsibility for the provision of direct services and supports;
* Case managers are not employed by an entity providing services;
* Case managers are not responsible for determining individual funding levels

### Local Area Coordination

Local Area Coordination is applied differently in the NDIS than it is internationally. In England, the service is available to anyone in the community, and people from all walks of life can access Level 1 support. Level 2 support is aimed at people with complex needs. Eligibility criteria are loosely defined, allowing LACs to work with people who might not be eligible for other statutory services. In NZ, while aimed at people with disabilities and their families, LACs also work with other people from the community through Level 1 support. Level 2 support is aimed at people who meet Ministry of Health’s definition of disability.

LACs in both England and NZ work with communities to make them more accepting of marginalised populations and people with disabilities. In England, two evaluations reported on separate levels aimed at community groups helping them to apply for funds, find new volunteers and identify delivery locations.

The coordinator’s role is at the centre of the service with listening, trust, knowledge of local community, and time they spend with each participant considered the most valuable traits. Community participation in the recruitment process has proven to strengthen community ownership and the coordinator’s accountability to the community.

The included reports showed that participants, and their idea of good life, should be at the centre of the LAC service. Further, sustainable funding, clear participant per coordinator ratios, and avoiding participant over-reliance on coordinators are essential for functioning of LAC service.

While the effectiveness of the LAC service is clear when it comes to participants, more rigorous data collection is needed to allow for an estimate of effectiveness for other stakeholders to be measured. However, we acknowledge that some LAC outputs and outcomes are less tangible and therefore harder to express through exact measures. SROI therefore seems like the most appropriate method to measure the effectiveness of LAC services for various stakeholders.

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Appendices

### Appendix 1 Review Methodology

#### Review protocol

Prior to conducting the review we designed a rapid systematic review protocol (See Appendix B). This document was refined in consultation with three members of Research and Evaluation team A/Prof Claire Harris, Dr Rebecca Armstrong and Ms Marie Garrubba. In addition, the protocol was reviewed by stakeholders Hannah Simkin and Bridey Sanders and subsequently approved for further research.

The protocol defined

* **Population** addressed in the search as people with permanent and significant disability (physical, sensory, intellectual or developmental disability, mental health problems, psychosocial disability, disorder or illness, or dementia), residing in any country and any type of residential setting (own home, group home, residential care setting, nursing home, hospital, institution).
* **Intervention** Models of support coordination for individualised programs that include services and/or equipment to manage the disability
* **Outcomes** This review was looking for observer-based outcome measures (OBOMs) and/or patient-reported outcome measures (PROMs). For effectiveness, the key outcomes are quality of life, client satisfaction and measures of independent living or participation. For cost-effectiveness, data that compares the specific model to any other model will be reported.
* **Context** Disability system research. Individual plan coordination for people with a disability to support them to implement their plan or develop capacity
* **Study design** We first searched for high quality systematic reviews published no more than 2 years ago. Further we searched for randomised controlled trials (RCTs), quasi RCTs, controlled before and after studies, and well-designed cohort studies in which participant groups are comparable. All included studies must report quantitative or qualitative data regarding outcomes or the effects (which can be positive and/or negative) of the use of support coordination/LAC service. Lastly, we searched for evaluation reports of LAC/SC models handsearching relevant websites.
* **Timeframe** 2010-current
* **Language** English

#### Database search

To locate relevant studies, we searched six academic databases - the Campbell Collaboration, Social Systems Evidence, ASSIA (Applied Social Sciences Index and Abstracts) EmBase, PubMed, PsychInfo. We also searched Google Scholar data base and LAC Network[[4]](#footnote-4) evidence repository for grey literature. In addition, after the consultation with the stakeholders following websites were hand searched - Inclusive Neighborhoods[[5]](#footnote-5), Centre for Welfare Reform[[6]](#footnote-6), Kendrick Consulting[[7]](#footnote-7), Derby City Council[[8]](#footnote-8), Thurrock City Council[[9]](#footnote-9), Community Catalyst[[10]](#footnote-10) and My Support Broker (MSB)[[11]](#footnote-11).

#### Search strategy

The four-string search strategy was developed to yield studies relevant for the research questions. This search strategy was used for the academic databases.

1. Disab\* OR impair\* OR disorder

2. Coordinat\* OR ‘case manage\*’ OR ‘case work\*’ OR plann\* OR broker\* OR support\* OR intermed\* OR partner OR connect\*

3. Effect\* OR cost-effect\* OR evaluat\*

4. ‘Quality of Life’ OR Satisf\* OR Independen\* OR ‘daily living’ OR particip\*.

When searching for the grey literature simplified search strategy was applied. Google Scholar: Disability and ‘support coordination’ Limiters included: Articles, articles dated between 2010-2020, English. In addition, when searching websites reviewers used hand search to locate relevant studies. Databases and websites were searched between 26/03/2020 and 02/04/2020.

#### Reference screening

Following the search, all identified citations were collated and uploaded into EndNote reference citation manager software, and duplicates removed. After de-duplication the references were uploaded into Covidence[[12]](#footnote-12), a web-based platform for streamlining systematic reviews. Titles and abstracts were screened by one reviewer (IR) for assessment against the inclusion criteria for the review. Potentially relevant studies were retrieved in full and assessed in detail against the inclusion criteria by two independent reviewers (IR and LOB). Studies were then critically appraised using standardised quality. Following critical appraisal, studies that did not specifically described/evaluated SC or LAC model were excluded.

#### Data extraction

Data were extracted from studies included in the review by one reviewer (either LOB or IR) using a standardized data extraction tool. The data extracted included specific details about the populations, study methods, interventions, funding sources, eligibility criteria for service, the provider of the service, and outcomes of significance to the review objectives (effectiveness, cost effectiveness, system and process outcomes)

#### Data synthesis

Extracted data was grouped separately for SC and LAC.

SC data was coded under Methods used in the study, Name of SC service and country of origin, Key functions, Service funding, Eligibility criteria, Service providers, Type of support, Cost of service provision, Evidence to support outcomes for people with disability, and Evidence regarding cost-effectiveness, system or process outcomes.

LAC data was coded under 12 categories Name of the service, Key functions, Participants engagement with LAC, Life events associated with accessing LAC, LAC role, Participants per LAC ratio, Admin tasks, Service funding, Cost-effectiveness, Eligibility criteria, Service providers, and Summary of strengths and weaknesses.

Coded data is presented as narrative and tables

### Appendix 2: Support Coordination equivalent models

| **Reference** | **Name of service and country of origin** | **Key functions, levels, and duration of the service** | **How the service is/was funded** | **Eligibility criteria for service (including for each category or level if applicable)** | **Who provides support** | **What type of support is provided** | **Cost of service provision** | **Evidence to support outcomes for people with disability** | **Evidence regarding cost-effectiveness, system or process outcomes** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Collings (2018) | **Service Coordination**  NSW Family and Community  Services, Ageing, Disability & Home Care Australia | Essentially a case management role. Intensity, and duration dependent on need. | State government | Not addressed | External providers | Support coordinator facilitates an individual’s capacity for social participation through:   1. linkage with the “right” community supports 2. resolving access barriers or points of crisis. | Not stated | No | No |
| Harry (2017) and Mahoney (2019) | **Cash and Counseling program**  USA | The amount and frequency with which an individual used the available supports varies by person and circumstance. | Medicaid, Veterans Affairs, Insurers | Each cash and counselling program has its own eligibility requirements (functional and financial criteria).  Medicaid programs have a functional requirement (the participant must require a certain level of care).  A support broker/ consultant/counselor **must** be available to each individual who elects the self-direction option | Wide variation in who provides support broker functions between states/authorities, including counselling or financial management service companies | **Counsellors** develop spending plan; provide information and advice about how a self-directed program works; provide advice re individual rights and responsibilities and locally available resources; recruitment/ hiring/training of support workers; and monitoring of the quality of care.  **Fiscal intermediaries** write checks for hired workers, withhold taxes.  Four key categories valued by consumers are:  Coaching, Problem Solving, Advocacy, and Monitoring | Not stated | No | No |
| Bogenschutz (2019) | **Case Management** (encompassing Support Coordination)  for people with intellectual and developmental disabilities (IDD)  **Virginia Department of Behavioral Health and Developmental Services**  USA | Case Managers provide a point of connection between an individual with IDD and the publicly funded service system | Medicaid (varies between states, with most states using some combination of federal, state, and sometimes local funds) | Not stated | Varies – in some instances it is delivered through public entities, whereas private non-profits or managed care organizations may be responsible for provision of CM in other locales. | (a) providing a point of connection between an individual with IDD and the service system  (b) monitoring of services to assure that services are of adequate quality and are leading to attainment of important life outcomes  All are meant to be provided in a collaborative fashion between the case manager and the person receiving services and/or their representative. | Not stated | No | No |

### Appendix 3 : LAC Models

| Reference | Name of the service | Key functions, levels, duration | How the service was/is funded | Eligibility criteria | Who provides support/service | Summary of strengths and weaknesses |
| --- | --- | --- | --- | --- | --- | --- |
| Yannitell Reinhardt and Chatsiou, 2018 | Local Area Coordination pilot program in Suffolk, England | LAC support local residents to: access information, identify their personal strengths, goals and needs; find practical ways of doing the things they want or need to do to reduce demand; develop and use personal and local networks to reduce isolation, participate in local community life; access support and services if required.  The report does not provide information about levels of the service or length of provision. | The funding for the two-year fixed-term posts came from the Transformation Challenge Award. | Not stated | Local Authority | The report identified that LAC provided benefits for participants:  1 in 5 participants was linked with a related service,  1 in 3 were supported to overcome barriers due to living in a rural area, 1 in 10 were supported by LACs to share their skills with their community.  Participants’ perceptions of wellbeing changed from an average 3 to an average 6.  The report showed that 5% of participants reported to have reduced inappropriate visits to GP or other health teams due to the LAC program.  The report highlighted:   * a need to reach out to a more representative part of the population. * the program should maintain the momentum and increase the number of Local Area Coordinators. |
| Gamsu and Rippon, 2018 | Waltham Forest Local Area Co-ordination Program, England. | There are two levels of support:  Level 1 support is the provision of information and/or limited support. Participants are provided with information or advice and usually no further support is needed. This level also serves as a connection that may be of benefit in the future.  •Level 2 support is a longer term relationship supporting people (children and adults); who are vulnerable due to physical, intellectual, cognitive and/or sensory disability, mental health needs, age or frailty and require sustained assistance to build relationships, nurture control, choice and self-sufficiency, plan for the future, find practical solutions to problems etc.  The report does not state for how long this support is provided. | The initial phase of the LAC scheme was fully funded by the Local Authority. | For this model there is no assessment or intake process. Anyone from the community can contact LAC for Level 1 support. | Local Authority | The report highlighted that LAC had a positive impact in the local communities. Data was reported via case studies.  This report identified:   * a need for the operational manager role to manage and support the Coordinators. * a need for broader understanding of LAC’s purpose * as the scheme develops in scale there would be a need for quality assurance. |
| Peter Fletcher Associates, 2011 | Local Area Coordination (LAC) pilot in Middlesbrough England. | Local Area Coordination is a service accessible to anyone in the community trough Level 1. Vulnerable populations have access to Level 2.  LAC is available for as long as people want the support.  The service does not operate through referrals or by having a waiting list.  LAC offers two levels of support:  Level 1 -provides information and/or limited support. There is no assessment needed to get this level of support.  Level 2 -continuing support to people (children and adults) who are vulnerable. | LAC is funded through the North East Improvement and Efficiency Partnership  (NEIEP). | Level 1 -the provision of information and/or limited support. There is no assessment or intake process.  Level 2 support is available for people (children and adults):   * who are vulnerable due to physical, intellectual, cognitive and/or sensory disability, mental health needs or age and require sustained assistance; * who are residents of the Netherfield, Park End or Priestfield areas of East Middlesbrough; * who might wish to access, in the short-term, provision of information, advocacy, advice and/or options; * who might access medium to long-term LAC support to ensure that plans and goals are achieved | Local Authority | This formative evaluation report identified that LAC made a positive impact in the local communities. Data was reported via case studies.  An hourly cost for the LAC service was calculated at £33.61, while an average cost of the LAC intervention was £92.77per case.  The report identified the need for the LAC service to be funded long term.  The report highlighted that:   * the relationship between the LAC service and access routes to both children and adults social care services needs to be formalised. LAC should become a key element in the way that people can access these services. * LAC was identified as the core of Council's response to people who fall outside the current eligibility for assessed care. |
| Sitch, 2014 | Local Area Co-ordination, Thurrock, England | There are two levels of support available through Local Area Coordination.  •Level 1 support is the provision of information and/or limited support. Participants accessing this level seek information/advice and no further support is needed at that time. However, a connection has been made and participants can benefit from it in the future.  •Level 2 support is a long term relationship supporting people (children and adults); who are vulnerable due to physical, intellectual, cognitive and/or sensory disability, mental health needs, age or frailty and require sustained assistance to build relationships, nurture control, choice and self-sufficiency, plan for the future, find practical solutions to problems etc. There was no indication in the report of the exact duration of the Level 2 support. | The Adult Social Care management team funded three LAC posts from their core budget. In addition, the Fire and Rescue Service part funded a seconded Firefighter to the role of LAC.  Three posts are funded from Public Health. The final three posts were at the time funded through the Better Care fund. | There was no requirement for assessment or intake process. Anyone from the community can contact the Local Area Coordinator for Level 1 support. | Not stated | This progress report identified that the LAC model needs continued funding in the longer term.  The report highlights the need for:   * understanding where the LAC role fits in alongside other community-based initiatives. * joint work with other partners in the community. * essential principles of LAC to be shared by community partners – working from a strength based rather than deficit based model.   NB The partners were not further elaborated in the report |
| Kingfishers, 2015 | Local Area Coordination Thurrock, England | There are two levels of support in this model.  While report does not give information about Level 1, Level 2 is aimed at individuals with complex needs, or multiple issues that require support.  There is no data about the duration of provision. | Not stated | Not stated | Not stated | The report highlighted that the greatest Social Value Distribution was to the participants with Level 1s at 22% and Level 2 at 60%. SVD for Health organisations account for 5% of the total value and public services as a whole 13%. The impact to Thurrock Council accounts for 8% of the total value.  The report highlighted Social Value Forecast: up to £4 for every £1 invested. The unintended negative was an increase in dependency on LAC.  The report stated the need for:   * capturing outcomes to better inform service delivery. * relationships with private sector, the Department for Work and Pensions (DWP) and JobCentre to increase opportunities for employment. |
| Kingfishers, 2016 | Local Area Coordination Thurrock Council and Derby City Council | LAC is a community based service support for residents in the community. LAC aims to build community resilience and social capital. Coordinators ‘walk alongside’ individuals providing personalised advice and support to enable them to ‘get a life, not a service’.  LAC provides two levels of support:  Level 1 - for low level support and advice;  Level 2 for longer term support for individuals with more complex needs.  The report does not state what the length of the Level 2 support is. | Both services receive funding through the Better Care Fund – a pooled budget to integrate health and social care across the NHS and Local Government.  In addition, as a result of working with Essex Fire and Rescue Service, Thurrock Council also received part funding for a post through secondment of a fire officer. | Not stated | Not stated | This report found that LAC in Thurrock needs to:   * identify opportunities to work with other signposting services to enhance reach of the LAC. Data shows that the engagement to date has brought 5.1% of social value distribution for Health, and 0.5% for Fire and Police Services. * explore working with young people and those with learning disabilities to aid their transition into adulthood. This was based on information from Derby Council however no data was provided to support this.   Report found that LAC in Derby needs:   * to explore potential for the service to be supported through the Fire Service, as it is the case with Thurrock. * better monitoring of outcomes for each individual case * to support individuals looking to return to work. This was based on information from Thurrock LAC however no data was provided to support this. |
| Marsh, 2016 | Local Area Coordination (LAC), Derby City Council, England | LAC aims to support residents in the local community to ‘get a life, not a service’, empowering individuals to find community based solutions instead of relying on services.  There are two levels of support in this model:   * Level 1 support—provision of information, advice and connections and/or limited and short term support; * Level 2 support—providing a 1 to 1 with relationship walking alongside people who are vulnerable due to physical, intellectual, cognitive and/or sensory disability, mental health needs, age or frailty, and require sustained assistance to build relationships, nurture control, choice and self-sufficiency, plan for the future and find practical solutions to problems. The report did not state length of provision for Level 2 support. | Funded through the Better Care Fund. | Not stated | Local Authority | This report identified positive outcomes for participants in both levels of support. Level 1 participants reported feeling less anxious 85%, less isolated 77%, feeling as part of community 55%. Level 2 participants feel less socially isolated 66%, as part of local community 57%, build trust with LACs 49%.  The report also highlights that 5% of Level 2 participants feel dependent on LAC.  This report identified Social Return of Investment financial proxies for various stakeholders. The overall the social value forecast was estimated to be £3.50 and up to £4 for every £1 invested. |
| Oatley, 2016 | Local Area Coordination on the Isle of Wight | LAC is central to the strategic vision for a new model of care for the island being led through the My Life a Full Life integrated program. LAC puts into practice a person-centred and strength-based approach to contribute towards prevention and early intervention intentions  There are two levels of support:  Level 1 support: the provision of information, connections and/or limited support. People accessing this level of support seek information/advice and no further support is needed.  Level 2 support: a longer term relationship alongside people (children and adults) with disabilities, mental health issues and older people, their families and/or carers and requiring sustained assistance to build relationships, nurture control, choice and self-sufficiency, plan for the future, find practical solutions to problems etc. There is no indication of the duration for this level of support. | LAC falls under the My Life a Full Life program. | There was no assessment or intake process. Anyone from the community can contact the Local Area Coordinator for Level 1 support. | Not stated | The report stated the evidence of cross organisational cooperation. LAC started working with a range of partners including children’s services, housing providers, police, GPs and District Nursing. This is supported with data on introductions to LAC. Of 76 participants, 11 were introduced by health services, 9 by Children Social Care, 6 by Housing, 6 by Voluntary sector 4 by GPs, 2 by Adult Social Care and 1 by Mental Health.  The report highlights a need for mapping and maintaining ‘human sized units’ to avoid program ‘stretch’ through areas becoming too large, or supporting too many people. |
| Darnton et al. 2018 | Local Area Coordination (LAC) Isle of Wight, England | Not stated | Isle of Wight (IoW) health are care system applied to become an Integrated Primary and Acute Care System (PACS) Vanguard site, and received additional funding to facilitate transformation of services | Not stated | Isle of Wight (IoW) health care system | The report identified that the LAC program helps people to access information, advice and support; take control and manage own health more easily. Data was collected via interviews and presented as a narrative.  The report identified that there is a collaboration of service and people, and services between themselves. People reported high R-Outcomes measures for not having to repeat their story and services talking to each other. Collaboration between services was reported to be important for the LAC programme success, this data was captured trough qualitative methods.  The report highlighted that people are getting the right support, at the right time and place from the most appropriate service. People reported statistically significant improvements in R-Outcomes for being able to look after their own health and feeling that they can get the right help if they need it. |
| Mason et al. 2019 | Local Area Coordination, Isle of Wight, England | LAC works with those in need of support around the various issues in their lives.  It may focus on health, physical activity, connecting with local services, and the local communities around them.  LAC attempts to build the capacity of individuals to take control over their own lives. | Not stated | Not stated | Not stated | This report identified that  Coordinators are helping participants in building social capital, identify what a good life is for them and how they can achieve this, feel like they can do more for themselves. Data was collected via qualitative interviews and presented as a narrative.  LAC is an open service - accessible to anyone in the community. This report has found that the introductions to LAC have been made through self-introduction, family members, with health advisors, at the food bank, etc. Data was presented as a narrative.  This report highlights a lack of younger people accessing LAC. The reports states only 2 of 17 individuals accessing LAC were age 25 and under. |
| Forshaw et al. 2016 | Leicestershire Local Area Coordination, England | LAC is a complex community-based intervention delivered in 10 local areas, in four of the County’s Districts. It is delivered by eight Coordinators.  LAC works with beneficiaries who are vulnerable and often experiencing a range of multi-layer complex challenges.  LAC is designed to have an impact on three levels: Individual, Community, and Health and Social Care Integration.  The levels were not further elaborated in the report. | LAC is part of the Unified Prevention Offer, Better Care Fund. | Not stated | Not stated | This report found that the LAC was effective in achieving its aims and strategic objectives. During one year LAC worked with 1,498 participants at Level 1 and Level 2. 830 participants were signposted by LAC, 174 supported to access benefits, and 21 referrals from the Police to LAC resulted in LAC contributing to a positive outcome.  The unintended negative was participants’ over-reliance on the service. The authors found that about 5% of participants may be dependent on LAC. |
| Swansea University, 2016 | Local Area Coordination (LAC) and Local Community Coordination (LCC), Western Bay, England | LAC and LCC Coordinators are embedded in the community and come alongside people of all ages, disabilities and backgrounds.  LAC and LCC are a local single point of contact working to reduce dependence on services and creating conditions for long-term resilience.  LCC is an emerging framework being shaped as it becomes embedded within the Local Authority. LCC shares its principles with LAC but does not fully implement all core design features.  There are 2 tiers for accessing both LAC and LCC:   * a light touch approach (Tier 1 cases) * complex and longer-term cases (Tier 2).   Interventions are not time-bound. The services also support families and communities in finding self-sustaining solutions to the challenges they face. | Not stated | Not stated | Local Authority | This report identified a need for co-funding plan which should include contributions from local authorities and partner organisations, including universities, housing providers, health (including public health), fire and police as well as consideration of the private sector.  The report highlighted a need for:   * common understanding of language and terminology used by LAC. It was stated that there were issues when communicating with partners. LAC has its own terminology which for some, sets it apart from the mainstream. * standardised data recording and storing method. |
| Gamsu and Rippon, -2019 | Haringey Local Area Coordination Service, England | LAC is a part of a wider policy reform within the Local Authority and local NHS. The reform aims to increase prevention.  In this model there are two levels of support:  Level 1: provision of information and/or limited support. There is no detailed review of participant’s personal circumstances.  •Level 2: a longer term relationship supporting people (children and adults) who are vulnerable due to physical, intellectual, cognitive and/or sensory disability, mental health needs, age or frailty and require sustained assistance to build relationships, nurture control, choice and self-sufficiency, plan for the future, find practical solutions to problems etc.  There is no information about the length of the Level 2 support. | Funding for the LAC pilot came from the Clinical Commissioning Group’s Better Care Fund. | Anyone from the community can contact the Local Area Coordinator for Level One support. | Local Authority and local NHS. | This formative evaluation report identified positive signs of impacts on participants. Data was reported via seven case studies produced by LAC coordinators.  The report highlighted that:   * pilot LAC service should be used as a basis for further development of the scheme. * need for managerial support. * need for an improved data collection but without overburdening LACs. |
| Lunt et al. 2018 | Local Area Coordination City of York | LAC works as early intervention, and is aimed for people in their local community who may be unknown to or ineligible for services, or current users of services. At the heart of the Local Area Coordination approach is the role of Coordinators, who ‘walk alongside’ individuals in their communities. There was no further data about the model. | Not stated | Not stated | Local Authority | This report focused on groundwork needed for establishing Local Area Coordination at the system level (recruitment, induction, training and supervision), leadership and management, and community mapping and engagement with target groups. The report does not discuss LAC model however it does describe the role of Local Area Coordinator. |
| Lunt and Bainbridge, 2019 | Local Area Coordination City of York, England | There are three levels of LAC engagement:  •Level 1 Support -provision of information, advice and connections. This is a short-term support.  •Level 2 Support -‘walking alongside’ those who are vulnerable (due to disability, mental health needs, age or frailty) and who require sustained one-to-one assistance. The report does not state duration of this provision.  •Community Groups-provision of assistance related to an existing or new community group. Assistance can be short or sustained, and includes activities such as connecting community groups, advice on funding and identifying delivery locations. | LAC was funded by the Local Government Association | Not stated | City of York Council (CYC) | This report identified that the LAC is making a real change in the community trough preventative interventions, and cases where support helped families navigate highly complex and challenging circumstances. Data was captured via qualitative interviews.  The report highlights:   * need for wider understanding of the LAC role and its remits * concern over the LAC growth and the need for the caseload management. |

### Appendix 4: LAC Elements

| **Reference** | LAC role | Participants engagement with LAC | Life events associated with accessing LAC | Participants per LAC ratio | Admin tasks |
| --- | --- | --- | --- | --- | --- |
| Yannitell Reinhardt and Chatsiou, 2018 | N/A | The source of introductions to LAC:  •26% of users are introduced by council-run services or staff, such as housing, etc.  •18% are self-referred and another 18% is referred by contacts of the immediate support network (family, friends, or other community members)  •13% are referred by health specialists.  There was no data about what is introduction. | N/A | N/A | N/A |
| Gamsu and Rippon, 2018 | LACs connected with local libraries, housing schemes etc. and formed relationships with local people involved in community and neighborhood based groups and resources. LACs formed links and presence in local sector professionals in range of agencies including health, social care, housing and community policing.  Some of the individual stories show how people have been enabled to become active contributors to the community or neighborhood where they live. For example, establishing new community resources such as a Breakfast Hub, a dementia singing group, a Boxfit group etc. | Sources of introduction:  •Faith Leaders  •Police Community Support Officers  •Owners of small cafés  •Community Libraries  •Active citizens - this group is the largest one  Self-introductions to the LAC was the most common means of introduction across all four wards. | People making contact with LAC are experiencing a range of complex issues, individually and as a cohort. These issues include health conditions for which individuals have stopped receiving treatments and for which treatment is required, health conditions for which treatment and intervention needs instigating.  There is evidence of broader psycho-social issues faced by participants; social isolation, loneliness, personal abuse and personal development issues. | N/A | N/A |
| Peter Fletcher Associates, 2011 | Offers support without time limits; Has detailed knowledge of local resources and directs people towards these. | N/A | N/A | Gives an example of an Australian LAC working in an urban area and supporting around 60 people. However, there was no link to the study. | N/A |
| Sitch, 2014 | LACs recruited by local communities in an inclusive recruitment process | Introductions came from:  •The Council’s initial contact service- Community Solutions  •Social workers and support planners across all services including mental health teams  •Third Sector organisations •Multi-disciplinary meetings (MDT’s) based around GP surgeries •The Mayor of Thurrock Council and ward Councilors •Direct from the community and meeting people at Community Events •Community Hubs  •Housing •Police and Fire Services | N/A | N/A | N/A |
| Kingfishers, 2015 | N/A | N/A | Level 1 and Level 2 Individuals, experienced the sense of overcoming social isolation. For some participants this meant being able to go out in the community to do shopping and pay bills leading to independence, for others it was about being active in the community.  Participants were supported with housing, e.g. to sustain their tenancy, or helping people secure a more suitable property for their health needs. For Level 2 individuals, the fire prevention measures through practical support, particularly those that were considered to be ‘hoarding’. | N/A | N/A |
| Kingfishers, 2016 | Coordinators knowledge of the local area – connecting individuals with local people and groups | N/A | There was evidence that through the support of the Coordinators, individuals felt more in control of their health leading to reduced demand on health and social care services. | N/A | N/A |
| Marsh, 2016 | In the interviews, participants described how they did not know where to turn for help prior to LAC. The Coordinator provided encouragement and listened to their issues, working together at the individuals’ pace to find solutions and help them achieve their goals. Participant value LAC as someone to rely on repeatedly as giving them hope, describing it as ‘sunshine in the window’, a ‘catalyst’ or ‘safety net’. | The term introductions is reflective of how LAC works with individuals where they can receive a referral from another service but then require an ‘introduction’ to the individual to start the relationship. | Decreased social isolation and feeling part of the community.  The decreased social isolation is as a result of Local Area Coordinators connecting participants with other people in the community and introducing them to local groups. | N/A | N/A |
| Oatley, 2016 | Recruitment of Local Area Coordinators increased community ownership of, and community accountability from Local Area Coordination in the communities they are immersed within. | Introductions have been received at a range of ‘layers’ across the whole health and care system and sectors, community organisations and members of community, other health care professional(s), Children Social Care, Friends, Housing, Voluntary sector, Family, GPs, Adult Social Care, Mental Health | N/A | Mapping and maintaining ‘human sized units’ to avoid program ‘stretch’ through areas becoming too large, or supporting too many people which increases the risk of a more traditional response of short-term fixing of problems, rather than building trusting relationships. | Recommendation to develop software/App capability. As caseloads grow it will become difficult to track. CRM type databases or an effective App would save time and log visits in a timely fashion. |
| Darnton et al. 2018 | Trust, honesty, credibility, and integrity: These are key attributes of the service, and key characteristics of the people working within the service. These are a key ingredient when working with people who are often hard to reach.  Long term approach: The service is not time limited and is able to work with people over the longer term. The service does however manage relationships so that long term relationships do not transition into a long term dependency on the service. | Introductions, as opposed to referrals, can derive from anywhere: professionals, community members, and individuals. Introductions came from Children’s Services, GPs, Inclusion North, Counsellors, Community Support Officers, Our Place Drop In, Housing, Local Links Trust/ People Matters, Police, local craft group, Children Around the Family (school), Primary Mental Health, Local Health Trainer, self (received leaflet from church), parents, foodbanks, Adult Social Care, Seagrove Social Group, Mothers Union Group, or another community members. | Reasons for introductions; a selection of reasons being child protection/drugs/anger/school; isolation; frequent GP visits; learning/health disabilities; falls and problems getting support; police involvement; mental health problems; not managing at home; separation; cancer; fear of falling, recently diagnosed with multiple-sclerosis; homeless; carer struggling and respite needed. | N/A | N/A |
| Mason et al. 2019 | The findings of the evaluation established that listening, trust and time were consistent across the three Local Area Coordinators. | Introductions to LAC came from a variety of methods self-introductions, being approached by the Coordinator, conversations with people in the doctor’s surgery waiting room, with family members, with health advisors, with people at the food bank and through the services (not specified). | N/A | N/A | N/A |
| Forshaw et al. 2016 | N/A | N/A | Reasons for accessing LAC: mental health and wellbeing, community contacts, social interactions / reduced social isolation, earlier positive preventative action (e.g. when increased use of services is a positive in terms of subsequent cost savings – for instance visiting the GP at a timely point) for instance correctly taking medication, falls prevention, home adaptations, heating installation, supported referral to Complex Mental Health Team, care package being put in place, support to move into sheltered accommodation, building individual capacity, greater control over life, debt / finance issues, training / employment / volunteering, control over their health, be independent at home for longer, avoiding crisis points including prevention of hospital admission due to potential further falls, homelessness, and via support to access mental health counselling, travel independently, eviction for financial reasons, clutter/hoarding and fire risk | N/A | N/A |
| Swansea University, 2016 | Interventions are not time-bound. There was an emphasis on nurturing trusting and supportive relationships with individuals and families which can take time to develop, building reliance and supportive connections to reduce the risk of future crisis and service dependency. | N/A | Reasons for accessing LAC isolation, mental health, older age, loneliness, isolation, physical and mental health, cases involving multiple issues. | N/A | N/A |
| Gamsu and Rippon, 2019 | LACs were seen as a “familiar face” at local events and activities; this means that an authentic, trusting and unofficial relationship can develop, often leading these hard to reach residents to approach their LAC for help of their own accord. | Most introductions are self-introductions, with a proportion of introductions that are made by statutory services increased at Level 2. | N/A | N/A | N/A |
| Lunt et al. 2018 | Knowledge of the local community was seen as a significant benefit. | N/A | N/A | N/A | N/A |
| Lunt and Bainbridge, 2019 | At the heart of the Local Area Coordination approach is the role of Coordinators, who ‘walk alongside’ individuals in their communities. | Coordinators develop voluntary relations: the language is one of ‘introductions’ and ‘connections’ rather than referral. The largest source of introductions are from individuals themselves (19%), Adult Social Care (9%) and Community Centres (7%). Together, these account for just over a third (35%) of total introductions to date. If we focus on Level 2 introductions, these are less likely to be self-introductions and are more likely to have been facilitated by Adult Social Care, Community Mental Health Teams (CMHTs), Housing Associations and Health Visitors. | N/A | It was reported that the growth and management of caseloads was the major concern expressed by Community Stakeholders. | N/A |
| Pike et al. 2016 | N/A | N/A | N/A | N/A | N/A |

### Appendix 5: Characteristics of included studies for Support Coordination

| Author | Type of study/ method | Studies included | Participant Characteristics |
| --- | --- | --- | --- |
| Fleming (2019) | Systematic Review | 73 (4 quantitative studies, 66 qualitative, 3 mixed‐methods) | People with disabilities in receipt of individualized funding (data for 14,000 people) |
| Lakhani (2019) | Systematic Review | 18 (3 systematic reviews, 12 qualitative, 2 mixed method, 1 cross-sectional) | People (or their family/ carers) in receipt of self-directed disability services and supports (total number of participants unclear) |
| Harry (2017) | Quantitative (secondary analysis of sub-group data from randomized controlled  trial) | N/A | 456 participants (or their proxies) aged 18 to 30 randomized to treatment groups with the opportunity to receive Cash and Counseling or control groups eligible for agency-based care (Florida, Arkansas, New Jersey, USA) |
| Bogenschutz (2019) | Qualitative (online survey and semi-structured interviews and focus groups) | N/A | 35 service directors,  113 Case Managers and their supervisors who provided service for individuals with intellectual and developmental disabilities (Virginia, USA) |
| Collings (2018) | Qualitative (focus  groups) | N/A | 99 planning practitioners for people with cognitive disability and complex support needs. (Metropolitan and regional locations  in New South Wales, Australia) |
| Mahoney (2019) | Qualitative (secondary analysis of  ethnographic case study data collected during randomized controlled trial) | N/A | 76 case stories developed from in-home interviews of a representative sample of participants randomized to Cash and Counseling group, their caregivers, and when possible, support brokers (“care units’) (Florida, Arkansas, New Jersey, USA) |

CASP Assessment of the Methodological Quality of included studies

| **Systematic Reviews a** | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 | Q7 | Q8 | Q9 | Q 10 |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Fleming (2019) | Chart showing an anlysis of questions for systemmatic reviews, randomised controlled trial studies and qualitative studies | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong | NA | NA | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong |  |
| Lakhani (2019) | +/− | text box with symbol for strong | text box with symbol for weak | +/− | +/− | NA | NA | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong |  |
| **Randomized controlled**  **trial studies b** | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 | Q7 | Q8 | Q9 | Q 10 | Q 11 |
| Harry (2017) | text box with symbol for strong | text box with symbol for strong | text box with symbol for weak | text box with symbol for weak | text box with symbol for strong | text box with symbol for strong | NA | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong |
| **Qualitative studies c** | Q1 | Q2 | Q3 | Q4 | Q5 | Q6 | Q7 | Q8 | Q9 | Q 10 |  |
| Bogenschutz (2019) | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong | +/− | +/− | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong |  |
| Collings (2018) | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong | +/− | text box with symbol for strong | tetx box with symbvol for strong | text box with symbol for strong | text box with symbol for strong |  |
| Mahoney (2019) | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong | text box with  symbol for strong | +/− | +/− | text box with symbol for strong | text box with symbol for strong | text box with symbol for strong |  |

a Questions for systematic review: Q1 = “Did the review address a clearly focused question?”, Q2 “Did the authors look for the right type of papers?”, Q3 “Do you think all the important, relevant studies were included?”, Q4 “ Did the review’s authors do enough to assess quality of the included studies?”, Q5 “If the results of the review have been combined, was it reasonable to do so?”, Q6 “ What are the overall results of the review?”, Q7 “How precise are the results?”, Q 8 “ Can the results be applied to the local population?”, Q9 “ Were all important outcomes considered?”, Q 10 Are the benefits worth the harms and costs?”

b Questions for randomized controlled trials assessment: Q1 = “Did the trial address a clearly focused issue?”, Q2 = “Was the assignment of patients to treatments randomized?”, Q3 = “Were all of the patients who entered the trial properly accounted for at its conclusion?”, Q4 = “Were patients, health workers and study personnel ‘blind’ to treatment? ”, Q5 = “Were the groups similar at the start of the trial?”, Q6 = “Aside from the experimental intervention, were the groups treated equally? ”, Q7 = “How large was the treatment effect? ”, Q8 = “How precise was the estimate of the treatment effect?”, Q9 = “Can the results be applied to the local population, or in your context? ”, Q10 = “Were all clinically important outcomes considered? ”, Q11 = “Are the benefits worth the harms and costs? ”

c Questions for qualitative studies assessment: Q1 = “Was there a clear statement of the aims of the research?”, Q2 = “Is a qualitative methodology appropriate?”, Q3 = “Was the research design appropriate to address the aims of the research?”, Q4 = “Was the recruitment strategy appropriate to the aims of the research? ”, Q5 = “Was the data collected in a way that addressed the research issue? ”, Q6 = “Has the relationship between researcher and participants been adequately considered? ”, Q7 = “Have ethical issues been taken into consideration? ”, Q8 = “Was the data analysis sufficiently rigorous? ”, Q9 = “Is there a clear statement of findings? ”, Q10 = “How valuable is the research? ”.

Answers legend: text box with symbol for strong = yes or strong; text boc with symbol for weak = no or weak; +/− = can’t tell; NA = not applicable

1. Please note that one of the reports compares LACs in Thurrock and Derby City Councils [↑](#footnote-ref-1)
2. “Other services” are Adult Social Care, Housing Associations, Police, and Fire brigade. “Health practitioners” refers to GPs, Community Mental Health Teams, and Health Visitors [↑](#footnote-ref-2)
3. Kako E, Sweetland R, Melda K, Coombs E, Smith M, Agosta J. The Balancing Incentive Program: Implementation Manual. San Francisco, CA: Mission Analytics Group, February 2013. [↑](#footnote-ref-3)
4. [https://lacnetwork.org](about:blank) (last accessed on 23/04/2020) [↑](#footnote-ref-4)
5. [http://inclusiveneighbourhoods.co.uk](about:blank) (last accessed on 27/03/2020) [↑](#footnote-ref-5)
6. [https://www.centreforwelfarereform.org/about-us/centre-team/simon-duffy.html](about:blank) (last accessed on 27/03/2020) [↑](#footnote-ref-6)
7. [https://www.kendrickconsulting.org/](about:blank) (last accessed on 27/03/2020) [↑](#footnote-ref-7)
8. [https://www.derby.gov.uk](about:blank) (last accessed on 27/03/2020) [↑](#footnote-ref-8)
9. [https://www.thurrock.gov.uk/local-area-coordinators-help-in-community/overview](about:blank) (last accessed on 27/03/2020) [↑](#footnote-ref-9)
10. [https://www.communitycatalyst.org](about:blank) (last accessed on 27/03/2020) [↑](#footnote-ref-10)
11. [https://www.mysupportbroker.com/](about:blank) (last accessed on 27/03/2020) [↑](#footnote-ref-11)
12. www.covidence.org [↑](#footnote-ref-12)