



Integrating Social Services for Vulnerable Groups

BRIDGING SECTORS FOR BETTER SERVICE
DELIVERY



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Foreword

Every society has vulnerable people. People who need multiple supports, day-to-day, to address personal challenges like extreme poverty, poor physical or mental health, and low education, and to offer them the best chances of turning their lives around. Every vulnerable person represents a social challenge, a moral responsibility, and a life that can be better lived. For governments, the costs of treating vulnerable groups is high. Lost opportunities for work and productivity, high social services costs, and long-term benefit dependency – from generation to generation – reduce the economic potential of a society and place a burden on social development and public budgets.

All governments are committed to providing protection against hardship. The important question addressed by this report is how effectively and efficiently this is done for the most vulnerable in society, and, in particular, how innovation in the form of integrated approaches to social service delivery contributes to these efforts?

As well as the obvious advantages for the people in need, effective public policies for the most vulnerable can have large public payoffs. For example, by supporting children with mental health needs effectively now, policy is likely to avoid costly negative outcomes in future. The co-ordination of policies for vulnerable groups reduces the likelihood of doubling-up services and spending on clients, generates economies of scale, and can also ensure that those with the highest need access the variety of services they need, in the right order. Integration also encourages the optimal take-up of available services, as services users do not need to repeat their experiences to multiple providers, and they can be supported by professional case workers or service coordinators. When services are taken up by those that need them most, they are more likely to be effective, and appropriately evaluated.

This book explores how services are being integrated for vulnerable groups across the OECD, and considers what works when delivering multiple supports for those most in need. The book opens by looking at what is meant by integrated services and what is meant by vulnerable people, and the opportunities, processes and challenges to deliver social services in an integrated way. The remaining chapters define and estimate the levels of vulnerability in families, children with mental health needs, the homeless, and the frail elderly in the OECD, before describing and assessing the integrated service approaches for these groups. The book concludes with a discussion of the main challenges and good practices for countries to consider when developing integrated social services for vulnerable populations.

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Acronyms and abbreviations

ACT	Assertive community treatment
ADL	Activities of daily living
AFC	Age-friendly Community
CASEN	National Socio-Economic Characterization Survey (Chile)
CBA	Cost-benefit analysis
CEA	Cost-effectiveness analysis
CHF	Communal Housing First
CLB	Student guidance unit
CMS	Case management services
CPS	Current Population Survey (United States)
DALY	Disability Adjusted Life Year
EBP	Evidence-based practice
ENIGH	Household Income and Expenditure Survey (Mexico)
ESU	Employment Services Unit (Finland)
ETHOS	European Typology of Homelessness and Housing Exclusion
FEANTSA	European Federation of National Organisations Working with the Homeless
FERPA	Family Educational Rights and Privacy Act (United States)
GDP	Gross domestic product
GP	General practitioner
HARP	Hospital Risk Admission Programme (Australia)
HBSC	Health Behaviour on School-Aged Children
HIPAA	Health Insurance Portability and Accountability Act (United States)
ICD	International Classification of Diseases
ICM	Intensive case management
ICP	Integrated Care Pilot (England)
ICT	Information and communication technology
ISfYP	Integrated Services for Young People (United Kingdom)
ISTAT	Italian National Institute of Statistics

ITEP	Therapeutic, educational and pedagogical institution (France)
LTSS	Long-term care services and supports
MILDT	Mission for the Fight against Drugs and Drug Addiction (France)
NAV	Norwegian Labour and Welfare Administration
NC	Navigator Centre (Sweden)
NEET	Not in employment, education, or training
NGO	Non-governmental organisation
NIMBY	Not in My Back Yard
NOKLUS	Norwegian Quality Improvement of Primary Care Laboratories
NYTKU	Project for Unemployed Young People with Mental Problems (Finland)
PACE	Programme of All-Inclusive Care for the Elderly (United States)
PCP	Primary care physician
PES	Public employment service
PLfYA	Project Learning for Young Adults (Slovenia)
PMS	Psycho-medical social
PPS	Educational and Psychological Counselling Services (Norway)
PRISMA	Programme of Research to Integrate the Services for the Maintenance of Autonomy (Canada)
PSE	School-based health promotion services
RCT	Randomised controlled trial
RRC	Regional Registration and Co-ordination Institute (Netherlands)
SATS	Special Care and Advice Teams (Netherlands)
SHF	Scattered Housing First
SHMO	Social Health Maintenance Organisations (United States)
SIPA	System of Integrated Services for Aged Persons (Canada)
SLID	Survey of Labour and Income Dynamics (Canada)
SPMI	Severe and Persistent Mental Illness
SSA	Social Security Administration (United States)
SVHO	Solving Veterans Homelessness as One (United States)
TaMHS	Targeted Mental Health in Schools (England)
TASC	Targeting Alcohol-related Street Crime (Wales)
VKIS	Vulnerable Kids Information System (New Zealand)
YO	Youth Opportunity (United States)
YTD	Youth Transition Demonstration (United States)

Executive summary

Many vulnerable groups have complex needs, which require multiple interventions. Providing adequate and varied services to address these costly and complex needs is a challenge for all countries of the OECD.

To enhance capacities to respond to vulnerable populations' complex social and health problems, and improve the effectiveness of traditionally separately delivered services, countries across the OECD are experimenting with innovative ways to deliver social services. Integrating services holds promise both in terms of reducing costs and improving outcomes for service users with multiple needs.

This report considers whether better co-ordination of social services for vulnerable groups can help welfare systems across the OECD to do more with less. It makes a unique contribution to a growing debate on how to best meet vulnerable groups' needs by identifying the extent of and trends in vulnerability, discussing the governance and implementation strategies of integrated approaches, and examining the empirical evidence on what works.

Organisation of this report

The administration, process and outcomes of the integration of social services depends on a number of factors, such as the organisational, financial and administrative structures in place at the national, regional or local levels. This report offers an insight on how social services are integrated in the OECD, encouraging cross-country comparison and considering lessons across countries.

The report draws its evidence from policies for four vulnerable groups with complex but differing needs: vulnerable families, children and youth with complex mental health concerns, the homeless and the frail elderly. The focus on these groups was decided following an expert consultation on integrated services and housing held at the OECD in Paris in November 2012 (see www.oecd.org/social/integratedservices.htm). For the purposes of data collection and comparison, this report broadly defines each vulnerable group as follows:

- *Vulnerable families*: families with children facing multiple needs, which increase the likelihood of poor family outcomes and heighten the risk of extreme poverty and social exclusion.
- *Children and youth with mental health concerns*: children in compulsory education experiencing mental distress, and young adults with mental health concerns as well as low qualifications and/or incomplete education (school drop outs) – conditions often associated with (long periods of) inactivity or unemployment.

- *The homeless*: homelessness represents forms of housing instability and housing exclusion, and homeless populations include people that lack any housing, or are in situations in which they cannot be regarded as adequately and/or sustainably housed.
- *The frail elderly*: older individuals suffering both acute and (multiple) chronic conditions which require continuous long-term care and support. Functional and physical disabilities and incapacities are also common.

Each chapter elaborates on country-specific definitions of vulnerable populations, and based on these definitions, the report provides comparable indicators on different aspects of vulnerability. Each chapter then compares national integration practices, and evaluations of these practices, for the purposes of improving service users' and service providers' outcomes as well as the costs of delivering the services. Each chapter concludes with a discussion of the opportunities for, and barriers to, effective integration of social services in each area.

Findings

The benefits of integrated social services for vulnerable groups

Service integration can be beneficial to both service users and providers, especially for vulnerable populations with multiple disadvantages.

- *Integrating social services for vulnerable populations has the potential to address the multiple underlying issues of vulnerable populations simultaneously.* For example, addressing a housing need of a vulnerable individual is insufficient if the service user has substance abuse problems and/or severe mental health concerns that require access to medical treatment.
- *Integrated services has the potential to reduce the cost burden of delivering support and care, as multiple visits, duplication of services, and costly interventions are reduced.* Integrating services can lead to earlier identification of vulnerable populations' multiple needs and hence enable targeted, earlier interventions.
- *Integration improves access to services,* which is particularly important to vulnerable people in need of priority services, such as the homeless.
- *Integrated services also facilitate information and knowledge sharing between professionals.*
- *More integrated models of service delivery increase co-operation and collaboration between providers and agencies, leads to improvements in service quality, and produces better outcomes and satisfaction with service delivery amongst service users and providers.*

The factors that hinder the implementation of integrated social services

The literature suggests that basic ways to integrate services can also “organically” lead to more complex and fruitful forms of integration. Employing methods such as the collocation of service providers has led to increased collaboration among service providers and co-operation among professionals from different sectors. Nonetheless, several factors hinder the implementation of even the simplest integrated models of service delivery, and the precise added-value of social service integration, in terms of cost savings and improved outcomes, remain uncertain despite the expectation of a win-win scenario, especially in the long-run.

- Reforms to social services for the vulnerable groups need to respond to the on-going development of mainstream social protection systems.
- Complex governance structures create serious challenges to immediate and effective integration of social service delivery.
- Differences in front-line professionals’ skills and employment conditions can inhibit effective integration and delivery both in terms of the ability and the incentive of professionals to collaborate effectively.
- Identifying who should receive integrated services, and the priority of receipt, creates implementation challenges in countries with barriers to comprehensive data sharing.
- The actual process of delivering integrated services, once vulnerable persons have been identified, is not immune to issues of stigma, and these will need to be effectively addressed if optimal take-up of services is to be achieved.
- Implementing an integrated service system requires significant financial input and undertaking organisational and structural changes in financing, management and practice in the short term.

Challenges for lesson-drawing across countries

Although there exist commonalities in the delivery of integrated services and similar barriers to integration across OECD countries, opportunities for lesson drawing in this field remain weak for a number of reasons:

- *There is no standard international definition, or agreement, of who is a member of a vulnerable group.*
- *There is limited evidence on the implementation of, and long-term evaluations of, integrated social services delivery for vulnerable groups.* While a complete understanding of service delivery is essential to properly inform social services policy, policy makers are missing important information about the efficiencies and outcomes of service delivery.
- *Cash and social service combinations offer good policy examples for integrating social services, but evaluations of actual implementation strategies are rare.* The introduction of integrated health and welfare services for young families could provide more working examples of outcomes.

Recommendations

Integrating services presents a unique opportunity to tackle the complex social problems experienced by vulnerable populations. Any shifts to integrated services should allow new integrated social services the time to establish their own working cultures, institutional knowledge and practices, and shared goals. Governments need to commit resources to longer-term investments in service development, outreach, and targeting, as well as conduct appropriate evaluations to understand fully the value of integrated social services.

The following specific recommendations stand out:

- New integrated social service policies must include cost-efficiency evaluations as part of implementation plans.
- The effects of integrated social services on users' health and well-being must be included in these evaluations.
- Collaboration should be facilitated between social service delivery agencies and their management groups through methods such as joint management boards or the provision of cross-sector educational training.
- Policy makers could reduce the costs of service delivery by facilitating vulnerable clients' early and easy access to gate keepers of integrated services.
- Targets for integrated services in a given sector should reflect the outcomes of collaboration, such as the achievements of partner services that are responsive to collaboration.
- Service users' satisfaction should be included in the list of monitored outcomes of integrated services and practices.
- Standard practices for recording, passing on, and acting on relevant service user information are needed, and auditing or overview is required.
- Collaborating agencies need to build secure, efficient and ethical data-sharing platforms for providers.
- Effective identification mechanisms to find and encourage the most vulnerable to access services and public benefits will optimise integrated social service delivery.
- Effective preventative and future service planning through the "discharge plan" is important in all service settings.

Chapter 1

Integrating service delivery for vulnerable groups

This chapter provides the conceptual framework for the integration of social services. It defines different forms and levels of integration and outlines the rationale for integrating social services for vulnerable populations with complex, and often acute, service needs. It then presents the potential benefits of integrated services for both service users and providers from a general perspective, including cost effectiveness and cost savings, better access to, and take-up of social services, and improved service quality and service use outcomes. The chapter concludes by discussing barriers to effective integration, such as fiscal federalism and incentives for shifting costs and/or clients between providers, uncertainty in outcomes, challenges related to service administration and joint working between providers, data sharing and stigma.

1.1. Introduction

In-kind services are increasingly a favoured social policy tool of governments across the OECD. Over the past 20 years, total spending on social services has been steadily increasing, whereas spending on cash transfers has been stable (see Figure 1.1). Spending on social services is likely to continue to grow in the context of ageing population and, in the short term as fallout from the Great Recession. With demand for services rising at the time when many countries have tight fiscal constraints, the purpose of the *Integrating the Delivery of Social Services for Vulnerable Groups* report is to open the discussion about whether better co-ordination of social services for vulnerable groups can help welfare systems across the OECD do more with the same or lower budgets.

This chapter begins by defining integrated services and vulnerable groups for the purposes of the report, and outlining the rationale for policies that integrate social service delivery for vulnerable groups. The final two sections of the chapter address key issues in implementing integrated social services, starting with a discussion of integrating social service governance and finance structures (vertically) and integrating front-line delivery agencies (horizontally – where service users access the services). The chapter concludes by presenting opportunities for, and barriers to, integrating social services from the general perspective.

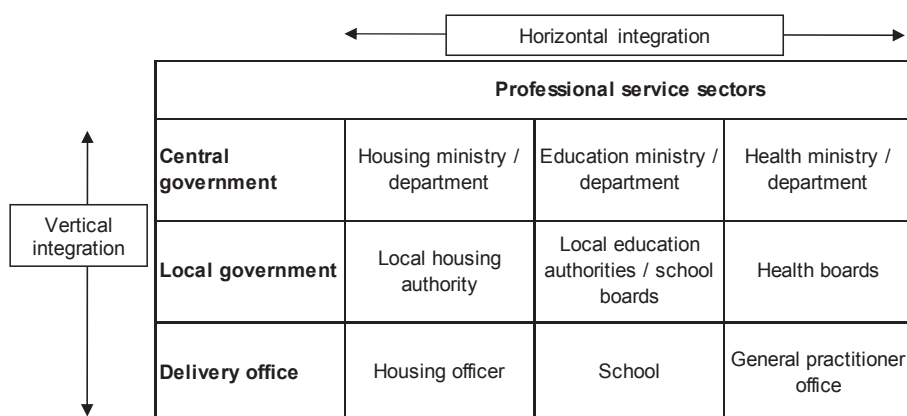
1.2. What are integrated services?

In its simplest form, the term “integrated services” refers to examples of joined-up social services, for the benefit of service users and to improve efficiency in delivery by providers. A more detailed definition can be drawn from the health literature: “integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between [different] sectors” (Kodner and Spreeuwenberg, 2002).

Services can be integrated either horizontally or vertically (see a simple model in Table 1.1). In health care, *vertical integration* has been referred to as “bringing together different levels in the care hierarchy” (England and Lester, 2005). For instance, this could mean integrating the hospital and community-based health services to ensure the continuum of care. In this report, vertical integration refers more broadly to integrating the hierarchy of governance and finance within multiple service settings. Vertical integration is critical for developing efficiencies and savings, and can be used to address global policy questions such as “who pays for what and when?”, “what is trying to be achieved?”, and “where should the potential savings for integration accrue?” (These issues are elaborated in Section 1.6).

Horizontal integration brings together previously separated policy groups, services, professions and organisations across different sectors to better serve users with multiple disadvantages and complex needs (Munday, 2007). Horizontal integration can occur at national, regional, local or delivery levels.

Integrated services can be delivered in many forms, depending on the extent of interaction, and the scope of support. Integration of services can happen via co-operation or communication among service providers, collaboration among professionals across different sectors, the physical or virtual collocation of complementary services, or a mix of these.

Table 1.1. Simple example of vertical and horizontal integration

Co-ordination amongst service providers: Collocation, collaboration and co-operation

Improving outcomes for society's most vulnerable groups *and* making better use of available public resources requires careful co-ordination at the service delivery level. For front-line services to be effective, all service providers should know what other services their clients might receive (and when they do so) in order to prevent the doubling up of interventions, and allow for complementarities in service provision to form. The definition of horizontal integration used in this report covers collocation, collaboration, and co-operation. Each defines a different degree of intensity of integration.

- *Collocation* refers to having all agencies in one location such as: legal, health – including mental health – housing, social or case management services. Having services in one location can reduce the complexity and the travel and time costs associated with take-up for service users (Sloper, 2004). Collocation also makes for easier accessibility between agencies that can help to promote collaboration among groups of service providers and professionals.
- *Collaboration* entails a higher level of integration than collocation. It refers to agencies working together through information sharing and training, and creating a network of agencies to improve service user experience. Collaboration is a necessary step for reducing the gaps in services for service users. By sharing knowledge, agencies and professionals can improve the referral process to other services offered by the centre (Sloper, 2004). The more knowledge professionals have about the different services, the better “needs-based” recommendations are available to service users.
- The highest degree of integration is achieved through *co-operation*. Co-operation is defined as professionals communicating *and* working together (for example “within small clinical teams or from multiple agencies”) on a service user's case (Rosenheck et al., 2003). Effective co-operation, through good communication, can be central to improving service users' outcomes. If professionals work well together, costs can be lowered as services are not duplicated, and the identification and response to service users' needs can occur more quickly (see, for example Chapter 4, Section 4.5).

Service spending on dependent populations is increasing

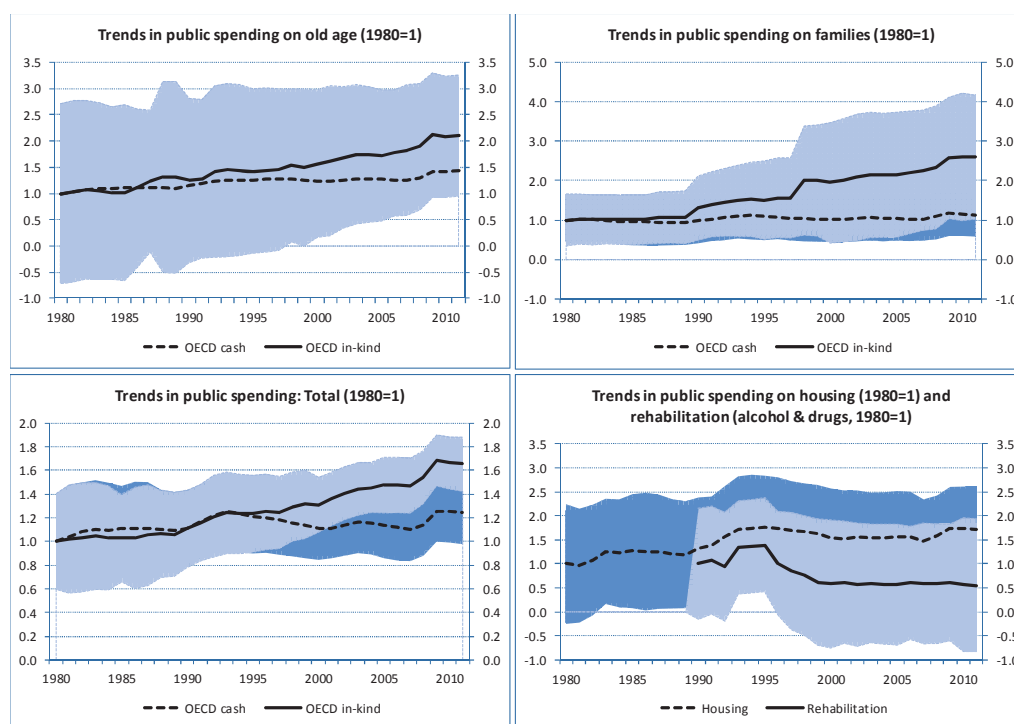
Although the discussion of service integration is recent, evidence shows that service spending on dependent populations has been steadily increasing over the past three decades.

Trends in social expenditure – in-kind and cash benefits

Figure 1.1 below provides an overview of trends in social expenditure on in-kind and cash benefits between 1980 and 2011. Within the last three decades, there has been a clear increase in total public spending on in-kind services in comparison to cash benefits, particularly in spending on families where there is a clear convergence across OECD countries. Housing spending overall has been increasing, whereas spending on drug and alcohol rehabilitation services – for the ten countries with data – has fallen.

Figure 1.1. Trends shows increases and convergence in service spending on families, the elderly and in total

Trends in average public spending, by cash (dashed line) and in-kind (solid line) with standard deviations (shaded area), 1980-2011



Note: Public spending standardised in relation to 1980 levels. Shaded area represent +/- 1 cross-country standard deviation relative to spending in that year. Since 1997, and fuller access to education spending data, there is a fuller inclusion of pre-school / childcare spending data. Data on old age, families and total spending include OECD23 (Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States). Data on rehabilitation of alcohol and drugs abusers is available for ten countries: Austria, Belgium, the Czech Republic, Finland, Greece, Hungary, Iceland, Slovenia, Spain, Sweden and the United Kingdom. Data on housing does not include Chile, Korea, Japan and the United States. Expenditure in Germany refers to Western Germany up to and through 1990 and to unified Germany from 1991 onwards.

Source: OECD (2012), *Social Expenditure Database*, available at www.oecd.org/social/expenditure.htm.

1.3. Who are the vulnerable populations?

Although integrated service delivery can be applied in any welfare settings with multiple or complementary needs, the people who are most likely to benefit from integrated service delivery are vulnerable populations with multiple disadvantages and complex needs.

The term “vulnerable populations” refers to people or households who live in poverty, or who are confronted with life situations that increase the likelihood of extreme forms of poverty (Richardson, 2009). These populations often face multiple risks and may require a range of services, from low-cost interventions such as food parcels, to more costly interventions such as housing, or mental or physical health care (for detailed definitions of vulnerable populations, see the following chapters).

To tackle vulnerability, services focused on the vulnerable populations should strive to reduce the living standard gaps between the average population and the services users; this can be done via prevention or treatment. To improve living standards of vulnerable populations, stability in housing, health, material conditions and food security are likely to be amongst immediate goals. As stated in the UN Universal Declaration of Human Rights, under article 25.1, “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” For the most vulnerable in society, there is inevitably a two-stage process in meeting needs. Once the basic needs are satisfied, service providers can help support the service user to become self-reliant.

In this report, four vulnerable groups are the focus of integrated service policy reviews: vulnerable families, the frail elderly, homeless people, and people with complex health needs.

Vulnerable populations and social care: Investment or just spending?

From the perspective of policy analysis, a distinction needs to be made between vulnerable populations that are dependent today, but have the opportunity to be re-integrated into work, and vulnerable populations that are dependent today and will need to be supported for the foreseeable future. This distinction is important for developing expectations for short or medium term plans for service integration, as well as evaluation of the outcomes (or cost-benefit analysis) of interventions by vulnerable group.

An example of groups that can be re-integrated into work include vulnerable families or homeless populations who are vulnerable due to limited educational attainment, job or housing insecurities, or behavioural difficulties (Rosenheck et al., 2003). In order to enable these people to maintain stability and encourage independence and employment, access to stable services that suit their complex needs must be ensured (England and Lester, 2005). Spending on these interventions may be considered a social investment, as governments can expect to save on social expenditures in the medium term if use of emergency services and more general welfare dependency falls, *as well as* productivity gains from private and public returns to work.

The frail elderly are an example of a vulnerable group for whom support should be designed to improve long-term efficiency and cut back on emergency service use. For the frail elderly, however, service integration is not a social investment. The growing share of

the elderly population, and with this, longer experiences of chronic diseases and dual or multiple diagnoses, is expected to increase health expenditure (Vondeling, 2004) as well as the demand for home-based social services. To prevent the costs of social care and health care from increasing in the future, more long-term integrated care delivery solutions are needed to better meet this group's complex needs.

1.4. Why integrate service delivery for vulnerable groups?

Drawing on evidence from the available literature, this section highlights the main benefits of integrating services both vertically and horizontally, such as cost effectiveness, accessibility, and quality of services for both service users and providers.

Cost effectiveness and cost savings

Cost effectiveness of services is one of the main reasons for integrating services. From a service user's perspective, an integrated approach can save money by providing access to multiple services in one place, or by reducing other transaction costs (telephone calls, other communications, time, and working hours). The providers and financers of integrated social services may save money if integration means a reduction in the use of emergency services, a reduction in duplicated or contradictory services across providers, or a reduction in welfare dependency over time.

Savings for service users

Whilst most of the general populations' needs can be effectively met via mainstream or singular forms of service delivery, integration of services is most cost effective for the populations that have multiple needs and utilise the most services. From a strictly service-user focus, it is via horizontal forms of integration that these savings can be made.

For example, in the context of ageing populations, the use of health care is expected to increase as elderly people are more likely to suffer from chronic diseases (such as diabetes or arthritis) or other health problems (Hardy et al., 1999). The literature suggests that if heavy health care users, such as the elderly population and those with mental health disorders, can access the multiple services in one place, the actual cost of health expenditure can be reduced. Moreover, case management of individuals with complex needs or in multiple service settings has the potential to further reduce costs and over-use of health services (Reich et al., 2012; Grone and Garcia-Barbero, 2001; for further discussion, see Chapter 2).

Not only are integrated services effective in reducing costs at the point of intervention, but integrated services provided at the first point of intervention can act as preventative measures and reduce later service use and costs. For instance, effective discharge plans – including a range of complementary follow-up services – reduce the likelihood of hospital readmissions (Rosenheck, 2000; Stewart et al., 2012). Reducing the number of interventions required by the service user through effective prevention, or effective management of priority services, will save time and money for the service users and may improve take-up.

Savings for providers

Integrated services help users navigate the system better and get the services they need more easily thereby creating savings for the providers too. In mental health services, for instance, there has been a recent shift from hospital-based to co-ordinated community

care in a number of OECD countries (e.g. Australia, the Nordic countries, or the United Kingdom). Co-ordinated mental health care and integrated treatment (such as assertive community treatment) have led to improved service delivery and better clinical outcomes. Following this, fewer readmissions and reduced use of intensive care services and contact with “community crisis teams” have resulted in cost savings (Stewart et al., 2012; Rosenheck et al., 2003; Woods and McCollam, 2002).

Horizontal service integration, particularly through effective collaboration, can also reduce gaps in priority services and avoid duplication of generic services from different agencies. Vulnerable populations may already be at a greater risk of being unaware or misinformed about the systems and services available to them, which can result in them enrolling in similar services with different agencies (Rosenheck et al., 2003), or missing out on necessary services altogether. With an integrated approach, the likelihood of over- or under-consumption of services can be significantly reduced.

Vertical service integration is necessary to reduce over-consumption of emergency services and under-consumption of preventative services. Strong vertical integration can provide a mechanism for shifting resources and increasing capacities in low-cost preventative settings – thus reducing over-spill into emergency services.

Accessibility and eligible take-up

Accessibility is an important consideration for the efficiency of integrated services. Accessibility refers to the ease, and the extent, of access service users have to the services to which they are eligible. Accessibility issues for the service user can vary depending on their needs or vulnerabilities, as there may be unique or augmented barriers to service access. Service providers may facilitate accessibility through various methods.

Service users and accessibility: Barriers and facilitators

Service users with multiple needs tend to have difficulty navigating through the system, which may result in them missing out on services they are eligible for (OECD, 2012b). The longer vulnerable groups go without access to priority services, the more severe their needs may become (Rosenheck et al., 2003).

Integrated service models, particularly those with case management, can help vulnerable service users navigate the system for reasons of time as well as transparency and accessibility: collocated services, for example, enable access to multiple services, which in turn enables a fuller assessment of needs and a faster delivery of appropriate services (Maslin-Prothero and Bennion, 2010). Case management is also important for non-vulnerable groups, as this is likely to reduce the personal and public cost burden of multiple application and multiple record collections across administrations.

Certain service users may also find it difficult to be physically present where services are delivered. For instance, service users with severe disabilities, chronic illnesses, or mobility problems (e.g. the elderly population) will have a harder time accessing centre-based services. This in turn may result in increased emergency and inpatient services use and hence increases in costs (Vedel et al., 2011). A successful system will facilitate vulnerable groups to access the services they need – through outreach, personal, or home-based services. Without this facilitation, integrated services, no matter how well organised, will not optimise coverage and will not reduce the need for repeat access to priority services.

Families that utilise social services (e.g. families in temporary social accommodation) often are on low incomes or are unemployed (OECD, 2011) and tend to have multiple needs for services across different sectors such as health, education and social services (Sloper, 2004). Families with insecure employment, or parents who are working more than one job or long irregular hours, may have difficulties attending appointments due to time constraints or employment obligations. There are costs related to accessing services and to taking time off work (especially when not salaried), which make accessing services more difficult.

In some cases limited personal and social skills will act as a barrier to accessing services for some vulnerable members of society, such as the homeless, or people with mental health problem. Imperfect information about the services, their conditions or requirements, may play into this reluctance to engage (OECD, 2012b; Maslin-Prothero and Bennion, 2010). Clear, direct and comprehensive information for service users, perhaps delivered by a known case worker, is conducive to greater engagement with all available and appropriate services.

Providers and accessibility

Collocation of different providers facilitates information sharing, which can in turn improve knowledge for agencies, promote communication among the different providers, and reduce the time professionals take when assisting service users access the right services (England and Lester, 2005; Sloper, 2004). In recent years, countries across the OECD have recognised the “five cars in the drive” problem, where a service user is receiving multiple service visits from different providers at home without proper co-ordination. When contact with service users is co-ordinated by agencies, or via a case-worker, it is less likely that treatment schedules will conflict.

Vertical integration is important for delivering the legal instruments and capital investments that will facilitate users’ access to the services they need. In terms of legislative instruments, outreach services to encourage participation of the most vulnerable may require the development of data-sharing policies (including privacy policies). Moreover, the development of conditional cash transfers (where cash benefits are usually centrally managed and services usually locally managed) could also facilitate access to services, and could require vertical integration. Pooling financial resources across government levels could also facilitate capital investment (building projects) to collocate services providers, which would in turn improve access and facilitate horizontal forms of integration.

Quality of services and improved outcomes?

Much of the evidence introduced in the following chapters suggests that integrated service delivery improves service quality for users and leads to better outcomes. For example, the integrated Housing First approach in England has reduced homelessness more effectively than emergency shelter options (Pleace, 2012). Moreover, integrated services can enhance providers’ work quality.

Integrated services can improve service users’ outcomes

Service users can get better outcomes when professionals collaborate and co-operate horizontally, at the point of service delivery, and when vertical integration enables common goals. For instance, children with mental health problems often benefit from the integration of mental health services with education institutions (OECD, 2012b).

The following chapters review the evaluative evidence of integration policies for improving services users' outcomes by vulnerable group. See also Box 1.1 for a brief note on the broader social welfare context that may influence the evaluation of what makes for high-quality integrated social services.

Box 1.1. How mainstream social protection affects service integration for vulnerable groups

One major complication in assessing the independent effect of integrated service delivery across countries is the fact that integrated services do not exist independently of broader social interventions. In many cases, integration of social services will not be comprehensive; for instance, integrated services may cover health and homecare for the elderly, but not pension rights or personal carers. Mainstream welfare states will influence the effectiveness of integrated service delivery practices (as well as pre-existing services) and in the case of integrated services' evaluations, may skew the interpretation of results.

Many questions arise that would be suitable for further investigation. For instance, if mainstream social security systems were more efficient, how might this affect the stock and flow of vulnerable groups into the integrated services need group? Moreover, how do inefficiencies in the mainstream system change the interpretation of how efficient high cost/high intervention systems really are, particularly in cost benefit analyses? How can high intensity service interventions for vulnerable populations be supported by the mainstream system (the reduction of inflow to certain vulnerable groups)? And when talking about prevention, are integrated services designed to prevent the use of emergency services, or prevent further or long-term engagement in standard social care services, and indeed the reintegration into a mainstream system?

Mainstream and more targeted policies should be systemically integrated and evaluated jointly. The mainstream system should be developed first, or reformed at the same time as integrated services for the vulnerable.

Case workers and case management

For some vulnerable service users, having a caseworker speak on their behalf with other service sectors is the most effective way to access the services they need. Issues of objectivity, urgency and priority all come into play. Across a range of services, professional case workers are more likely than users to have the skill sets to communicate effectively with service providers.

Case management services (CMS) makes it easier for service users to navigate through the system, and through CMS, service users' broad needs can also be professionally evaluated earlier. For services to be most efficient, the human interaction aspect of the delivery needs to facilitate full disclosure of both circumstances and needs, and honest interpretation of progress. Misinformation, stigma, and associated system failure can be avoided through efficient case management.

Caseworkers can take on the role of a trusted confidante. Sharing certain information, such as present address, employment status, family status or earnings (their own or their family members), may be perceived by service users as a risk to their housing, their benefits, or other services they receive (OECD, 2011). Moreover, when multiple services are required, and the service user does not have full information regarding their eligibility, clients may miss additional supports. Having a caseworker that can clarify their situation and advise before decisions are made can be crucial to successful interventions.

Integrating services with CMS often produces higher quality care for families (for further discussion, see Chapter 2). Much of the literature shows that integrated services for families and children are effective when one worker acts as an access point for all the

other professionals that the service users need (Sloper, 2004). Via the case worker, families can communicate with the school counsellor, the therapist, special education teachers, and other professionals, on the most effective schedule. This is likely to produce efficiency gains for both the service users and providers. Moreover, the case worker and other professionals can meet and discuss relevant issues in the services users' absence.

Integrating services improves providers' outcomes

When professionals are working together directly, rather than relying on the service user having to go from one agency to another, providers save time through direct contact and professional clarity (Maslin-Prothero and Bennion, 2010). Some studies suggest that co-operation itself evolves and becomes more efficient over time. For instance, when professionals are aware of the kind of work other professionals are doing, the communication becomes easier and benefits each other (Maslin-Prothero and Bennion, 2010). Services that are integrated can improve communications and collaboration among service providers, which strengthen over time, and provide increasing returns on the initial investment. As agencies learn more about each other, the important process of referral becomes more efficient.

1.5. What it takes to work together: Integrating horizontally and vertically

The following section lays out the main policy and provider considerations in regards to service integration for vulnerable people. The first sub-section discusses the main issues related to vertical integration of services including fiscal federalism, and governance boundary conditions. The following sub-sections discuss horizontal integration and related issues, before assessing how vertical and horizontal forms of integration together produce opportunities and barriers to effective and efficient service delivery across the vulnerable groups of interest.

Vertical integration of organisation, finance and management

A common challenge for all OECD countries integrating social services are the multi-governance issues by region and department that can create competing incentives in terms of management and finance; these competing incentives serve as barriers to the creation of multi-agency service delivery for vulnerable groups.

The multi-governance finance issues are commonly referred to fiscal federalism, or in long-hand: governance organisation of finances between central, regional and local governments, within the boundaries of political remits that limit ministerial, departmental and local government level collaboration across welfare sectors (such as, health, education, social assistance benefits, housing and so on).

How levels of government interact and how the delivery and regulation of social welfare are assigned across government levels is critically important for understanding the potential for integration social services policies. Each vulnerable group chapter (see the following chapters) maps considerable variation in the organisation, finance and management of social welfare services for various vulnerable groups across OECD countries. This mapping exercise is used to help identify good practices in the report, and their potential for policy transfer between countries or vulnerable populations.

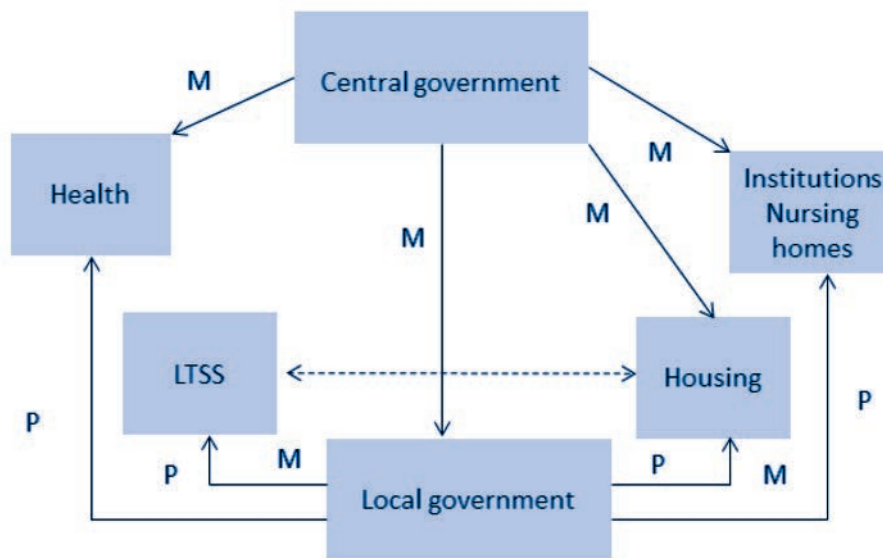
Fiscal federalism¹ and issues for cost shifting and people shifting

The following section introduces an example of fiscal federalism, and the related issues for integrating services effectively.

It is common for central and local governments to divide responsibility for financing across different types of services. Figure 1.2 provides an illustration of the possible flow of money (M) and people (P) around housing and services for older adults to illustrate the incentives that are created by fiscal federalism. As portrayed in Figure 1.2, the central government has the main responsibility in paying for health care and institutional care such as nursing homes. Community-based long-term services and supports, some housing, and co-ordination of complex arrays of services commonly fall on local government (see Chapters 2 to 5 for maps of how this is done in reality in OECD countries). Moreover, provision of care frequently occurs at the local levels. Thus, in caring for a vulnerable population, local government faces some inputs that are in essence free (health care and nursing homes as depicted in Figure 1.2).

The implication of free-to-access services for local governments, when providing for the needs of vulnerable populations, is that incentives will exist to make more use of services funded by central governments and less use of services funded from local budgets – this essentially amounts to *cost shifting*. These incentives may be exacerbated in cases where local governments face strong budget constraints. One implication of this is that human services, long-term care services and supports (LTSS), and co-ordination efforts that are more heavily funded by local governments in many nations may be “under-provided” or “under-funded” relative to levels that might be more effective for the service users and more efficient system-wide.

Figure 1.2. An example of split finance responsibilities across social services



Note: Key: Lines with “M” refer to the flow of money from governments (central or local) to service providers. Lines with “P” refer to the flow of service users from local government decision makers to service providers. LTSS: Long-term care services and supports

Source: Frank, R.G. et al. (2012), “Housing with Services: Models, Populations and Incentives”, Paper prepared for the first OECD consultation on Integrated Services and Housing, available at www.oecd.org/social/integratedservices.htm.

Examples of such responses to vertical intergovernmental financing rules are common. For example, in the Netherlands, local revenues depend on a property or land value tax, and so providing affordable housing options to older adults' may actually disadvantage the local government with respect to revenues. Community supports and co-ordination services that are not medical are the responsibility of the local authority. Thus, there are incentives for communities to devote too few resources to housing with services for older adults (Frank et al., 2012), and there is a utilisation of expensive nursing home care by older people, funded by the central government in cases where community-based support appears to be more practical.

A second example comes from US approaches to community-based care for people with severe mental illnesses. Since 1980 the assertive community treatment (ACT), a community-based outreach approach for people with a severe or persistent mental illness (SPMI), has been shown to be cost effective. However, funding of ACT programmes fell heavily on local mental health treatment programmes whereas the local treatment programmes could make use of public mental hospitals for free (funded by state government). The result was too little investment in ACT programmes that could make housing with services work for people with SPMI and a continued reliance on costly public psychiatric hospitals, at the same time, that were being reduced in size and scope of activities. This type of disconnect contributed to growth in homelessness and unstable housing among people with a SPMI (Frank and Glied, 2006) as people (not costs) were shifted from one service to another.

In both of the above examples, the economic incentives of local government-designed community-based care and support programmes were distorted by intergovernmental financing arrangements. That is, public financing insulated local governments from one set of input prices and made them face more of the costs for other inputs. In both cases the resulting outcomes were that insufficient resources being directed toward housing with services and too many resources were directed to institutional care.

Fiscal federalism and the “wrong pockets” problem

Intuitively, improving service users' outcomes and generating system-wide efficiencies and cost savings should be so attractive that one might assume that service providers would collaborate and integrate as much as possible. However in practice, the efficiencies within different social service sectors that promote better outcomes and cost savings are not easily aligned or exchanged. This problem is largely due to what is termed, by some, as the “wrong pockets problem”.

The wrong pockets problem can be explained as follows: Multiple financial and management arrangements between co-ordinated groups can result in cost shifting between groups, but also under-investment within any given group when the returns from investment are not shared equally or proportionally between the co-ordinating bodies. This underinvestment can occur both in terms of funding and staff hours/productivity. In contrast to cost shifting, this “*return-shifting*” results in disincentives to increase investment in cases where other service partners (budgets or other resources) would benefit most. The “wrong pockets” problem refers specifically to a disincentive to invest when savings or benefits would mostly accrue to another service provider (a positive spill-over effect), and should be distinguished from incentives a single provider may have to over-use “free” services paid for by other providers.

In cases where the delivery of one service does not account for the benefits produced in another service it is likely that services would not be provided at optimal levels (there

would be no information sharing to identify the appropriate levels of intervention). This situation could also lead to an undersupply of, or under-investment in, the services, or an under-optimal targeting of these services for the benefit of complementary service providers (Frank et al., 2012).

The wrong pockets problem presents challenges for both management and financial integration. Assume the example of two service providers, an educational service “A” and a health service “B”: without integration of management systems between these services it is not possible to identify opportunities to invest more in educational service A to the benefit of health service B (or the optimal rates to do this). Without some form of financial integration, there is no route by which savings accrued in the system of health service B can benefit educational service A, and in turn create the incentive for increased investment (or changes in standard practices). In absence of these systems, the hard work of educational service A lines the pockets of health service B. When observed, this provides another disincentive to system-wide optimal investment, when unobserved, this is a missed opportunity and generates inefficiency in social service provision.

Horizontal integration of front-line services for vulnerable groups

The extent of horizontal integration of social service delivery depends on the extent of actual interactions (see Section 1.3), whereas vertical integration might depend more on the legislated extent of interaction. For this reason horizontal integration often exists within the constraints of vertical integration. The majority of OECD countries, as shown in Chapters 2 to 5, manage different services across different government ministries and levels of governance, financial arrangements, and management. Vertical aspects of system-wide service delivery can have important implications for horizontal integration of front-line services:

- In cases where there is potential for overlaps in the services that are provided by different public programmes run at different levels of governance (nurse care in locally managed elderly care home and nurse care in centrally-managed public hospitals) there are incentives for cost shifting (Frank et al., 2012).
- There can be spill-over effects between programmes governed at different levels (Frank et al., 2012). That is, expansion in one programme can affect the clients and their demand in another programme. This can make it difficult to predict the amount of collaboration actually needed, and the planning and cost sharing between agencies.
- Where no overarching mechanisms exist for collaborating agencies to benefit from savings made in other parts of the public service system, incentives for integration, or engagement in cost saving practices (particularly long-term) are inhibited.

These vertical constraints will ultimately dictate the extent to which horizontal integration can occur. With this in mind, the following sections introduce the forms and frameworks for horizontal integrations, and review some recent examples of policy initiatives in the area of horizontal integration.

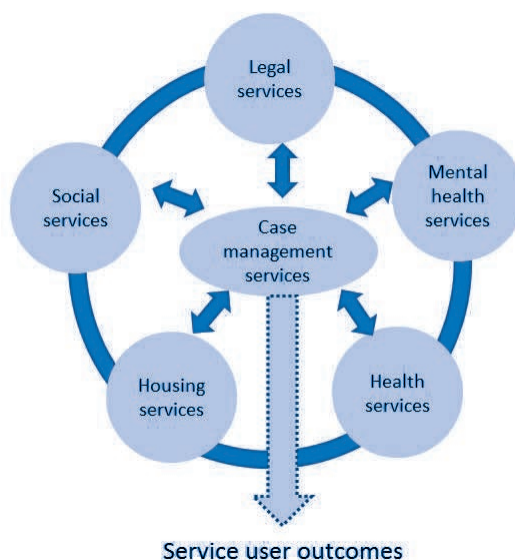
A model for horizontally integrated services

To frame discussion of integrated services in this work, it is necessary to define a model for integrated services and associated terminology.

In developing a model of service integration, and importantly to assess it, it is also necessary to acknowledge the type of goals achieved by integrating services. In this work, the goal for service integration for vulnerable users is to “enhance quality of [support] and quality of life, service user satisfaction and system efficiency for [service users] with complex, long-term problems cutting across multiple services, providers and settings” (Kodner and Spreeuwenberg, 2002).

Figure 1.3 presents a model of an overarching, horizontally-integrated, service delivery. The model represents a one-stop centre where service users can access the support they need in one place. The one-stop centre can be physical or virtual, and can be explicitly defined as “integrated” or not. In some cases this will include services that the user is eligible for, or in need of, but previously has been unaware of the possibilities of access.

Figure 1.3. A basic model for horizontally integrated services delivery



This example of an integrated services delivery model includes a number of attributes that require the following clarifications:

- The purpose of the model is to deliver output in the form of *service user outcomes*. The term “service user” is used throughout this document to describe the consumer of public services. It is used without prejudice, and refers to an individual or a household or a family unit.
- In this integrated model, it is assumed that a service user has entered the integrated setting following the assessment of their needs from a caseworker (in case management services – CMS), or via one of the service agencies (in cases where CMS is not the entry point, the term “lead agency” is used to describe the first specialist agency to which the service user presents).
- The various service agencies are all single *service providers*. The five example agencies included in the model are: legal, mental health, health, housing, and social service agencies. The term “providers” is used throughout this chapter as a catch-all term to describe individual service providers, or a group of integrated service

providers. The number and specialism of the agencies may change depending on the circumstances and needs of the services user in question (for priority needs see Box 1.2).

- The *outer circle* represents the connection between the service providers. The circle can be used to represent the various forms of integration between service providers. Arrows within the integrated setting, going back and forth to case management services (CMS), represent the potential for service providers to share information through and with the CMS.
- At the centre of the model, the *case management services* can take different forms, from an agency or individual, with an “overview role” of the interventions for the service user, such as a case worker assigned to represent the service user in the delivery process. The CMS, agency or individual, can actively manage the integration (whether it is simple co-operation, collaboration, collocated service, or a mix of all of these). The CMS may also take the form of an information exchange system (i.e. computerised closed-network for data sharing), designed as an information sharing hub at the centre of a service “network”.

Needless to say, to meet the defined goals of service integration in practice, this model would have to be adjusted to account for the specific country settings including variations in service demand, public administration and expenditure levels.

Box 1.2. A model for prioritising services and service users

Models of integration provide a framework for understanding how services can be linked to service users, but they do not provide an insight regarding the questions of who should receive the services as a priority, and in what order, and how these two issues might interact. For that reason, theoretical models, outlining the prioritisation of services for different vulnerable groups, are needed to complete the picture.

The OECD’s first Expert Consultation on Integrated Service Delivery focused on people with very high needs, but when comparing these groups by vulnerability, it should be appreciated that the prioritisation of services in a scheme of necessary services is likely to be different. As an example of how this might work, Figure A illustrates differences in four vulnerable populations from the perspective of services required (the numbers one to five order services by priority). In each case, housing supports may be necessary, but they are positioned in a different order of priority in each context.

Figure A. The role of housing services in integrated services for vulnerable populations

		Housing services						
Vulnerable families			1	2	3	4	5	
Homeless people				1	2	3	4	5
The elderly		1	2	3	4	5		
People with complex health needs	1	2	3	4	5			

Box 1.2. A model for prioritising services and service users (cont.)

This model highlights the need for a distinction to be drawn between the order of service delivery and the desired outcomes for different service users. Using the example of vulnerable families, and the services they require, it might be the case that the ultimate goal for the user is to achieve self-sufficiency through employment. To achieve this might mean delivering housing, health and education services, in an integrated way and in advance of employment supports.

For the purpose of this work, and to help interpret the differences in service delivery and access by stages of need, a distinction needs to be drawn between services delivery for the same vulnerable groups in terms of services for prevention and services for treatment.

When service users present for their first service, providers first become aware of the extent of their needs. In the case of the most vulnerable populations, this first service is often a service designed for emergency treatment – to help the service user meet basic needs (health, housing, or basic material goods such as food). The emergency services are likely to be the most costly, insofar as they will require treatment of acute need, delivered first as a matter of priority. Following the emergency service, providers may want to help the user access further services in support of self-sufficiency or dependency. These second stage interventions can be interpreted as preventative interventions, designed to avoid repeat visits to emergency treatment services (such as hospitalisation, prison, or emergency shelter), or in early diagnosis, or early intervention, designed to prevent emergency service use altogether.

In further discussion, priority services will refer to those which are deemed necessary to meet basic needs, and provided immediately. Supportive services will refer to those delivered as a secondary priority for the service users, and as self-sufficiency focused, in order to prevent repeat demand for priority services.

1.6. Opportunities for, and barriers to, integrated services delivery

As outlined above, integration of services represents many advantages to both service users and providers. Nonetheless, there are also a number of arguments for maintaining services separated, including uncertainty in outcomes; administration of social services and fiscal consolidation; data sharing problems or problems around joint working.

Uncertainty in outcomes

The benefits of integrated service delivery tend to be long term and evidence of the efficacy of an integrated service delivery model is not immediate (Hardy et al., 1999). Hence, there might be barriers to investment, such as short-term competing interests and political will (Vondeling, 2004). As integrating services may entail large capital costs and fundamental changes to the way services are delivered, policy makers and stakeholders need to be reassured about the efficacy of this kind of public investment.

To support long-term financing of integrated service delivery, there is a need for further economic evaluation of these systems (Vondeling, 2004). The planning and implementation of these types of service delivery is also made more challenging due to the lack of high-quality empirical evidence on the impact of integration and standardised tools for measurement and comparison (Armitage et al., 2009).

While the costs of integrated services for vulnerable populations with complex, multiple needs are likely to be high, better outcomes are not always guaranteed. Homeless people, who are new to services require multiple services (e.g. housing assistance, health care), a combination which is usually associated with increased costs but not necessarily improved outcomes (Rosenheck, 2000).

A review of the literature suggests that integrated service delivery might only be effective for certain populations. For people with chronic diseases, evidence on improved outcomes is easier to obtain, as the less they use hospital services, the lower their medical costs (Reich et al., 2012). With regard to vulnerable populations, on the other hand, the results take more time to materialise since these populations require stable housing and income and health services, rather than more direct chronic disease management in the community. Hence, some policy makers might be reluctant to provide long-term funding for comprehensive integrated service programmes targeted to these vulnerable population groups (Rosenheck, 2000).

A final potential downside to integrated services is that quick and comprehensive treatment may result in misdiagnosis of a service user's needs. This is more of a risk when there is one case worker, or gate keeper, making the diagnosis; and in turn, this may result in an increase in the vulnerabilities experienced by the service user.

Obstacles to administering integrated social services

Like any other type of social service, integrated social services are likely to require a large fixed capital cost (such as investment in buildings and equipment needed to deliver the service). In times of tight fiscal constraints in many OECD countries there will be a certain reluctance to invest large sums on new structures for social policies. Running costs are also an issue: sustainable streams of public investment are necessary for optimal service delivery. This is particularly important for integrated services: if a public body withdraws funding from an agency in an integrated setting, there is the obvious potential for a “domino effect” in belt-tightening or closure. If the funding for an integrated service comes from several different Ministries, for instance, then the potential for this “domino effect” is multiplied due to a set of unrelated risks and competing interests in each sector (Vondeling raises this issue, 2004).

Sustainable, and unique funding streams, are not only a main factor in securing the long-term ambitions of integrated service delivery. This is also the issue – in the shorter term – for pilots. Many of the pilot programmes are run over restricted time periods because of limited funding (Vondeling, 2004). Funding, and the security of funding, plays directly on the plans and decisions of the service providers and managers (Mur-Veeman et al., 1999).

Successful joint working also requires a careful balance of the financial input. Commitment to integrated working by professionals and allocation of their time is likely to depend on the amount of funding each agency receives for the same project. Moreover, the short-term nature of, and limited funding for, integrated service programmes may prevent long-term contracts and limit opportunities for promotion for the staff. Hence, service providers may be less inclined to fully invest in integrated working (Maslin-Prothero and Bennion, 2010).

In addition to financial investment, integration of services also entails significant structural and organisational changes to the often complex administration and management of the service system. In a number of OECD countries, the responsibility of providing and delivering care has been decentralised to regional or local authorities. Hence, establishing an integrated service model in a decentralised system would require adapting it to different local or regional circumstances. Whilst decentralised structures may facilitate collaboration across the social and health sectors at a local level (Woods and McCollam, 2002), available evidence from the literature suggests that the effectiveness and outcomes of service integration can depend on the local contexts, such

as geographical location or socio-demographics (Mur-Veeman et al., 2008; Williams and Sullivan, 2009).

Full integration of services can be very difficult to achieve when services are provided not only by the public sector but also by non-profit organisations and private providers, due to the multitude of actors and different administrations (Munday, 2007). Moreover, managing both competition and collaboration among care providers can also be great challenge in some countries. Policies introduced to increase competition in the health or social sector, such as free choice of provider (e.g. in Sweden) or increased involvement of the private sector, tend to lead to further fragmentation of care and may hinder efforts made to integrate these services (Ahgren and Axelsson, 2011).

Challenges of joint working between professionals: Culture, skills mismatch, and work conditions

The potential for divisions to form between different professions may remain a significant barrier to integrated working. Differences in culture, skills or work conditions between professionals can impede joint working (Maslin-Prothero and Bennion, 2010). Integrating services may lead professionals to develop an internal hierarchy, with its own incentives and disincentives to collaboration where some service providers hold a higher status (skills, pay and conditions) than others (Munday, 2007). There is, however, some evidence that cross-agency working can be facilitated, for example through joint training (Maslin-Prothero and Bennion, 2010) or strong management (Sloper, 2004).

Providing a balance in integrated services between sectors, and professionals, is complicated by the involvement of private companies, informal carers, and voluntary care in some cases (see Box 1.3 for an elaboration of this point).

Box 1.3. Private companies and voluntary or informal carers: Their role in integrated social services

An important consideration in the integration of social services outside of the public, and the governmental debate, is the role of private companies and informal carers in providing key social services.

Private company involvement can range from the running of private hospitals, schools and prisons, to running services within an existing public service setting (e.g. school meal services in public schools in the United Kingdom), or being outsourced to provide home care services of different types (from personal care to housework). Informal carers, most commonly found in home settings, can be volunteers or relatives (paid or unpaid), who mainly provide personal and domestic-type services.

Some considerations for formal public service providers, when integrating with private and informal or voluntary provision are as follows:

- How can public providers monitor the quality of private and voluntary services in integrated settings?
- What public systems need to be in place in case of failure in the private systems (such as bankruptcy) in integrated settings?
- How do integrated public services providers ensure that people with voluntary carers continue to receive their service entitlements when voluntary carers are sick or on leave?
- When private or voluntary service providers are required to invest more time or resources for the efficiencies to be seen in the public service (as well as for the benefit of the service user), how can they be compelled to do so?

**Box 1.3. Private companies and voluntary or informal carers:
Their role in integrated social services (cont.)**

In regards to the final question: Without methods by which to compel private companies to invest more into the system of delivery, there remains the potential for inefficiencies in the (integrated) service system. To encourage private companies to meet standards, and invest flexibly, monitoring of these companies via customer service feedback which results in active sanction when necessary (or the opposite: such as civic awards) may be of use (see for example the monitoring of private companies delivering personal homecare in the community of Nacka, in Greater Stockholm, Sweden). Regulation is also an option (discussed in more detail in Chapter 6, Section 6.3).

Furthermore, finding ways to value the additional efforts by the private companies or informal carers could provide public systems with the resources to appropriately award private service providers for additional efforts, create incentives in private companies to make investment or practice-based decision that produce “system-wide” returns. Such mechanisms should clearly link efforts of private services to savings made in the public service system.

While outcomes of inter-organisational working may be promising at first, some evidence suggests that trust and respect between professionals and agencies, joint planning, or other practices to encourage integrated service delivery might decline or “level off” in the later course of the project (Greenberg and Rosenheck, 2010).

An overarching concern for social service integration is the effect integration may have in terms of changing workloads, and any potential realignment of public budgets going to specialist agencies within a team. The public policy literature on power and resource dependency in policy delivery would suggest that an imbalance in resource management can impact on dependency, and in turn affect interests, motivations and behaviours in different agencies to different degrees (Parsons, 1999). Differences in interests, motivations and behaviours at the provider-level (driven by differences in skills sets, work conditions, or culture) can lead to inefficiencies, or failures, in service delivery.

Data sharing problems

Data and information sharing for effective integration of services is complicated, and can lead to legal challenges. Information sharing for integrated services can be restricted through legal issues relating to service user’s information and privacy (Maslin-Prothero and Bennion, 2010). In the most complex cases, each agency may have to get legal advice prior to sharing information because violations could result in liabilities. Where advice is regularly sought, cost barriers to integrated service delivery may result.

Another factor relating to data sharing includes the costs, and in some cases the potential for start-up problems, associated with setting up a sufficiently comprehensive data-sharing tool. This may involve a computer system, which means not only having the hardware, software and technical assistance costs, but also the training of staff.

Stigma

Stigma associated with the take-up of services for vulnerable groups, may lead service users to avoid visits to providers of services they need (OECD, 2011). Stigma may not only lead to a complete withdrawal from services, but a selected withdrawal. Some service users would prefer to choose an agency outside the network of integrated services to avoid stigma associated with services for other vulnerable groups (for example persons with mental health support needs may not wish to be treated in the same location as drug addicts).

Note

1. With the permission of the authors, this section is largely reproduced from Frank et al. (2012) prepared for the OECD Consultation on Integrated Services and Housing in November of 2012.

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Chapter 2

Integrating service delivery for vulnerable families: Preventing disadvantage?

Family vulnerability is a growing problem across the OECD. Vulnerable families and children are disproportionately affected by the current economic downturn and their number is growing in many OECD countries. Attempting to respond to these concerns, several countries have taken measures to address the complex needs of this group by bringing different services together. Drawing on these integrated family service initiatives across the OECD, this chapter seeks to answer the following questions: how are services integrated within existing family welfare structures? Are joined-up family services effective in preventing cycles of disadvantage and social exclusion? This review finds that different forms of integrating service delivery have the potential to improve service-use outcomes for families with multiple needs. The lack of robust evidence on the (cost) effectiveness of these initiatives, however, hinders long-term investment and up-scaling of existing initiatives.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

2.1. Introduction

Family vulnerability is an increasing concern across the OECD. Recent austerity measures and tighter budget constraints have resulted in cuts and changes to family benefits in many OECD countries. Moreover, the Great Recession itself has led to job losses and wage and benefits freezes, which have contributed to greater levels of vulnerability in some families. Consequently, more (cost) efficient delivery of social protection services for families has become a priority concern amongst OECD countries.

Vulnerable families at risk of social exclusion are commonly identified by the multiple risks and overlapping needs they experience. The transmission of these risks to next generations is also common: children growing up in vulnerable families are more likely to emerge with multiple problems themselves (see for instance, Australian Government, 2012). Despite this knowledge, and increasing commitments to tackle family vulnerability through integrated approaches, the evidence-base on “what works” in integrated service delivery settings remains weak – both in terms of outcomes and costs.

This chapter reviews different approaches to integrating family services in the OECD, and is organised as follows: Section 2.2 presents the main findings. Section 2.3 defines vulnerable families in the international context, and briefly looks at estimates of this group's social cost. Section 2.4 presents internationally comparable estimates and recent trends of vulnerable families' size and composition. Section 2.5 discusses the successes and failures of recent integrated service delivery initiatives for vulnerable families, drawing on available evidence on service use outcomes and cost efficiency. Section 2.6 concludes by exploring different ways of integrating social services for vulnerable families across OECD countries.

2.2. Main findings

OECD country approaches to vulnerable family support can be very different, as are the ways in which they have been integrated. Yet few good policy evaluations exist, and so direct recommendations for “what works” when integrating services to tackle family vulnerability are limited. From the available evidence, a number of findings stand out:

- *Vulnerable families are common in OECD countries, and their numbers are growing.* In many OECD countries, there are more vulnerable families today than there were pre-crisis (OECD, 2014c). Vulnerable children and families have complex needs that are often insufficiently addressed in mainstream social protection systems. While integrated services for these groups have shown considerable promise in improving efficiency and some social welfare outcomes, this area of policy innovation would benefit from more rigorous evaluation.
- *The social costs of vulnerable families can be considerable.* Although difficult to measure accurately, both the use of acute intervention services and the transmission of vulnerability to next generations represent a high cost to societies.
- *Integrated vulnerable family services have the potential for both public efficiency gains and improved outcomes for the families concerned.* Unlike integrated services delivery for other vulnerable groups, initiatives targeting families and children are unique in their potential of preventing cycles of disadvantage or the development of other vulnerabilities later in the lifecycle.

- *Integrated delivery of family services is most effectively embedded when taking a whole-system approach.* Integration of services at the delivery level works better when it is accompanied by integrated family services governance and accountability arrangements. Lack of support or commitment at the higher governance-level will impede the up-scaling of effective initiatives. Moreover, whilst top-down approaches to integration facilitate breaking the “silo-mentality” when planning and implementing services, they risk failing to enforce new methods of services delivery if not accompanied by clear strategies on how to deliver services at the local level.
- *Successful initiatives share common characteristics, such as case management and a community-based single-entry point to services,* although existing programmes can vary greatly in their scope and design. *Home-based services (e.g. mobile family support teams),* in contrast, offer a solution to providing services to families reluctant to receive them, or unable to access co-located services (e.g. in rural areas, mobility issues). Integrated home services also enable providers to assess and treat the full range of problems adults and children face.
- *Integrated early years support offers most potential when tackling vulnerability.* Whether preventing vulnerability as part of universal services, or further social exclusion and intergenerational disadvantage in the context of targeted means-tested initiatives, placing an emphasis on multiple interventions in the early years has most impact on child and family well-being (OECD, 2009). Early years interventions – when outcomes are more malleable – can enhance both social efficiency and social equity.
- *When developing strategies that target a limited number of families with complex needs, it is necessary to avoid stigmatising this group when defining them vulnerable.* Stigma can result in under-optimal take-up of (costly) services designed for those most in need.

More evidence is needed on what drives vulnerability in families, how this vulnerability is passed between generations, how the recent economic recession has contributed to the size and attributes of this group, and what interventions work best. In this context:

- *Further investment in data collection and clear definitions are needed to effectively design and assess the effectiveness of integrated family service initiatives,* both in terms of family outcomes and public costs. Lack of robust evidence will impede long-term investment in innovative delivery methods, whilst short-lived initiatives prevent obtaining the needed evidence to justify investment in the long term. In particular:
 - The measurement and evaluation of integrated family initiatives can be improved by clearly outlining a *family outcomes-based framework* to facilitate systematic collection of data and the measurement of the impact of a given programme. These frameworks can also positively affect interagency working.
 - Notwithstanding privacy concerns, *data-sharing* agreements can enhance the understanding of vulnerable families’ services use and needs, and allow for more accurate cost-benefit analyses.
- *A strong reflection on how spending cuts and austerity measures affect the most vulnerable families is needed.* For instance, some countries risk increasing demand for costly intervention services in later life when cutting funds from early intervention integrated services.

2.3. Family vulnerability across OECD countries: Issues of definition

Family vulnerability is a multifaceted concept. Several, interrelated factors contribute to what makes a family vulnerable, such as persistent financial insecurity, unemployment, low education, family violence, bad parenting practices, insecure or poor housing and health problems (both mental and physical health). Family vulnerability affects the whole household instead of individuals alone. Households confronted with insecurity, whether related to poor health, finances, housing or neglect are also highly predisposed to social exclusion: the risk of criminality or dropping out-of school is considerably higher amongst families experiencing long-term unemployment or instability which in turn leads to further marginalisation (see Section 2.4).

Given the complexity behind the notion of family vulnerability across OECD countries, definitions to identify this group vary country by country and often the term is not even nationally defined (OECD, 2013). However, in order to make direct international comparisons of the size and composition of vulnerable families, before assessing policies to address their vulnerabilities, it is necessary to define this population in the OECD context.

Vulnerable families: A growing public concern in OECD countries

Strategies and initiatives addressing family and child vulnerability, including criteria to estimate the extent of this group in a national context, have grown in number in recent years across the OECD. Although these criteria are country-specific, and there is variation in what is considered a vulnerable family, there is a relatively broad consensus on the underlying factors leading to family and child vulnerability.

The *Troubled Families Programme*, for instance, is a British Government initiative that proposes the clearest definition for family vulnerability: it has identified 120 000 troubled families based on four criteria (for more information, see Box 2.1 in Section 2.6.). It includes households “involved in crime and anti-social behaviour; not having children in school; having an adult on out-of-work benefits and causing a high cost to society”. The last criterion calls for local authority discretion, and may include for instance families with health concerns, such as mental health or substance abuse problems, or families subject to frequent police call-outs or arrests (UKDCLG, 2012a).

The Australian *Family Support Programme*, a national programme that complements state and territory government services for vulnerable families, offers a broader definition to family vulnerability and targets families with more varying levels of need. The programme targets families and children who “are vulnerable to poor outcomes due to multiple or complex needs and who lack resources (financial, physical or social) to support their well-being and positive family functioning” (Australian Government, 2012). In the United States, the definition of vulnerable families also refers to limited resources but is primarily restricted to “poor households experiencing homelessness or lacking stable housing” (Building Changes, 2012).

A number of OECD countries (e.g. the Czech Republic, Ireland, the Netherlands or New Zealand) have targeted efforts to tackle vulnerability among children *within* families. Whilst the elements of family and child vulnerability strongly overlap, indicators to measure the extent of vulnerable children might also include aspects such as “poor maternal health behaviour in pregnancy [and] recurrent child maltreatment” (as part of the “Supporting Vulnerable Children Plan” in New Zealand) or “conduct and hyperactivity problems” (“Youngballymun” initiative in Ireland).

When tackling family vulnerability through targeted programmes, it is, however, imperative that these definitions do not stigmatise families identified as in need of support. Questions have been raised, for instance, around the definition of a troubled family in the United Kingdom, suggesting that families filling the criteria of this initiative are presented as causing trouble instead of having problems (Fletcher et al., 2012). A considerable number of families may be confronted with vulnerability, most often triggered by financial insecurity, at some point of their lives. Hence, the multiple needs of vulnerable families should be dealt with in a non-stigmatising manner to prevent further social exclusion.

Building on these national definitions, for the purposes of this chapter, vulnerable families are defined as “*families with children facing multiple needs that increase the likelihood of poor family outcomes that lead to a risk extreme poverty and social exclusion*”. Individual factors used in this chapter to estimate numbers of vulnerable families across OECD countries are: the persistent risk of poverty; housing insecurity; long-term unemployment; experience of criminality, and demand for child protection services.

The social cost of vulnerable families

It is widely agreed that vulnerable families with high support needs are associated with high costs to the society (UKDCLG, 2012a; UKDCLG 2012b; New Zealand Government, 2012). However, the extent of these financial costs is hard to measure. A number of costs are associated with family vulnerability, including, but not limited to, long-term benefit dependency; taking children in custody; contact with the police or the criminal justice system, or the use of emergency health, mental health and substance abuse services.

An analysis of estimated total government spending in the framework of the *Troubled Families* initiative, for instance, suggests that GBP 8 to 9 billion is spent on these families each year (UKDCLG, 2012a). To put this in context, the cost of intervening for 120 000 vulnerable families in England (or 1.5% of families of the 7.8 million families across the United Kingdom claiming the Universal Child Benefit in 2011-12) is equivalent to around 11% of the total of public spending on family benefits and payments for those on low-income benefits in the United Kingdom in a given year (data on total spending and benefit receipt for the 2011-12 financial year from Browne and Hood, 2012). This underlines the need for efficiency in spending.

Importantly, the transmission of disadvantage to next generations is likely to cause the highest long-term cost, although it is not accurately quantifiable. Existing evidence suggests, however, that effective delivery of early years services combined with a focus on prevention and early intervention is likely to be more cost effective compared to the cost of crisis interventions targeted at this group at later stages of their lives (Statham, 2011; see also Section 2.6).

2.4. Indicators of family vulnerability; the size and composition of vulnerable families

Whilst it is impossible to precisely estimate the shares of vulnerable families cross-nationally different aspects of vulnerability, including persistent poverty, joblessness, housing instability, and criminality can be compared. The following indicators are derived from European Statistics in Income and Living Conditions, the Gallup World Poll, UN Surveys on Criminal Trends, and the *OECD Income Distribution Database*.¹

Differences between household types are not explored in detail in this report. However, it is worth noting that single parent households and large families are generally more exposed to vulnerability than two-parent households (*OECD Family Database*, 2012). In terms of economic well-being, for instance, one parent and large households have higher income-poverty risks: the lack of one parent, or having additional children, tends to produce a greater strain on both economic and time resources (OECD, 2011a).

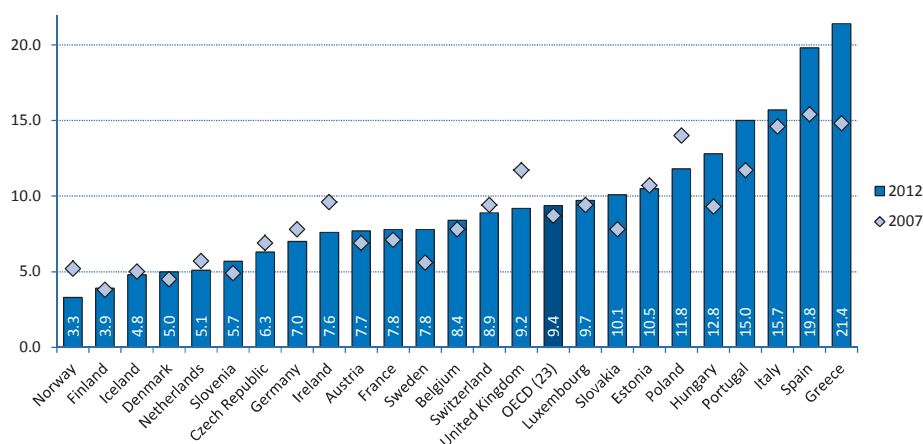
Families in persistent poverty

Combating and preventing long-term financial hardship is a central objective of governments across the OECD, and identifying families in persistent poverty is therefore a good starting point for the measurement of vulnerable families. Financial uncertainty can also have an effect on households' service use when services are poorly co-ordinated: whilst these families are generally more dependent on various social services and benefits, they may also be reluctant to engage, either due to financial or time constraints, or in the fear of losing rights to their entitlements.

Although all vulnerable families do not necessarily fall under the poverty line, the resource-based definition of family vulnerability requires the measurement of families *at-risk of poverty*. Moreover, because the disadvantages and risks vulnerable families face are often long-standing – or the result of extended periods of poverty risk (for example homelessness) – the measure of persistent poverty will provide a good estimate of vulnerability to extreme poverty and financial and housing insecurity (Figure 2.1 – for more income poverty figures see OECD, 2014c).

Figure 2.1. The risk of persistent poverty in households with children has increased in most European countries of the OECD

Persistent at-risk of poverty rate, households with dependent children, 2007-12, for EU OECD countries



Note: At-risk of poverty refers to relative income poverty and is defined as the share of all dependent children (under 18-year-olds) living in households with an equivalised disposable income of less than 60% of the median. Persistent poverty refers to the proportion of households with children at-risk-of-poverty in the current year and at least two of the preceding three years. Information for non-EU OECD members is missing. Data for United Kingdom refers to 2009 and 2010. No data currently available for non-EU OECD countries.

Source: Eurostat (2014), “Statistics on Income, Social Inclusion and Living Conditions”, available at http://ep.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/introduction.

As shown in Figure 2.1, around one in ten households with children live at a persistent risk of poverty. The highest rates of families at-risk of persistent poverty are found in the countries that have been most affected by the recent economic crisis (Greece, Italy, Portugal and Spain). Cuts in benefits and austerity measures affecting family services taken in these countries are likely to exacerbate the risk of poverty for vulnerable groups (Daley, 2012). Anecdotal evidence suggests that a considerable number of families in Spain, for example, have had to face evictions and sleep rough in the context of the on-going economic recession. There is also a clear division between northern and southern European countries in these rates: Finland, Iceland and Norway exhibit the lowest shares of persistent poverty at rates below 5%.

Since the onset of the crisis, the persistent at-risk-of-poverty rate amongst households with children has increased on average across OECD-EU countries (Figure 2.1). Several countries have seen increases in the numbers of households with children at-risk of persistent poverty, notably those with mid to high rates to start with.

Persistent risk of poverty and low levels of income are also strongly linked to *low levels of parental education*. Indeed, families where parents have low levels of educational attainment are the most strongly affected by the current economic downturn. From 2008 to 2010, unemployment rose 3.8% on average within this group compared to 2.7% for people with upper secondary education or 1.4% for those with a tertiary degree (OECD, 2012b). In 2011, 50% of EU children living in households where parents had a very low level of education (0-2 ISCED) were at risk of poverty (Lopez Vilaplana, 2013).

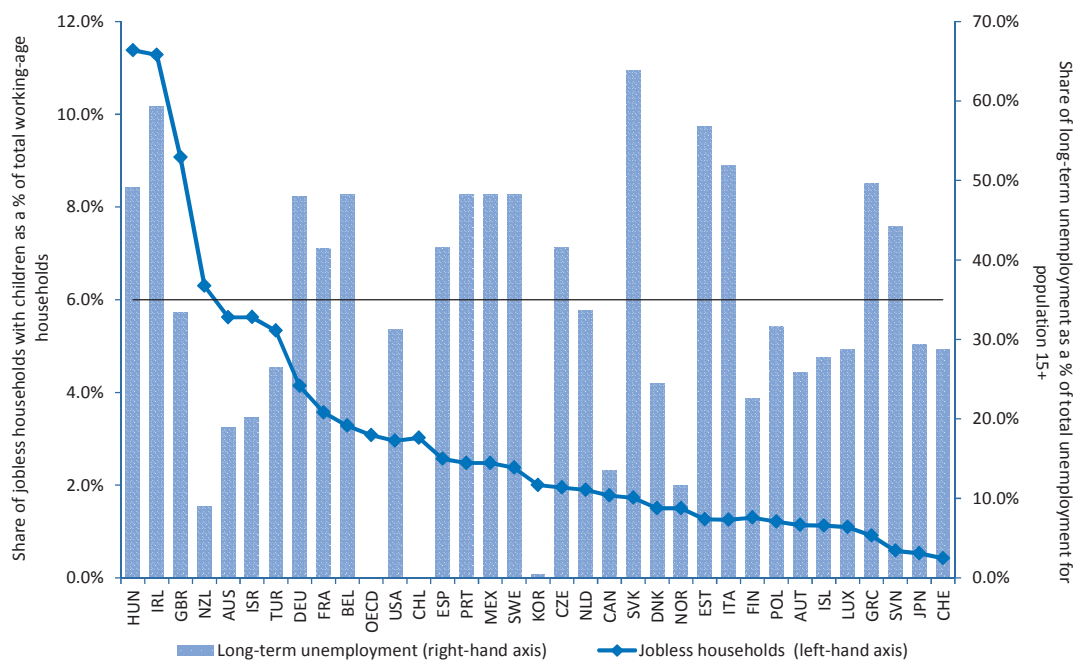
Jobless households and long-term unemployment

One of the main causes of persistent poverty and benefit dependency is unemployment, especially in the long term. The risk of unemployment is significantly higher amongst the most vulnerable households who live in insecure housing, have low skill levels, or suffer from poor health or mental health problems. Because of the multiple needs vulnerable families face, employment support alone may be insufficient to effectively facilitate re-integration to the labour market.

Family joblessness refers to households with children where no adult works (Figure 2.2, left-hand axis). In 2011, 2% of OECD families were jobless. The shares of jobless families across OECD countries were particularly high in Hungary (11.4%), Ireland (11.3%) and the United Kingdom (9.1%). Austria, Japan, Slovenia and Switzerland on the other hand, all recorded low shares at below 1%.

However, joblessness data alone does not capture families experiencing unemployment in the long term, which is likely to produce a greater strain on family well-being. Long-term unemployment is associated with greater difficulties of labour market reintegration and consequently increases the likelihood of social exclusion. Whilst no data is available on the proportion of *families* affected by long-term unemployment, the share of long-term unemployment as a percentage of total unemployment in the working age population can be used to cautiously predict the prevalence of long-term unemployment amongst households with children (Figure 2.2, right-hand axis). In the Slovak Republic, for instance, 64% of the unemployed were out of a job for 12 months and over in 2011. In Estonia, Ireland and Italy, the incidence of long-term unemployment was also high at over 50% of the unemployed. In Korea, Mexico, and New Zealand, in contrast fewer than 10% of the unemployed were unemployed for more than a year.

Figure 2.2. Jobless households as a percentage of total households and long-term unemployment as a percentage of total unemployment in 2011 (or latest year available)



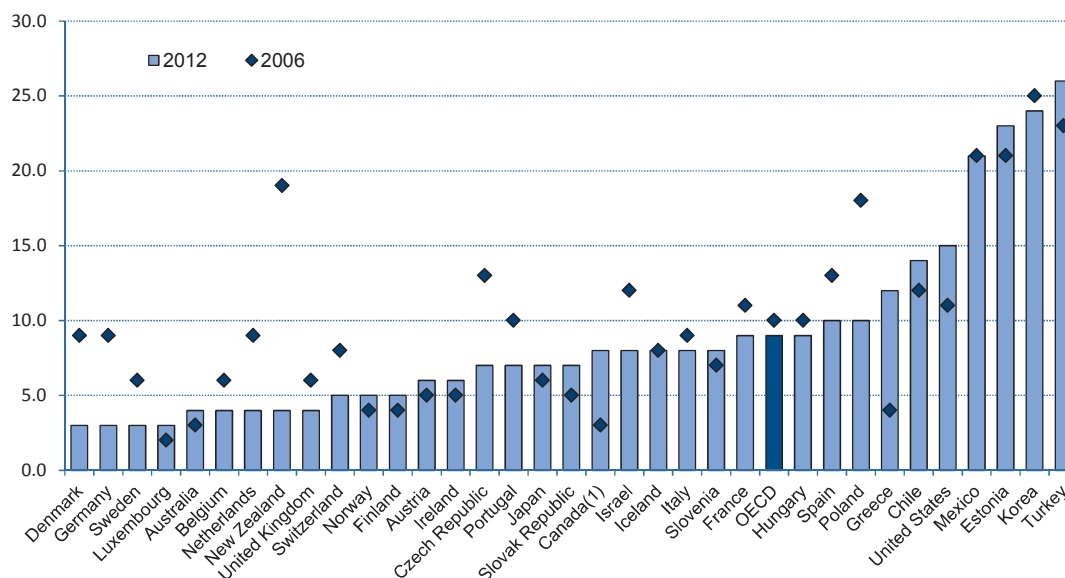
Source: OECD (2014), *OECD Income Distribution Database*, available at www.oecd.org/social/income-distribution-database.htm; OECD (2014), “Labour Statistics”, available at www.oecd.org/std/labour-stats/.

Housing instability

Housing instability is a key indicator of vulnerability. For example, not having a permanent address is likely to impede families’ access to the labour market or access to social welfare benefits (Richardson, 2009). Housing costs often also account for a considerable part of household income, especially in lower-income families.

Housing affordability (i.e. having trouble paying for housing within the past year) gives a good indication of the proportion of families facing unstable housing situations. As shown in Figure 2.3 below, on average almost one in ten respondents had trouble affording adequate housing for themselves and their families within the past year. In Estonia, Korea, Mexico, and Turkey, this share was twice as high. The OECD average has slightly decreased since 2006. In Greece, on the other hand, the share has tripled between the years 2006-12, the highest increase across the period.

Whilst the number of homeless families is counted differently across the OECD, some national estimates suggest an upward trend in the number of homeless families. In the United States, for instance, vulnerable families facing homelessness are the fastest growing segment of the homeless population at the national level: according to some estimates, up to 240 000 families, or 0.3% of all family households² could be homeless in a single day (Wertheimer, 2012). In addition, recent evidence from the United Kingdom also illustrates an increase of 44% in the number of vulnerable families in temporary bed and breakfast accommodation between 2010 and 2011 (Ramesh, 2012).

Figure 2.3. Housing affordability, 2006 and 2012 or latest available year

Note: The Gallup World Poll was conducted by telephone in approximately 140 countries in total, and all OECD countries, using a common questionnaire translated into the main national languages. Samples are designed to be nationally representative of the resident population aged 15 and over in the entire country, including rural areas in most cases. Sample sizes are limited to around 1 000 persons in most countries [exceptions include Iceland and Luxembourg (c. 500); Japan and New Zealand (c. 750)]. Data for Germany and Japan are the average of four quarterly samples.

1. According to Canada's National Household Survey, housing affordability changed very little between 2006 and 2011. In Canada, a household is defined as being in core housing need if its housing does not meet one or more of the following criteria: adequacy (no need for major repairs), suitability (size) or affordability (spending more than 30% of household income for rent).

Source: Gallup World Poll (2012), www.gallup.com/strategicconsulting/en-us/worldpoll.aspx.

Criminality/engagement with the police, and demand for child protection services

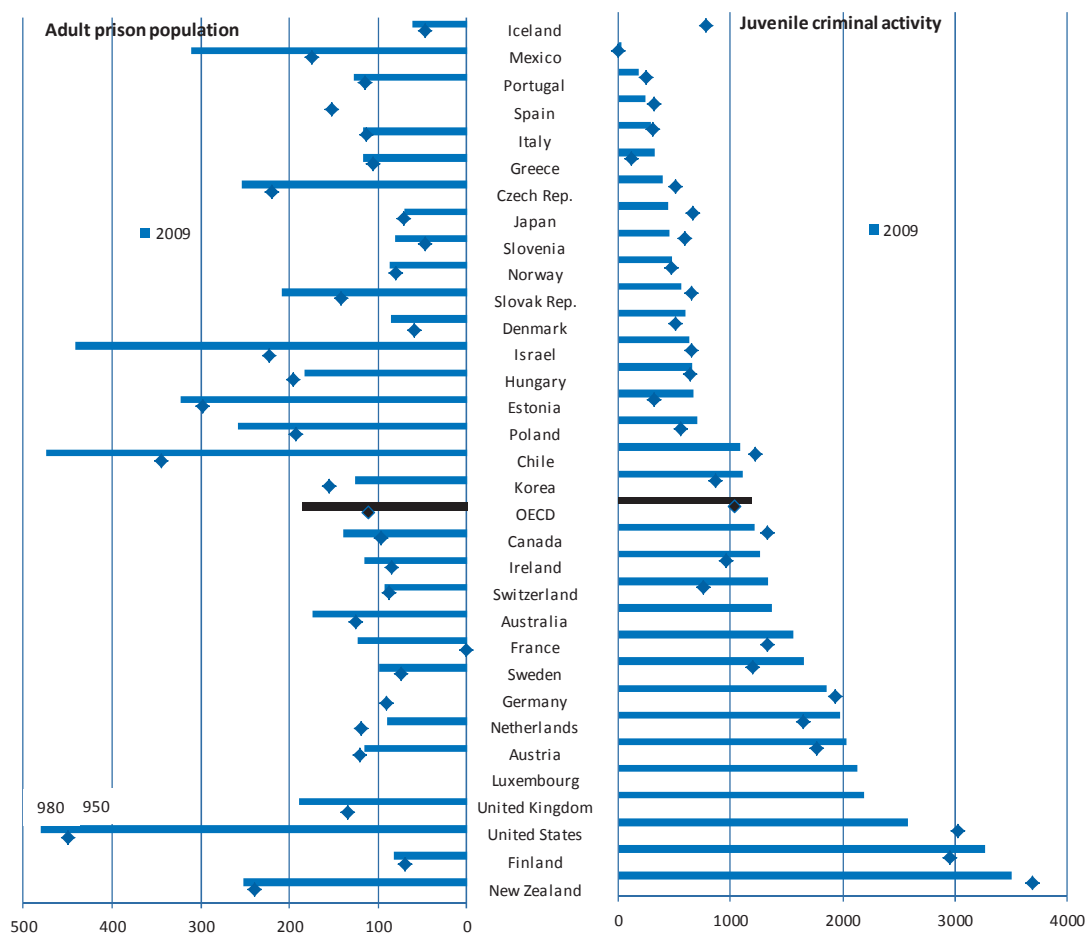
Given the high costs of crime to societies, criminal activity and engagement with the police are also important indicators of family vulnerability. Episodes of criminal behaviour are likely to put the employability of these youth at risk by preventing them from accessing the labour market. Vulnerable or neglected children growing up in unstable environments also have a higher risk of developing educational, health and behavioural problems later in life (OECD, 2011a).

However, engagement with the police or the criminal justice system is only one indicator of vulnerability – the two characteristics are certainly not mutually inclusive nor is the experience of criminality necessarily linked to vulnerability. Caution should also be used when comparing the rates of juvenile criminality, as there are differences in the legal definition of a crime across OECD countries, as well as different approaches to the counting and recording of offences.

As illustrated in Figure 2.4, rates of juveniles brought into formal contact with the police or/and or the criminal justice system are particularly high in Finland, New Zealand, and the United States. On average across OECD countries, almost 1 200 juveniles per 100 000 population were involved in criminal activity in 2009, an increase of approximately 15% since 2003.

Figure 2.4. Prison populations and juvenile crime rate, 2003-09 or latest available year

Adults held in prisons, penal institutions or correctional institutions and juveniles brought into formal contact with the police and/or criminal justice system, all crimes per 100 000 population



Note: For adult prison population, 2009 information for Canada; Israel, Turkey, Italy, and Switzerland refer to 2008. For Ireland, Spain and Germany, information for 2004 refers to 2003. For juvenile criminal activity, 2003 data for Czech Republic, Greece, Israel and Italy refers to 2004, Slovakia, Spain and Switzerland for 2005. No 2003 data available for Australia, Mexico and Luxembourg. No data available for Turkey. For the UK data, juvenile criminal rates refer to Northern Ireland, whilst prison populations refer to England and Wales.

Source: United Nations (2013), “United Nations Surveys on Crime Trends and the Operations of Criminal Justice Systems”, available at www.unodc.org/unodc/fr/data-and-analysis/United-Nations-Surveys-on-Crime-Trends-and-the-Operations-of-Criminal-Justice-Systems.html.

Moreover, some forms of juvenile delinquency tend to be linked to prison sentences later in life. It can also be observed that, although there are large variations in the rates of prison population in the OECD, the proportion of adult prison population has also increased by approximately one third between the years 2003-09, with 186 adults per 100 000 of the adult population in prisons in 2009.

Regarding other aspects of engagement with the police, the demand for child protection and family social services has increased in the years following the economic crisis in some countries. In Ireland, for example, the number of child protection cases

received by social work departments rose by 23% between 2007 and 2010. The need for child protection services has also been increasing in Scotland and Slovenia (Ruxton, 2012), as has the number of children taken into care in the Czech Republic and Finland (Eurochild, 2009; Sotkanet, 2013).

Summarising relative vulnerability risks for families in the OECD

Table 2.1 summarises the comparable family vulnerability indicators across countries, with darker shaded cells showing higher rates of vulnerability compared to the OECD average. Denmark and Norway are the only two countries with relatively low vulnerability amongst families across the board. Chile, Ireland, Korea, Turkey and the United States have at least one high and no low areas of family vulnerability.

Table 2.1. Summary of vulnerability indicators shows large variation in relative risks across countries

	Persistent poverty rate (%), 2012	Family joblessness, 2011	Housing insecurity, 2012	Juvenile crime, 2009
Australia	...	5.6%	4.0%	1365.9
Austria	7.7	1.1%	6.0%	2039.0
Belgium	8.4	3.3%	4.0%	...
Canada	...	1.8%	8.0%	1215.2
Chile	...	3.0%	14.0%	1087.5
Czech Republic	6.3	1.9%	7.0%	399.2
Denmark	5.0	1.5%	3.0%	596.9
Estonia	10.5	1.3%	23.0%	674.3
Finland	3.9	1.3%	5.0%	3265.8
France	7.8	3.6%	9.0%	1565.9
Germany	7.0	4.1%	3.0%	1859.2
Greece	21.4	0.9%	12.0%	327.0
Hungary	11.4	11.4%	9.0%	654.8
Iceland	4.8	1.1%	8.0%	...
Ireland	7.6	11.3%	6.0%	1259.5
Israel	...	5.6%	8.0%	629.8
Italy	15.7	1.3%	8.0%	294.3
Japan	...	0.5%	7.0%	438.1
Korea	...	2.0%	24.0%	1104.8
Luxembourg	9.7	1.1%	3.0%	2126.5
Mexico	...	2.5%	21.0%	29.6
Netherlands	5.1	1.9%	4.0%	1971.3
New Zealand	...	6.3%	4.0%	3509.4
Norway	3.3	1.5%	5.0%	478.5
Poland	11.8	1.2%	10.0%	702.4
Portugal	15.0	2.5%	7.0%	184.6
Slovak Republic	10.1	1.7%	7.0%	567.3
Slovenia	5.7	0.6%	8.0%	455.2
Spain	19.8	2.6%	10.0%	244.0
Sweden	7.8	2.4%	3.0%	1649.4
Switzerland	8.9	0.4%	5.0%	1336.8
Turkey	...	5.3%	26.0%	...
United Kingdom	9.2	9.1%	4.0%	2189.0
United States	...	3.0%	15.0%	2577.1

Note: Data in the table are taken directly from Figures 2.1 to 2.4; for detailed notes, please refer to the relevant figure. Darker shaded cells denote rates of vulnerability at least one-half standard deviation above the OECD average. Lighter shaded cells denote rates of vulnerability at least one-half standard deviation below the OECD average. Mid shaded cells are around the OECD average.

Source: Data in the table are taken directly from Figures 2.1 to 2.4; for source notes, please refer to these Figures.

The evidence introduced above indicates that a significant proportion of households with children are confronted with at least some aspects of vulnerability. Furthermore, despite sharp variations in these trends across the OECD, the numbers of families

confronted with vulnerable situations appear to have grown in many countries in recent years. These increases in vulnerability coupled with current tighter budget constraints have encouraged many OECD countries to find ways to deliver family services more (cost) efficiently. Investment in integration of social service delivery has grown as part of this move.

2.5. Assessing the effectiveness of integrated service delivery for vulnerable families: What works?

Although different models of integrated service delivery for vulnerable families are expanding across the OECD, there is still only limited evidence on their effectiveness, especially in the long term. This section introduces the evidence for integration of vulnerable family services on two fronts: family outcomes and cost effectiveness (for a discussion of how the services are integrated in practice, see Section 2.6).

Integrated services and positive outcomes for vulnerable families and children

Available evidence of how integrated services contribute directly to a range of families outcomes is rather limited in scope. Of the few policy evaluations that exist, many are too short in focus to assess long-term outcomes for families, or are not of sufficient quality (for instance using objective, large, quasi-experimental approaches).

Effectiveness of integrated service delivery for vulnerable families in the short term

While the evidence-base on the effectiveness of integrated services in the long term is weak, short-term evaluations offer some measurable outcomes. Initiatives to integrate service delivery are often evaluated relatively soon after their implementation and therefore capture the more intermediate effects of integration. A review of the literature highlights a number of benefits of integrated forms of service delivery to both service providers and vulnerable families.

Integrated service delivery methods for vulnerable families show a number of benefits for practitioners. Integration has shown to facilitate changes in the working culture, which result in a better understanding of other professionals' roles; to better information sharing between professionals and agencies, and a reduction in the duplication of services, and better communication with local communities (Statham, 2011).

In general, vulnerable families' perceptions on integrated services delivery also emphasize positive front-line effects (Sloper, 2004). Both better parenting practices, and parents feeling more effective in their roles, for instance, are highlighted in several programme evaluations, such as the *Communities for Children* in Australia; *Early Start* in New Zealand; the *Every Child Matters* and *Sure Start* programmes in the United Kingdom or the *Head Start* in the United States. Similar outcomes are also recorded in assessments of universally accessible family centres in the Nordic countries (Kekkonen et al., 2012). Other common observations include improved experience of service use or better clarity of, and accessibility to, services (Statham, 2011).

In addition, some short-term evaluations also record other family outcomes. The *Communities for Children* initiative (Australia), for instance, produced some beneficial effects among the most vulnerable families, including improvements in “children’s early receptive vocabulary and verbal activity”, decreased unemployment rates, and mothers’ increased community involvement (Australian Government, 2009). Family and Children’s Centres have shown potential in reaching minority groups. In Sweden, family centres play an important role in integrating immigrants to the society (Abrahamsson et al., 2009). *Sure Start* centres have also been successful in involving some minority groups (Ofsted, 2009) but their impact on these hard-to-reach groups has been debated (Ward, 2007).

The evidence on long-term outcomes

Most long-term evidence on integrated service delivery comes from programmes providing early years support to disadvantaged families and children. These evaluations show some promising, yet mixed results. An evaluation of the Australian *Early Years Centre* Initiative, for example, showed improved “developmental, social and behavioural outcomes for children” and enhanced outcomes for vulnerable families in general (Queensland Government, 2013). Assessment of the *Early Start* programme in New Zealand also recorded some measurable outcomes, including lower rates of physical abuse of children and decreased inpatient hospital use for childhood accidents (New Zealand Government, 2012). Other long-term evidence of the impact of integrated service approaches to families includes fewer children with challenging behaviour excluded from schools (Webb and Vuilliamy, 2001) or improved physical child health in the context of the *Sure Start* programme (UK Department for Education, 2012).

In some cases, integrated service delivery policies for families with multiple needs may result in improved outcomes in the beginning, but have less of a positive impact on long-term outcomes. A national longitudinal research project using randomised control design in the United States found that access to the *Head Start* programme has resulted in positive outcomes in parenting, health and cognitive domains for 3- and 4 year-old children. By first grade (two or three years later), however, there was little evidence on the beneficial effects of access to *Head Start* for the programme population as a whole (US Department of Health and Human Services, 2010).

Notably, the long-term effects of integrated services on vulnerable families are not consistently positive. An evaluation of the local interagency strategy co-ordinated under a central co-ordinating agency in Maryland, for instance, showed that while there were some measurable improvements, such as fewer juvenile crimes and improved educational performance for vulnerable families, the rates of teenage pregnancies also increased during the controlled period (Statham, 2011). Moreover, it appears that some programmes fail to reach the most vulnerable: in the United Kingdom, for example, the *Sure Start* Centres have shown some positive results on family outcomes but seem to have very little effect on the most disadvantaged children and families (Hamel and Lemoine, 2012).

Limitations of existing evidence

There are a number of methodological limitations regarding the available evidence on the effectiveness of integrated service policies for vulnerable families. First, much of the available evaluations rely on professionals’ perceptions. While views of providers can sometimes be considered as a proxy for improvement, providers’ assessment of outcome

cannot be considered a robust measure of effective integration (Statham, 2011). Information on service users' perspective, on the other hand, is generally more limited.

Second, evaluations of policies targeting vulnerable families often highlight the lack of randomised controlled trial (RCT) design and control and comparison groups. Literature on evaluations of family intervention projects in the United Kingdom, for instance, suggests that evidence of the effectiveness of innovative service delivery models should be strengthened if their impact was compared to a control group, i.e. families not receiving intervention (UKDCLG, 2012a).

A number of factors explain the infrequent use of RCTs in programme evaluations especially at the national level. First, individuals eligible to a benefit or a programme might be reluctant to be randomly assigned to a control group of an experiment. Second, despite the uncertainty of programme effects, it is often politically unpopular to restrict access to benefits. Finally, RCTs may also entail considerable implementation and evaluation costs. In addition, to verify whether a given programme can be taken to scale elsewhere, a number of experiments that vary in geographical location or type of intervention are required (Banerjee and Duflo, 2012). Of course, many of these problems are not limited to RCTs but can also occur in observational methods.

Towards better assessments of outcomes?

Concerns about the weak evidence base of integrated services for vulnerable families have been addressed in a number of ways. Indeed, some factors have shown to improve the measurement of short and long-term outcomes for families resulting from integrated delivery of services. Outcomes-focused strategies and policies where levels of anticipated effects of integration are clearly outlined, for instance, enable easier assessment of the impacts of these policies (Statham, 2011).

Frameworks for the assessment of vulnerable families and children have also been implemented in a number of OECD countries, including Australia, Canada, England, Finland, Ireland, New Zealand, Norway and Wales. Evidence from England and Wales suggests that successful implementation of these frameworks results in improved interagency working (ibid.). These frameworks have also shown to lead to increased collaboration between different agencies, families' access to services, as well as better assessments and more holistic approaches by professionals (Leveillé and Chamberland, 2010).

Data-sharing agreements can also lead to better evaluations on child and family outcomes. Although there are many concerns as regards to sharing information across agencies and between professionals, sharing information enables a better understanding of service use by clients, leading to more precise estimations of potential cost efficiencies of integrated service delivery. Such agreements are generally made on a consent basis and have been piloted so far for example in Wales (*Wales Accord for the sharing of personal information*), New Zealand (*Strengthening Families* programme), in the Netherlands (*Youth Reference Index*) or in New York City (*Common Client Index*). Gaps in service provision can also be identified when information is shared between agencies (Statham, 2011).

Cost effectiveness

Given the high long-term costs of vulnerability to both families and to the society as a whole (see Section 2.3), there is a strong cost-efficiency argument for integrated service delivery for vulnerable families.

However, for a number of reasons, uncertainty remains as to whether the benefits of integrated service delivery will offset the initial financial investments made by different stakeholders:

- There is limited evidence on cost effectiveness of these delivery methods. Due to the lack of measurable data on family and child outcomes of integrated delivery methods, comprehensive cost-effectiveness analyses of these initiatives are not feasible neither can a differentiation be made between short and long-term savings.
- Evaluations show mixed results. Stradling and MacNeil (2010), for example, evaluated the use of resources of the *Getting it Right for Every Child* initiative in Scotland. First, the demand for services with limited resources grew within the integrated framework as early identification and targeting of children with special needs increased. Findings, however, suggested that this demand was likely to decrease in the longer term as a result of service providers' increased use and knowledge of planning and assessment tools. Whilst there were some savings associated with fewer meetings and reduced paperwork, these were partly compensated by increased costs associated with adapting to new tasks and responsibilities (e.g. new assessment and planning tools and multidisciplinary team working). The authors conclude that integration can facilitate achieving more and improved results with the same resources (Stradling and MacNeil, 2010)
- It is hard to determine to which extent anticipated savings of programmes targeting vulnerable families actually result in cash savings, and which can generally be better described as resources freed up within the system (Lawlor and McGilloway, 2012). Integrated models of delivering services to these families are only likely to be cost effective in the long term and therefore require embedding in the working practice. In many cases, the economic impact of these models, delivered through mechanisms such as improved educational attainment, may also require several years to become evident (Brown and White, 2006).
- Some evaluations show that services for vulnerable families delivered in an integrated framework might not result in significant cost savings, but can shift resources from corrective interventions to more prevention and early intervention focused approaches (Loman and Siegel, 2005).
- Local service providers might be reluctant to invest and engage in new methods service delivery to save money for a centrally run service, although this issue can be addressed via alignment of monitoring and funding of these initiatives.

2.6. How can family services be integrated to improve access to, and outcomes of service use?

Vulnerable families with the highest service needs are often those least likely to access mainstream services. Increasing evidence shows, however, that integrated forms of service delivery are often the most effective when addressing this issue of weak demand coupled with high, complex needs (Australian Government, 2012). This section explores

recent national and sub-national efforts to integrate service delivery for this vulnerable group with multiple service needs.

Integration of services in the context of family welfare structures

Tackling family vulnerability via integrated service delivery requires joining-up services across a range of service providers. But for horizontal integration to be effective, disincentives to integration between different levels to governance must be effectively addressed. Understanding how structural factors of family welfare systems affect the delivery of child and family services at the national and sub-national levels is therefore key to designing integrated service initiatives. The clearest distinctions occur in delivery and funding methods of service delivery (decentralisation of publicly provided services vs. the principle of subsidiarity) as well as in the extent of accessibility to services by families (targeted vs. universal services).

Decentralisation of service provision for families and the principle of subsidiarity

There are great differences between countries regarding central and sub-central government involvement in, and responsibility for, family services. In a number of OECD countries (e.g. the Nordic countries), state involvement in delivering social and health services is high, and the provision of services is devolved to regional or local authorities. In Sweden, for example, municipalities are in charge of providing health and social welfare services, which include financial assistance, childcare, primary school, secondary school, and school health services. In local settings, co-location of different service providers and agencies is common and tends to encourage strong co-operation and communication between, for instance, municipal health, education and family departments.

Decentralisation can also affect the identification process of vulnerable families. As part of the British *Troubled Families* programme, for example, local authorities are asked to define families causing a high cost to taxpayers at the community level. Whilst this allows some flexibility in identifying local families in need, it may also result in wide variations within this target group at the national level.

In many OECD countries, the central or sub-central governments also contract the provision of social and health services for families out to private providers. When different family services are provided by private non-profit or for-profit agencies, effective co-ordination of services generally requires a greater effort and commitment at higher governance levels compared to countries where local authorities have the responsibility of providing most health and social services. Indeed, these subsidiaristic systems “offer no institutional basis for co-ordination [of the health sector] with welfare services” (Katz and Hetherington, 2006). See Table 2.2 for predominant modes of family services provision.

Table 2.2. Predominant mode of provision (public vs. private) of selected services for families

Primary health care services		Early childhood education	Social housing
Australia	private group practices	government dependent private	public/private
Austria	private solo practices	public	public
Belgium	private solo practices	government dependent private	public/private
Canada	private group practices	public	public
Chile	private	government dependent private	/
Czech Republic	private solo practices	public	public
Denmark	private group practices	public	private
Estonia	/	public	public
Finland	public centres	public	public
France	private solo practices	public	public/private
Germany	private solo practices	government dependent private	private
Greece	private solo practices	public	private
Hungary	private solo practices	public	public
Iceland	public centres	public	public
Ireland	private solo practices	independent private	public
Israel	/	public	/
Italy	public centres	public	public
Japan	private clinics	independent private	/
Korea	private solo practices	independent private	/
Luxembourg	private solo practices	public	public
Mexico	public centres	public	/
Netherlands	private group practices	public	private
New Zealand	private group practices	government dependent private	/
Norway	private solo practices	public	public
Poland ¹	private clinics	public	public
Portugal	public centres	public/private	public
Slovak Republic	private group practices	public	public
Slovenia	/	public	public/private
Spain	public centres	public	public/private
Sweden	public centres	public	public
Switzerland	private solo practices	public	/
Turkey	public centres	public	/
United Kingdom	public funded group practices	public	public
United States	private	public	public/private

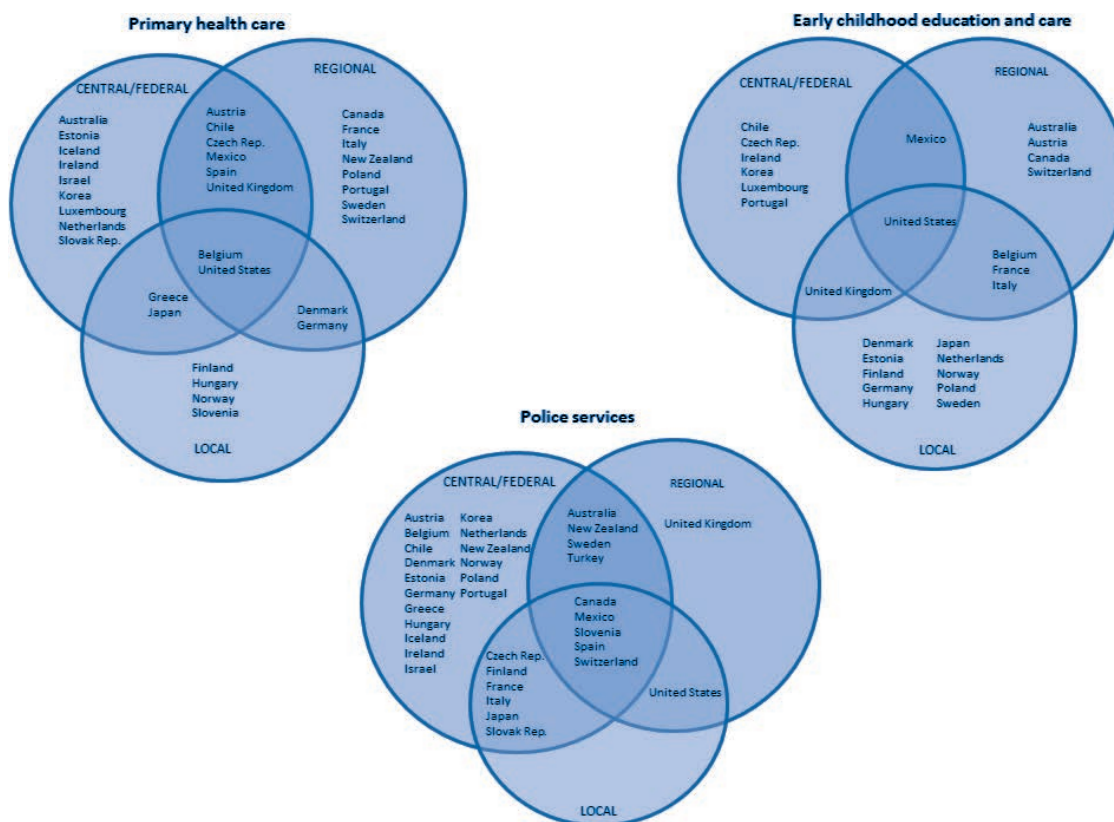
Note: **Primary care** services include first contact services for diagnosis and treatment of acute and chronic illnesses, health promotion, disease prevention, health maintenance, counselling, and patient education, in a variety of health care settings. These services can be provided by primary care physicians and nurses or other types of professionals. **Secondary care** refers to medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialised knowledge, skill, or equipment than the primary care physician has.

1. Based on correspondence with Polish representation to the OECD. A **government-dependent private institution** is an institution that receives more than 50% of its core funding from government agencies or one whose teaching personnel are paid by a government agency. The term “government-dependent” refers only to the degree of a private institution’s dependence on funding from government sources; it does not refer to the degree of government direction or regulation. An **independent private institution** is an institution that receives less than 50% of its core funding from government agencies and whose teaching personnel are not paid by a government agency. The term “independent” refers only to the degree of the institution’s dependence on funding from government sources; it does not refer to the degree of government direction or regulation. The symbol “/” refers to no information being available.

Source: Paris, V., M. Devaux and L. Wei (2010), “Health Systems Institutional Characteristics: A Survey of 29 OECD Countries”, *OECD Health Working Papers*, No. 50, OECD Publishing, Paris, <http://dx.doi.org/10.1787/5kmfxfq9qbnr-en>; OECD (2013), “OECD Questionnaire on Integrated Social Services Delivery, Part 1, Vulnerable Families”, unpublished Social Policy Questionnaire; OECD (2011), *Education at a Glance 2011: OECD Indicators*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/eag-2011-en>.

Finally, as family services are often managed at different levels of governance, families with multiple needs may also risk “falling through the cracks” if links between sectors are not strong or enforced (Figure 2.5).

Figure 2.5. Family services are often managed at different levels of governance



Note: “Regional” refers to regions and states in a federal setting. “Local” primarily refers to municipalities and communities.

Source: OECD (2013), “OECD Questionnaire on Integrated Social Services Delivery”, unpublished Social Policy Questionnaire.

Universal vs. targeted family services

A broad distinction can also be drawn between countries depending on whether services provided for vulnerable families are universal or targeted. In other words, are all families eligible to receive services, or are public services restricted to those considered to be in need?

The *cascaded* model is common in countries with universalistic family service principles and high state involvement in service delivery. Families with multiple risks can access specialised, tailored support via universal services, such as the school or the health care system. Whilst these universal services tend to take a preventative approach, they can refer and guide families with more complex needs to more tailored support and specialist services. Access to social services can also be made available via local agencies or centres for families. In Denmark, for instance, each municipality has a “pedagogical and psychological advisory unit”, which guarantees anonymous access and co-ordinates access to specialist services (Hamel and Lemoine, 2012).

An alternative approach to providing services for vulnerable families is service delivery solely targeting families at risk. In the United States, for example, integrated support for vulnerable families and children is means-tested and targets those who have already fallen under the poverty line, or are at a risk of becoming homeless. The *Troubled Families Initiative* in the United Kingdom, on the other hand, takes an alternative approach to targeting vulnerable families: within this framework, councils are encouraged to prioritise “troubled families” by tying a part of the funding into a payment-by-results scheme (i.e. further funding is provided to councils if a family reaches certain defined targets on measures including improved school attendance, a reduction in anti-social behaviour and juvenile crime). A number of countries are also targeting vulnerable, low-income families with conditional cash benefits.

Making integrated family services delivery a priority at the national level

Local initiatives to integrate service delivery for vulnerable families exist across the OECD, but yet few countries have adopted a “whole-system” change to the way services are delivered. In fact, the majority of established integrated family service models merely complement existing statutory services in limited areas or restrict access to low-income families. A number of countries, however, have established broad, national-level strategies in recent years where integration forms the core element of delivering front-line services to vulnerable families. In addition, integrated forms of family support are also well-embedded in the delivery of mainstream in-kind services in countries with strong, universalistic family welfare services.

Co-operation across departments at the governance-level is generally long-standing

Across OECD countries, it is common that the planning and implementation of any large-scale national programmes is carried out in co-operation or in consultation with a range of stakeholders at the governance-level. In the Czech Republic, for instance, the successful implementation of the *National Strategy to protect Children’s Rights*, approved by the Czech Government in 2012, is to be monitored by an interdepartmental co-ordination group. This interdepartmental group has also been given the role of co-ordinating activities to improve the provision of seamless services for vulnerable children (OECD, 2013). Moreover, a multi-stakeholder steering group was also established to monitor the implementation of the on-going national Strategy for Children and Families (2012-20) in Estonia.

Some OECD countries with a long-standing commitment to family service integration have taken a step further from these generally informal governance arrangements to developing formal, integrated governance structure arrangements for the provision of family services. In 2007, for instance, the Ministry of Youth and Families was established in the Netherlands, creating “an umbrella ministry” operating under the Dutch Ministries of Health; Welfare and Sport; Justice; Education, Culture and Science; and Social Affairs and Employment with the goal of enforcing co-operation in the area of youth and family service delivery (CfBT Education Trust, 2010). Similar agencies also exist in Australia, New Zealand, the United Kingdom, and Maryland in the United States (Governor’s Office for Children, 2013).

Recently, the Irish Government also established a Department dedicated to delivering the Government’s commitments in the area of children and young people (OECD, 2013). Additionally, as part of a national commitment to reform public service delivery for Irish

families, the establishment of a Child and Family Support Agency is also currently underway. The main aim of this agency is to realign services into a single integrated agency (Ireland Department of Child and Youth Affairs, 2013).

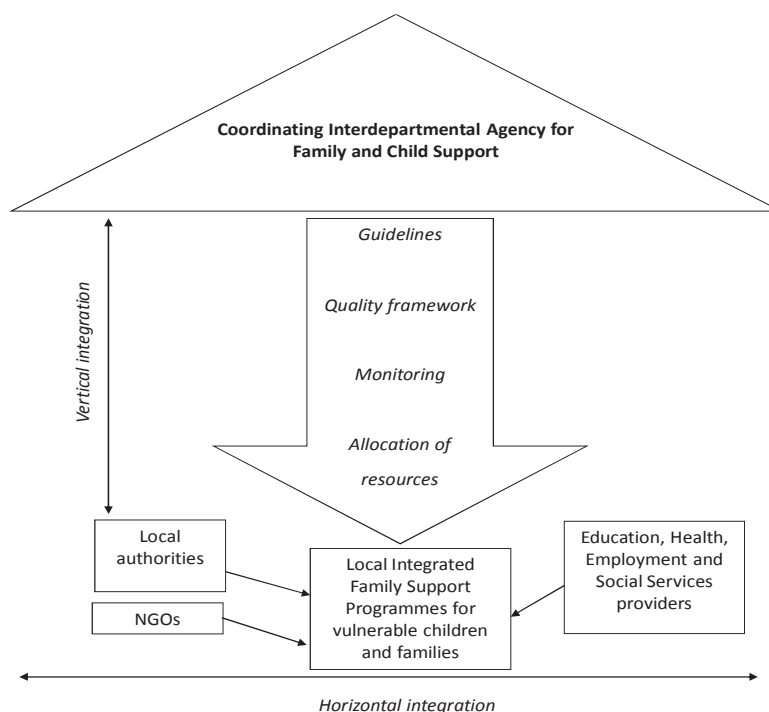
But embedding integrated services delivery at the local-level requires a “whole-system approach”

Communication, co-operation or integration across departments at the governance-level facilitates moving from a silo-mentality to taking a more collaborative approach to family services delivery. However, there is a risk that these arrangements have little impact if they are not accompanied by defined tools on how to provide integrated services at the delivery level.

Currently, few OECD countries have adopted a whole-system model to integrating family services delivery. Here, a “whole-system” approach to integration refers to joining up services’ at the local level supported by horizontal and vertical integration of different departments and levels of governance. These comprehensive approaches form part of large-scale national strategies, where tackling family vulnerability via integration of services has been identified as a political priority.

A basic example of a “whole-system” model is presented below (Figure 2.6). In this model, an interdepartmental central government agency is involved in joining-up services not only as regards to funding local programmes, but also in terms of setting the guidelines or monitoring and assessing the quality and type of services provided. At the community level, different services providers, both public and private, are brought together to deliver integrated services under the oversight of a lead agency.

Figure 2.6. A basic model of a “whole-systems approach” to integration



Australia is a working example of prioritising integration and joining-up services. Within the past decade, the Australian Government has made specific funds available for improving collaboration between service providers, community members, non-government organisations, businesses and all levels of government. The on-going *Family Support Programme* was established in 2011 and attempts to increase the provision of early intervention, prevention and targeted support for vulnerable families. This programme followed the *Stronger Families and Communities Strategy* (2004-09), which aimed to facilitate and encourage collaboration at all levels to enable communities to tackle their own issues at a local level. The idea behind the initiative was that providing funds to help “co-ordinate effort in local communities across community services, education, health and other sectors and across various government initiatives” would strengthen both families and communities (Australian Government, 2009).

The *Communities for Children initiative* is funded under the Family Support Programme and is a place-based response to programme management and service delivery that focuses on children up to five years old and their families, with a particular focus on prevention and early intervention. Service providers are brought together under a lead non-government agency that oversees wide community consultation with the aim of developing solutions to address locally identified needs (e.g. parenting, family relationships, education, health, crime, problems with gambling and suicide prevention) (Lewis and Taylor, 2005).

In New Zealand, integration is also acknowledged as the most efficient way of delivering services to vulnerable families and children. The *Strengthening Families Strategy* has been in place in New Zealand since 1997 and takes a multi-sector approach providing cross-sectional co-ordinated services. The aim of the programme is to improve the well-being of New Zealand’s most at-risk children, young people and their families. More recently, in a *White Paper for Vulnerable Children* (2012), the current government re-enforced its commitment to tackling child vulnerability by enforcing integration between both different central Chief Executives (jointly accountable for achieving results) and local service providers. The government’s plan also envisages the creation of Regional Children’s Directors responsible for co-ordinating services and new assessment tools that ensure a whole assessment of children’s needs. Other innovative elements of the strategy include establishing a “Child Protect Line”, a single point of contact that will enable identification and assessment of vulnerable children’s needs and co-ordination with multi-agency children’s teams providing the appropriate services.

Similar steps towards an integrated, whole-system approach to family services delivery have also been taken in Ireland. In addition to the establishment of a dedicated department for child and family affairs and a co-ordinating Child and Family Support Agency, the government has committed to adopting an area-based approach to tackling child vulnerability via the delivery of integrated services by Children’s Services Committees (OECD, 2013).

Finally, tackling vulnerability and preventing intergenerational disadvantage has also been a government priority in the United Kingdom with the past decade. Whilst moving towards integrated delivery of services in addressing the multiple needs of this group is seen as key to achieving outcomes, the focus of the government has shifted from preventing disadvantage in the early years into targeting highly dysfunctional families (see Box 2.1).

**Box 2.1. From Every Child Matters to Troubled Families:
A decade of battling family vulnerability in the United Kingdom**

In 2003, responding to shortcomings in family social services delivery, the UK Government launched the Every Child Matters initiative to address the needs of the most vulnerable children and to protect them from neglect and abuse. Enforced by the Children Act 2004, this national strategy promoted multi-agency working as part of a whole system reform.

Within the framework of this initiative, integration of services was imposed at all levels by integrating front-line delivery at the local level and creating inter-agency governance structure. Importantly, early intervention and prevention services reaching all children were at the core of the national framework, aiming to shift the focus from “dealing with the consequences of difficulties in children’s lives to preventing things from going wrong in the first place” (Department for Education and Skills, 2003). Although there were variations across communities, these new working methods were generally well-received across service providers and users and produced promising outcomes and best-practice examples such as providing integrated support at schools or local multi-agency partnerships (Winchester, 2008).

In 2010, the focus of integrated services delivery shifted in the context of a change of government and the economic recession. The new cross-departmental Troubled Families initiative, targeting families with complex needs, was announced. This initiative aims to turn around the lives of 120 000 families with long-standing problems and complex social needs. Case managers, or “key workers” assess the families of focus and co-ordinate the multidisciplinary support provided within the programme.

In June 2013, the programme was extended to include another 400 000 “high-risk” households within the scheme, with an additional funding of GBP 200 million for the years 2015 and 2016. While increasing the number of participating families is encouraging, researchers have debated whether this small number of families receiving support can effectively reach all in need. Moreover, the compulsory nature of the programme and labelling could also increase risky behaviour (Fletcher et al., 2012).

Integrating services has also been a core strategy to improve child and family well-being outcomes in Scotland within the past decade. The on-going Getting it Right for Every Child-strategy dates back to 2004, and shares similar goals with ECM. As part of the strategy, a “named person” is assigned to every child to ensure the recording of routine information and provide guidance with particular concerns. In case of more complex needs, a lead professional co-ordinates and manages the delivery of multiple services.

Integrated service delivery as part of universal statutory family services

The tradition of providing integrated support to families with complex needs is also long-standing in more comprehensive welfare states, such as the Nordic countries, which rely on principles of equality and universal access to services for all families. Indeed, the core objective of universal family support services is to “secure the most equal starting points possible for children” (Kekkonen et al., 2012). Integrated services, such as the family centres (see Section 2.4), tend to be well embedded in the mainstream service delivery and play a central role in preventing social exclusion and fighting poverty (ibid.; European Commission, 2012).

In the Nordic countries, municipalities are required to provide all families with child guidance and family counselling services, which most commonly take place in an integrated setting (Hamel and Lemoine, 2012; Norwegian Directorate for Children, Youth and Family Affairs, 2013). In Finland, provision of integrated services is even legally enforced: the recently reformed Child Welfare Act (417/2007) legally obliges municipalities to provide services for children and adolescents in a co-ordinated manner and multi-agency setting. While the availability of these services may vary across regions, they are generally available to all families seeking support.

As local authorities provide most family welfare services in the Nordic countries, co-ordination of services across sectors at the sub-central government level is also well-

established. Indeed, links between sectors are traditionally strong and whilst this type of local-level co-ordination of services involves more formalised joint-working, non-compliance is generally not sanctioned (Katz and Hetherington, 2006). Close collaboration between different Ministries also tends to be long-standing in these countries: in Norway, for example, links between the Ministry of Education and Research and the Ministry of Children, Equality and Social Inclusion are strong (Norwegian Directorate for Children, Youth and Family Affairs, 2013).

Sustainability of national-level strategies and scaling-up local-level experiments

Successfully addressing the complex, cross-cutting needs of vulnerable families entails strong political will and requires sustainable long-term funding streams. In fact, there is a risk of discontinuity in integrated service initiatives due to political cycles and priorities. Establishing effective integration and embedding new methods of delivering services at the local level requires time and cannot generally be measured after a four-to-five year political period. Moreover, evaluations of short-term initiatives do not capture the long-term impacts of efficient service delivery for vulnerable families (see Section 2.5).

Furthermore, the limited number of countries that have adopted comprehensive, national-level strategies to enforce integrated child and family services delivery have only recently been established or are in the process of being implemented. While these generally draw on successful, smaller-scale initiatives providing integrated family support, wide-scale evaluations on their effectiveness are yet to be conducted.

Finally, in the current economic environment, scaling-up local experiments or means-tested programmes can be challenging, as they often entail significant implementation and infrastructure costs. Up-scaling of these programmes at the national level, however, is easier in countries where comprehensive structures of community-based child welfare services already exist.

Integrated service delivery for vulnerable families at the local delivery level

The effectiveness of integrated service delivery to vulnerable families depends on local settings where services are delivered. Given the differences in service provision across OECD countries, and the relative freedom of communities in organising the way services are delivered, a wide range of integrated models exist on the ground. Nonetheless, the vast majority of programmes targeting vulnerable families, both universal and targeted, place emphasis on prevention and early intervention and most integrated service initiatives evolve around early childhood education and care services.

Table 2.3 illustrates some common forms of integrated delivery of services across OECD countries, either as local or regional initiatives or at the national level.

Table 2.3. Provision of integrated ECEC and universal family support in OECD countries

	Universal family support	Means-tested early years programmes	Conditional cash Transfer programmes
National	Finland, Denmark, Iceland, Norway, Sweden, Slovenia	Australia, New Zealand, United States	Chile, Mexico, Turkey, Finland, Hungary
Regional or local	Belgium, France, Italy, Netherlands, England, ¹ Germany, Czech Republic ²	Canada, Hungary, Korea, Czech Republic	United States (New York City)

1. The Sure Start Children’s Centres initially aimed to target vulnerable families in disadvantaged neighbourhoods but have since expanded to all local communities and is also available to all families living in the area.

2. Information for the Czech Republic refers to pro-family NGOs providing services to families with varying needs. Their activity is funded through Annual Grant Program from State Budget, organised by the Ministry of Labour and Social Affairs since 2005.

Source: OECD (2013), “OECD Questionnaire on Integrated Social Services Delivery, Part 1, Vulnerable Families”, unpublished Social Policy Questionnaire.

The expanding universal family centre-model

The most common universal family social service is perhaps the *Family Centre* model. In most cases, these family centres bring together a fully co-located range of services central in promoting the well-being of both the children and their parents.

In Sweden, the pioneer of this form of family support, municipal family centres offering a variety of services to families have been in place since the 1970s (Kekkonen et al., 2012). These centres, which are free-of-charge, are open to all families and offer cross-sectional services, including educational support for children under six as well as health and social services for families. Families have access to services provided by multidisciplinary teams consisting of paediatricians, nurses, psychologists, social workers and other professionals from pregnancy until child’s entry to primary school. These centres form a core part of Swedish family welfare services and also play a central role in the on-going national strategy for developing family support in Sweden (Kekkonen et al., 2012).

In addition to the Nordic countries where these centres play a central role in providing services for families, similar “one-stop-shops” for families following the Nordic family centre model have also been introduced for instance in Belgium, Canada, the Czech Republic, France, Germany, Italy, the Netherlands, Poland and Slovenia in the past years, although these centres are not yet turned into a national service available nation-wide (European Commission, 2012).

The *Good Parent Good Start* programme in Poland, for example, draws from the Nordic family centre model. Established in 2007, the pilot initiative implemented in the Warsaw districts enforces co-ordination between local health, welfare centres and childcare centres and aims to secure young children a home environment without abuse or neglect. Parents are offered free access to educational resources and support services. Information and educational material are available to all families, whilst families screened as vulnerable will be offered tailored, free-of-charge support (European Platform for Investing in Children, 2013). In Italy, centres for families (*Centri per il famiglia*) form part of municipal social services and are widespread especially in the Emilia Romagna region, which co-ordinates and finances them (ibid.). Early Years Centres available to all families looking for parenting support also exist at the regional level in Canada, in the province of Ontario.

Finally, developing youth and family centres in every Dutch municipality was also outlined in the *Every Opportunity for Every Child (Alle Kansen voor Alle Kinderen, 2007-2011)* policy initiative (European Commission, 2012). A degree to regulate the organisation of parenting support to offer easy access to information and multidisciplinary support via “parenting shops” at the local level is also in force in Flanders since 2007.

Shortcomings of the universal family services in reaching vulnerable families

Universal family services and the Nordic cascaded service model can be considered relatively successful when preventing vulnerability (Kekkonen et al., 2012). Evidence suggests, however, that the universalistic model is most effective when dealing with less severe needs and problems of vulnerable families, such as issues related to communication with family members or service providers (European Commission, 2012).

A number of other concerns have also been raised regarding the effectiveness of these models. Universal family support services, for instance, may not always effectively prevent the use of corrective measures, such as taking children in custody. Indeed, despite focus on prevention and early intervention, corrective services remain commonly used: in Finland for instance, only 20% of current funding on family services is spent on prevention (Patana, 2014). Moreover, there has also been some criticism that early identification of children with mental disorders does not necessarily translate into early intervention in some OECD countries.

In countries where service provision is decentralised and not targeted, large regional variations in the availability of services and the level of co-ordination can exist. For instance, universal services in bigger municipalities or regions may offer comprehensive family support, whereas issues of physical access in rural areas can restrict the availability of some services. Indeed, in some settings co-located universal services can be impractical, and vulnerable families may be better served through targeted interventions (Ofsted, 2009).

Integrated provision of early years services to reduce disadvantage

As shown in Table 2.3, many OECD countries offer means-tested integrated early years support to qualifying families, either at the national or sub-national levels. These targeted services can be either preventative or corrective. The vast majority of OECD countries, however, have increasingly shifted the focus to prevention and early intervention of child and family services, given the widely documented benefits of these approaches (see Section 2.6).

The *Head Start* in the United States, for example, is a federal programme that provides a wide range of services to low-income families and children up to 5 years old. Public and private agencies can obtain grants, from the Office of Head Start on a competitive basis to provide integrated family and child services in centres or schools, child care homes, or at children’s own homes. The Office of Head Start, within the Administration of Children and Families of the Department of Health and Human Services, ensures that services are provided as described in the Head Start Performance Standards and in accordance with the Head Start Act of 2007 (Office of Head Start, 2013). Given the relative freedom on models of service delivery of the Head Start as many other targeted initiatives, there may be large variations of modes of service delivery between communities. Common methods include, for example, physical co-location; case management, and home-based services.

Physically co-located services and multidisciplinary teams for vulnerable families with young children are similar to the family centres in their structure, and exist in many OECD countries. These integrated service models aimed at reducing disadvantage among pre-primary children and their families have been established, for example, in Australia, Canada, Hungary, Ireland, Korea, New Zealand and the United Kingdom. These services are most commonly concentrated in deprived neighbourhoods, and target disadvantaged families.

Sure Start children’s centres, for example, were established in the United Kingdom in 1998 to provide integrated services with a focus on prevention in the early years for families with young children. With a special focus on the most disadvantaged, *Sure Start* centres aim to improve outcomes for families receiving these services and to provide all children with as equal readiness as possible for compulsory education and beyond (UK Department for Education, 2012). Since being initiated, *Sure Start* has expanded from local programmes in disadvantaged communities to offer services to a greater number of families through children’s centres in less deprived areas. The *Sure Start* approach has also been introduced in Hungary in 2003, and currently reaches approximately 12 000 children in 115 sites. The long-term aim of the Hungarian Government is to transform these *Sure Start* children’s centres into a national service (Hungarian Ministry of Human Resources, 2012). The *Dream Start* centres in Korea also focus the provision of integrated services to low-income families in areas where the number of disadvantaged families is high (see Box 2.2 for further details) (Korean Ministry of Health and Welfare, 2012).

Box 2.2. Dream Start – Customised, integrated family support for vulnerable children and families in Korea

The Korean *Dream Start* was established in 2006 as a demonstration project that involved the integration of health, welfare and child protection services. First operating in selected public health centres and city areas, *Dream Start* has since become a major government welfare programme, progressively reaching all areas of the country.

The *Dream Start* centres aim to adopt a local, “whole family” approach instead of only concentrating on children’s needs. A key aspect of effective services for the vulnerable is identifying those who need the services most. For *Dream Start*, children are identified using a national administration data record of disadvantaged families with children aged 0-12. Parents are then sent letters, or brought into the service by outreach (home visits) (Korean Ministry of Health and Welfare, 2012).

As well as providing care for the children in the centres, and parenting advice for parents, the children are assessed for personal needs using a special assessment tool for physical, cognitive, and emotional well-being. Based on the assessment the children are then directed to specific support services (counseling, health care, etc.). As part of the delivery process, *Dream Start* collects longitudinal data for evaluation purposes: recent experimental evaluations show participating children have better outcomes than non-participants across a range of cognitive and behavioral outcomes.

In terms of the implementation aspects of *Dream Start*, and integrating services for vulnerable families, Korean social care workers have reported a similar set of work constraints to those seen in other OECD countries. For instance, there has been difficulties in bringing service managers from different services together to decide on joint goals and responsibilities, whereas the practitioners themselves have been more willing to integrate (yet mismatch between worker contracts from different specialties has also created barriers to effective partnerships).

Case management is a common feature of many of the targeted initiatives to integrate service delivery for vulnerable families. Case management services form an integrated part of, for instance, the Strengthening Families and the *Dream Start* programmes. The latest government policy in the Netherlands (2012) also states the central role of social

caseworkers in providing services for families with multiple needs (OECD, 2013). Case co-ordinators have also been recently introduced in Finland as part of the on-going reform of social and health services. Since 2012, Estonian families with complex needs also have access to case management as part of the *Provision of Need-Based Services to Persons with Multiple Problems by Case-by-Case Networking* pilot project. Although this programme, providing a range of services such as debt counselling and psychological and family support is not family-specific, most of the service users are families with multiple needs (ibid.).

Case management services show great potential when dealing with vulnerable families as with other vulnerable groups. Not least because the “five cars in the drive” concept would suggest that unintegrated delivery of social services could be overwhelming, confusing, and potentially contradictory for the service user, increasing the potential for inefficiency on the provider-side. Indeed, evidence shows that integrated services for families and children are effective when a service provider acts as an access point for all the other professionals that the service users need to engage with (Sloper, 2004).

Finally, home-based services are generally offered as part broader initiatives to integrate services for families with complex needs. Home-training programmes to support parents, for example, have existed in the Netherlands since the 1970s. Home services to support vulnerable single mothers have also been introduced in Ireland and the United Kingdom (McKeown, 2000).

Delivering services at home represents a number of advantages: these approaches can effectively address some of the barriers related to vulnerable families’ take up of services. These include issues such as affordability and physical accessibility to services. Indeed, home-based models of family support address issues such as transport, child care or lack of motivation and can enhance families’ feelings of security when dealing with service providers. Moreover, families’ home environment allows professionals to gain better understanding of the needs of parents and their children (McIntosh et al., 2009).

Other approaches to tackling disadvantage – conditional, means-tested support

Some countries have taken a different approach to improving outcomes of vulnerable, low-income families by integrating health care and education with welfare benefits. Programmes aimed to reduce disadvantage in Chile, Mexico or Turkey, for example, are based on this principle of conditionality. In exchange for a cash benefit, poor families qualifying for the programme are required to do regular health check-ups or enrol their children in school. These conditional cash transfer programmes are common in developing countries in particular, and have shown significant increases in outcomes in terms of for instance health and education within low-income families (World Bank, 2009).

The conditional *Solidario* programme in Chile or *Oportunidades* in Mexico represent the major social assistance programmes in these countries. However, a similar, although universally available cash benefit to all mothers also exists as part of comprehensive family welfare services in Finland. The Finnish Social Insurance Institution (SII) provides Maternity Grants in the form of a maternity package (contains child care items) or as cash benefits (EUR 140 tax free in 2012) to expecting mothers, and in doing so integrate health and welfare services. Expecting mothers (who need to be residents in Finland and be covered by the Finnish Social Insurance System) may obtain the Maternity Grant after at least 154 days of pregnancy and after undergoing a medical examination at a maternal

welfare clinic or a doctor's office before the end of the fourth month of pregnancy (Finnish Social Insurance Institution, 2012). A similar policy is also in place in Hungary, where expecting mothers can obtain a lump sum of HUF 64 125 after at least four prenatal medical examinations (Hungarian Government, 2013).

Critiques of targeted early years services

Means-tested or targeted support for vulnerable families can focus on the most vulnerable families and on community-specific issues when located in disadvantaged neighbourhoods. However, these services tend to have a corrective approach and risk excluding families and children who may be on the verge of serious vulnerability. It has also been argued that some of these “Early Years” services to reduce disadvantage entail high costs compared to modest outcomes (see Section 2.4.) Consequently, there has been some debate (e.g. in the United States and England) on whether these initiatives should be downscaled: as a result of the far-reaching cuts in funding for local authorities by the central government in the United Kingdom, for instance, the funding for Sure Start children’s centres appears to have decreased, resulting in closures of a number of these centres in recent years (Butler, 2013). The children’s services budget in Manchester in the United Kingdom, for instance, has decreased by 25% since 2011 and is likely to be cut by another 15% by 2015 (ibid.). There is, however, a considerable risk that cutting funding from early intervention and prevention services will lead to increased costs and use of corrective services later in life.

The benefits of early intervention and prevention

The importance of early intervention and prevention especially in the context of tackling family vulnerability has been increasingly acknowledged across OECD countries. Indeed, the majority of recent initiatives targeting this group, whether national policies or local experiments, place great emphasis on delivering services in a preventative manner. In Finland, for example, the reformed Child Welfare Act legally obliges municipal child welfare services to focus on prevention and early support (Finnish Child Welfare Act, 417/2007).

A distinction needs, however, to be made between different stages when discussing prevention. In fact, although prevention and early intervention are explicit aims of all initiatives integrating services delivery for families, their focus differs depending on whether the services provided are universal or targeted. Universal family services, such as the co-located family centres, or health and mental health support provided in schools, aim to prevent vulnerability across children and families in the general population. Prevention as part of targeted family support, such as means-tested early years services or conditional cash benefits on the other hand, place emphasis on intervention at a second stage, aiming to prevent intergenerational disadvantage and further marginalisation of families already considered vulnerable.

Spending on early childhood can also contribute to narrowing the gap between lower and higher socio-economic groups, preventing vulnerability and social exclusion later in life. Studies show that early intervention and prevention can also enhance children’s cognitive and educational attainment and provide “employment and earnings gains in adulthood” (OECD, 2011a). Some evidence suggests that integrated working is likely to be more effective when focusing on prevention (Statham, 2011).

Evidence from the United States underlines the importance that the quality of early childhood education and care plays in child well-being. The *Perry Preschool* experiment

in the United States, for example, provided high quality preschool education to disadvantaged, poor children at high risk of failing school. The results from the long-term evaluation of the experiment show substantial and lasting results in terms of economic and educational outcomes (Coalition for Evidence-Based Policy, 2013, see also Carcillo et al., 2015). Evidence from the Perry experiment illustrates how early childcare improved outcomes in terms of adult employment and income (e.g. higher rates of high school completion; higher earnings or fewer crimes compared to control group) (Schweinhart and Weikart, 1993; Schweinhart, 2003). A cost-benefit analysis of the programme – taking into account savings in welfare or criminal justice and return in taxes – suggests a USD 12.90 return per public dollar invested (HighScope, 2013).

Notes

1. Both the household level surveys and the Gallup World Poll will suffer from under-reporting when referring to vulnerable families. Families in temporary accommodation, who are homeless, and those experiencing severe forms of deprivation, neglect or mistreatment, are likely to be missing from household surveys. This is also the case for the Gallup World Poll, which is conducted by telephone. When results are available, information is self-reported, which may compound data quality issues resulting from under or overestimation of the data. The UN data on criminal trends, on the other hand, relies on administrative information but does not allow a more detailed analysis of the different types of juvenile criminal activity.
2. According to the US Census Bureau, 2010 Census Summary File, there were a total of 77 538 296 family households in the United States in 2010. Family households refer to households containing at least one person related to the householder by birth, marriage, or adoption.

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Chapter 3

Integrating services for children and youth with mental health concerns

Mental ill-health affects many individuals, and represents a large and rising burden of disease across the OECD. Episodes of mental illnesses for many people begin in childhood or young adulthood, and can contribute to vulnerable situations, such as low educational attainment in the first instance, or unemployment or financial hardship in the second. While OECD countries are increasingly investing in developing cross-sectoral approaches to promote mental well-being, the education, employment or social sectors most involved with children and youth often lack the capacity or expertise to effectively address the complex needs associated with mental health concerns. This chapter discusses the challenges of, and opportunities for, integrated delivery of services to improve outcomes for children and young people with mental health needs, and presents some good-practice examples of policies 1) to promote mental well-being in school-settings and 2) to tackle inactivity in youth with mental health problems.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

3.1. Introduction

Mental illnesses and socio-economic vulnerabilities are strongly linked. Not only can unemployment, unstable housing situations or financial hardship affect individuals' mental well-being, people suffering from severe mental disorders also face considerable disadvantage in the labour market, record poorer educational outcomes and health status, and often rely on social transfers as their primary source of income.

Tackling mental ill-health at an early stage in the lifecycle helps to prevent vulnerability in later stages, and to reduce future demand for costly services. Mental disorders often develop in childhood, strongly affecting educational outcomes or contributing to school drop-out. Schools offer great potential in terms of mental health prevention and early intervention, and many OECD countries are experimenting with ways to promote well-being and to address mental health issues at schools.

There is also a strong relationship between mental illnesses and youth vulnerability. This relationship commonly associates with poor educational attainment, youth unemployment, poverty and substance or alcohol abuse. Inactive youth with mental health concerns and low qualifications face considerable difficulties (re-)entering the education or employment systems. Co-occurring mental health and substance abuse problems, on the other hand, may expose individuals to the most extreme forms of vulnerability, such as homelessness. Integrated service delivery is an emerging way to address the multiple needs of these youth across the OECD.

This chapter reviews recent integrated efforts to improve educational, health and labour market outcomes for children and young people with complex (mental health) needs. Section 3.2 presents the main findings. Section 3.3 discusses the prevalence, vulnerability associated with, and the burden of mental ill health upon individuals and societies. Section 3.4 reviews recent developments in mental health services in the general population and highlights the need for a multisectoral approach to promote mental well-being. Prevention and early intervention oriented mental health initiatives targeting compulsory school-aged children are discussed in Section 3.5. Section 3.6 concludes with integrated service policies for youth and individuals with mental health concerns at risk of unemployment and inactivity.

3.2. Main findings

The main findings of this review of integrated services for children and youth facing mental health issues are as follows:

- *Mental illnesses are common amongst young people.* A cross-national survey of 13- and 15-year-olds reveals that approximately one in 12 children in the OECD report feeling low on a daily basis (HBSC, 2012). Evidence from Australia, on the other hand, suggests that as many as one in four people with a mental health problem experience their first episode of mental ill-health before the age of 12 (OECD, 2014).
- *Mental health problems can result in high costs for individuals and societies if not addressed effectively.* Available national estimates suggest that the indirect costs of mental illnesses – economic costs and attributable to the disease – are significant, accounting for 0.9% of GDP in Canada, 2.4% in England, or 1.1% in France – this puts the indirect cost estimate in a range equivalent to four to 10% of total social expenditure in 2009 prices, and at a similar level to direct spending on mental health services in these countries.

- Integrating services both within and across the health, social, education and employment sectors has the potential to alleviate the private burden of mental ill health, both the direct and indirect public costs associated with vulnerability.
 - Poorly co-ordinated mental health care *within* the health sector can lead to costly re-admissions and lengthy stays in hospital settings for patients who could be effectively treated in community care. Available data on unplanned readmissions to the same hospital for patients with schizophrenia from 15 OECD countries suggests that co-ordination issues are fairly common: on average almost 13 per 100 patients were readmitted within 30 days in 2011.
- *Increasing the role of the education system in providing mental health support can yield positive returns in terms of symptom reduction and problem prevention.* Investing in early intervention and prevention by improving co-operation between the education and (mental) health systems can have positive returns in terms of compulsory school completion and educational attainment. This, in turn, can reduce future demand for services for individuals with highly complex needs. From this perspective, there is scope for further focus on mental health services in education systems across OECD countries (currently 15 out of 27 ongoing mental health plans have a stated focus on education).
- A variety of school-based mental health initiatives illustrate the potential that schools can have in reducing stigma and promoting students' mental well-being. However, *a number of challenges to effective service integration for students with mental illnesses remain:*
 - School-based mental health programmes can be effective in raising mental health awareness or helping teachers to identify students with multiple mental disorders. However, further focus should be placed on addressing and identifying mild to moderate disorders, which affect a large number of students.
 - Roles and responsibilities of different service providers need to be clearly stated and co-ordination with school-based support and local services must be strengthened to ensure appropriate treatment and follow up for students experiencing mental health concerns.
 - Lack of funds for integrated services provision can also often be an obstacle, resulting in waiting times for consultation and/or treatment, and stress and high work load for professionals. Sufficient funds and time must be secured to allow new methods of services delivery to become embedded and providers' new roles clearly defined.
 - School-based mental health initiatives need to be rigorously evaluated. More data is needed on the outcomes of school-based mental health and welfare programmes. Despite the large number of mental health initiatives targeting students, few countries collect data on their effectiveness, in particular in the long term.
- *Monitoring and identification of early school leavers must be improved.* Municipal outreach workers following up on and providing support for school drop outs in Finland, the New Possibilities programme in Norway, or the Dutch Regional

Registration and Co-ordination institutes are innovative examples of enhancing understanding and targeting vulnerable and inactive youth.

- *Integrating support and providing mental health services as part of multidisciplinary initiatives targeting vulnerable youth can improve their mental well-being and engagement with study and work.* Mental health services should play an important part of youth activation programmes to facilitate transition from inactivity to education or employment.
- Integrated services targeting youth with mental health concerns share common characteristics of service delivery: *Co-location and case management* most effectively bring services together for this group, and enable taking a person-centred, non-stigmatising approach into services provision. Moreover, evidence suggests that *regular and meaningful contact with service providers and incorporating local conditions (e.g. availability of community services) into programme design* are associated with better programme outcomes.
- *Strong government steering is important to encourage mental health promotion and prevention across different sectors.* This can enhance the capacity of other sectors in terms of dealing with individuals suffering from mental illnesses. Strong steering can also help prevent incentives to move individuals from one public assistance scheme to another for cost-shifting purposes instead of investing in mental health support services.

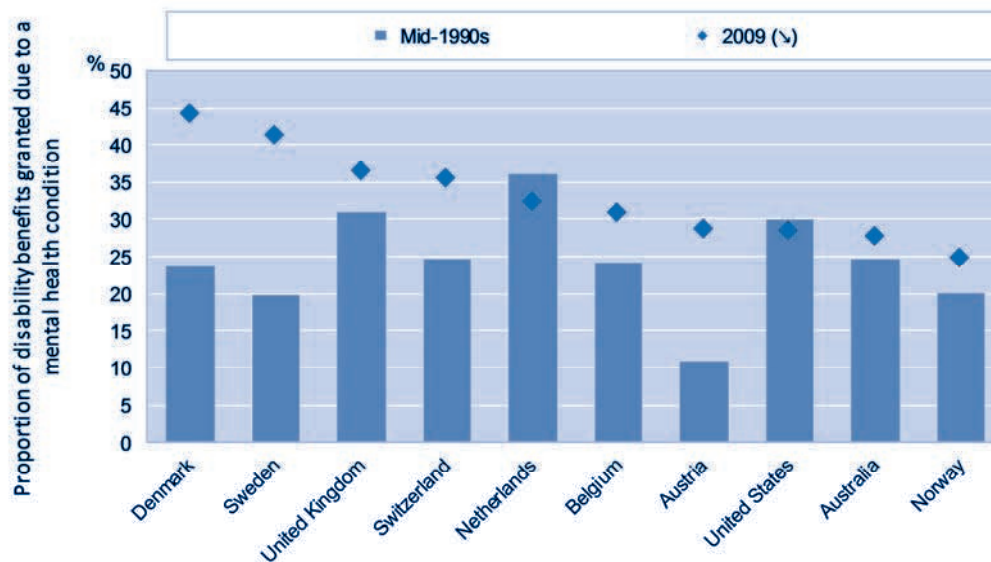
3.3. Mental disorders are common, and their burden of disease is increasing

Mental disorders represent a considerable burden of disease across the OECD. Mental ill health also negatively affects educational and employment outcomes and individuals with mental disorders face a considerable poverty risk. In many countries, the costs associated with mental ill health have also increased considerably within recent years (OECD, 2012a). This section looks the prevalence of mental disorders across different age groups, and discusses the social costs of vulnerability associated with mental illness.

Mental disorders represent a large burden of disease

While estimating the proportion of persons suffering from mental disorders across countries is challenging (Richardson, 2009), existing evidence shows that the prevalence of mental disorders, in particular mild-to-moderate illnesses, is high across the OECD (most recent cross-national data suggests that approximately one in eight people had a diagnosable mental illness within the past year) (ibid.). Although prevalence rates are difficult to compare internationally due to definitional issues, data on disability benefit receipt suggests that the *burden* of mental disorders has grown in recent years. An OECD study (2012b) shows that since the mid-1990s, spending on people with mental disorders in a number of OECD countries has increased. Moreover, the proportion of disability benefits granted for people with a mental health condition has also grown (Figure 3.1).

Figure 3.1. Newly granted disability benefits for people with a mental health condition¹ as a proportion of all disability benefit grants in selected OECD countries, mid-1990s and latest available year



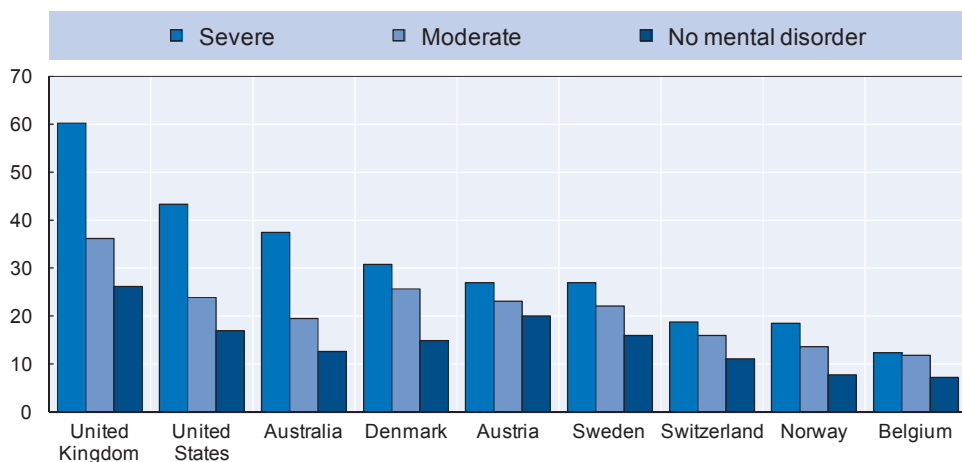
Note: Countries are ranked in descending order by the proportion of newly granted disability benefits due to mental disorders in 2009.

1. Data on mental health conditions include mental retardation/intellectual disability, organic mental disorders and unspecified mental disorders for: Austria, Belgium, Sweden and the United States (of which mental retardation/intellectual disability, accounts for 4.6% of the total inflow in 2006). Data for Australia include organic disorders and Switzerland mental retardation. Definitions are based on the WHO (1993) classification on mental disorders.

Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/9789264124523-en>.

The rise in the share of disability benefit claims due to mental disorders may be largely explained by two factors. First, it appears that people with co-morbid conditions (i.e. one or more conditions that occur together with the primary condition) increasingly take mental disorder as “the primary cause for incapacity”. Second, given that mental illnesses are more often viewed as disabling, claimants with mental disorders are more often granted a full benefit, their claims are less frequently denied, and they are less likely to move off benefits than those with somatic (i.e. physical) conditions (OECD, 2012b).

Associated with benefit dependency, the poverty risk of people with mental disorders is also considerable compared to those in good mental health (Figure 3.2). In Australia, the United Kingdom and the United States, for example, people with a severe mental disorder are twice as highly likely to be poor than those with no mental disorder.

Figure 3.2. People with a mental disorder face a considerable poverty risk

Note: Countries are ranked in descending order by poverty risk for people with severe mental disorders.

Source: OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/9789264124523-en>.

A considerable proportion of mental disorders develop before reaching adulthood

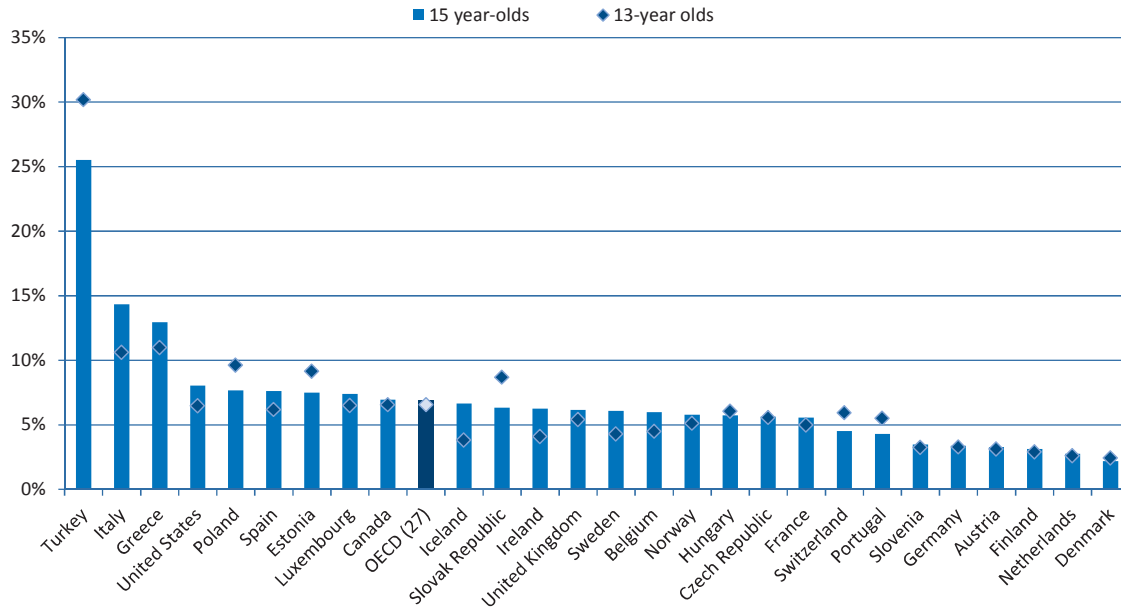
A considerable proportion of mental disorders develop before reaching adulthood. Many family-related factors are known to affect the development of mental disorders in childhood, such as poor physical health, maternal emotional distress or bad parenting practices (Bayer et al., 2011). Evidence from Australia, for example, suggests that 64% of people experience their first episode of mental illness before turning 21, and 25% before the age of 12. Nonetheless, only 25% of under 25-year-old Australians with mental disorder access mental health services (OECD, 2014).

In recent years, children's mental well-being has become a major concern in several OECD countries. The number of children and adolescents reporting mental ill health or using specialist mental health services, for instance, has increased in a number of OECD countries such as Finland and Sweden (Patana, 2014). In Norway, the share of behavioural and emotional childhood disorders leading to disability (e.g. ADHD) has increased from 25% to 80% from 1990 to 2010 (OECD, 2013a). The growing number of suicides committed by young people in Korea, as well as the high rate of early school leavers in Denmark, Norway and Sweden, has also gained attention in recent years (Hewlett, 2014).

The OECD-wide median age of onset for mental disorders is 14 years, with anxiety and personality disorders beginning around age 11 (OECD, 2012b). While information on the prevalence of mental illnesses among children is generally scarce, the survey on *Health Behaviour on School-Aged Children* (HBSC) provides some self-reported, cross-national data on 13- and 15-year-old students' mental well-being (Figure 3.3).

Figure 3.3. Proportion of children feeling low daily in selected OECD countries, 2010

13- and 15-year-old students answering to the following question: in the last six months, how often have you had the following?
Feeling low about every day.



Note: Answer categories include about every day, more than once a week, about every week, about every month, rarely or never.

Source: Author's calculations of Health Behaviour in School-aged Children data (2013), "2009/2010 Survey", www.hbsc.org/. See also Currie, C. et al. (2012), "Social Determinants of Health and Well-being Among Young People. Health Behaviour in School-aged Children (HBSC) Study: International Report from the 2009/2010 Survey", World Health Organization, Copenhagen, www.euro.who.int/data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf?ua=1).

The proportion of 13- and 15-year-old children feeling low on a regular basis varies considerably across OECD countries. In Turkey, approximately 30% of 13-year-old and 26% of 15-year-old students reported feeling low about every day in 2010, followed by Greece, Italy and the United States with shares over 10% for both age groups. The lowest shares of 13- and 15-year-old students with daily mental health concerns were in Denmark and the Netherlands at below 3% – countries where intervention for youth with mental health needs are in place.

Mental disorders are often associated with youth vulnerability

Young adults with mental health concerns are vulnerable to low qualifications and/or incomplete education (dropping out of school), conditions which are often associated with (long periods of) inactivity or unemployment. As for children with mental health concerns, it is challenging to obtain a clear picture of the extent of mental ill health among youth across the OECD. Nonetheless, available estimates from national health surveys from ten OECD countries suggest that mental disorders among 15-24 year-olds are common: on average, approximately one in four young adults suffers from mild-to-moderate or severe mental disorders (OECD, 2012b).

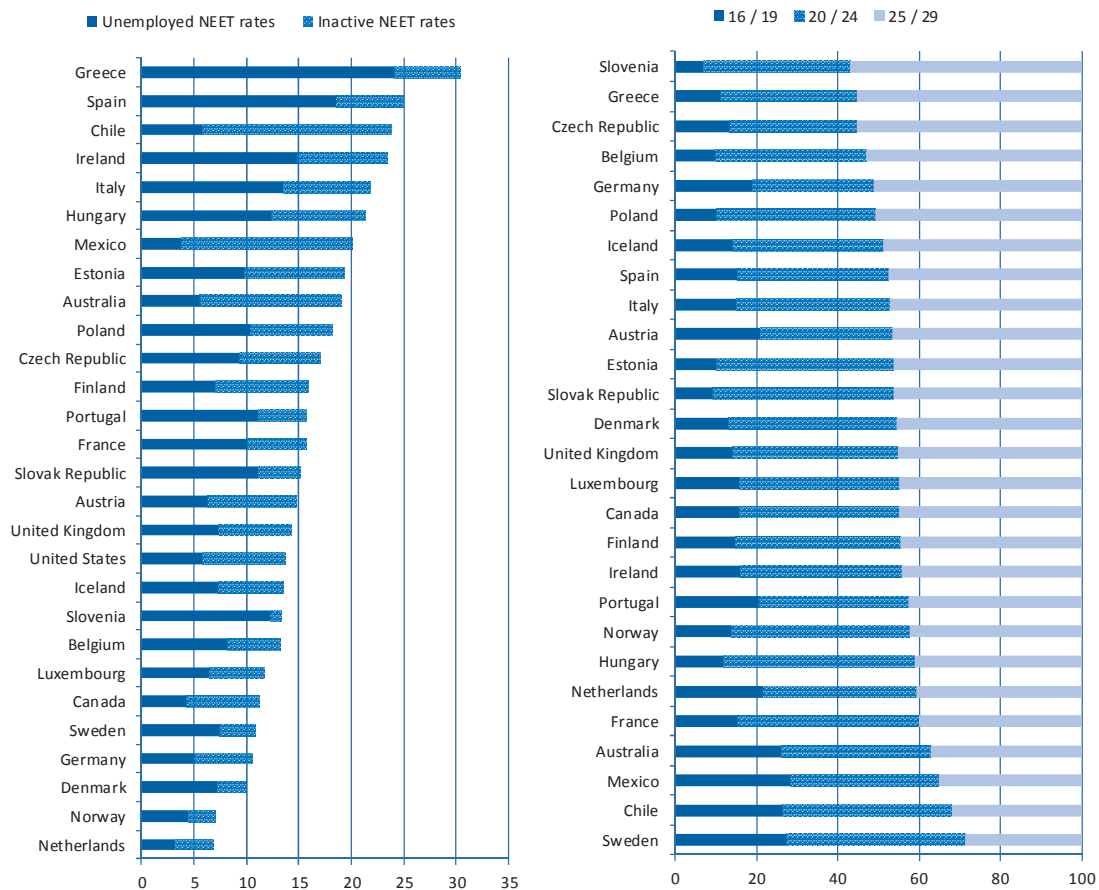
However, as students with mental health concerns are more likely to drop out of schools, and that (longer periods of) inactivity and unemployment are often linked with more or less severe mental health concerns (see Section 3.5), the proportion of youth “not in employment, education, or training” (NEETs) provides a proxy for youth vulnerability (for a comprehensive analysis of NEET characteristics, see Carcillo et al., 2015).

The proportion of NEETs varies considerably across the OECD (Figure 3.4, left panel). NEET rates range from 7% in the Netherlands and Norway to as high as 30% in Greece. The risk of being young and inactive or unemployed also depends on age (Figure 3.4, right panel). About half of all NEETs are below 25, although 15-19 year-olds are much less likely to be NEETs than 20-24 and 25-29 year-olds. The proportion of 15-19 year-old NEETs ranges from 7% in Slovenia and 9% in the Slovak Republic to 28% in Mexico and 27% in Chile and Sweden.

Figure 3.4. NEET rates vary significantly across countries, and about half of all NEETs are below 25

Panel A. NEET rates for 15-29 year-olds, as a percentage of all youths in 2011

Panel B. Breakdown in percentage of NEET by age group in 2011



1. Numbers are for individuals aged 15-29 years; for the United States, the age range considered is 16-24 because no information on student status is available for individuals aged 25 years and above.

2. Data are for 2011 except for Canada (2009), Ireland (2010) and Mexico (2012).

Source: OECD calculations based on EU-SILC for European countries, Hilda for Australia, SLID for Canada, CASEN for Chile, ENIGH for Mexico and CPS for the United States.

Finally, suicide rates in children and adolescents can also be used as an indicator of the failure of effectively addressing the complex needs of youth with severe mental health concerns. Trends in suicide across 10-14 and 15-19 year-olds vary widely across countries. While on average suicide among 10-14 year-olds is rare across the OECD at below 1 in 100 000, in a number of countries as many as one in 10 000 15-19 year-olds committed suicide in 2010, including the proportion of 15-19 year-olds committing suicide is quite large, including Estonia (13 in 100 000), Finland (11.7 in 100 000), Ireland (10.7 in 100 000), New Zealand (17 in 100 000) (see Annex 3.A1 for suicide trends in OECD countries for 10-14 and 15-19 year-olds).

The financial burden of vulnerability associated with mental ill health is considerable

Although difficult to estimate accurately, the economic burden of vulnerability associated with mental ill health on individuals and societies can be considerable:

- In addition to disability benefit claims (see Figure 3.1), studies suggest that individuals with mental illnesses record, for example, higher unemployment rates and are more likely to lose their jobs. Mental ill health also negatively affects work productivity and absenteeism (OECD, 2012b).
- Co-morbidity of mental disorders with somatic health conditions is also relatively common, often leading to higher mortality, health care use and costs for individuals within this group (Naylor et al., 2012). In England, for example, health care use costs are at least 45% higher for individuals with co-morbid long-term somatic and mental health conditions compared to individuals with long-term physical illnesses only (ibid.).
- The lack of appropriate follow-up and co-ordination after discharge from hospitals can also lead to costly, unplanned readmissions (see Section 3.4). Some evidence also suggests that mental illnesses have also shown to increase risky behaviours, such as smoking (Naylor et al., 2012).
- Finally, there is also a link between criminal behaviour and mental ill health: the prevalence of mental health problems among prisoners has been estimated at approximately 40-60% (WHO, 2014), compared with a global lifetime prevalence of mental disorders of approximately 25% in the general population (WHO, 2001).

Some national estimates exist on the direct and indirect costs¹ of mental illness. In Canada, for example, the total costs of mental ill health were estimated at CAD 19.8 billion, or 1.8% of GDP in 2000, of which indirect costs accounted for 51% (Jacobs, 2010). In England, costs were estimated to be equal to 4.1% of GDP (GBP 51.6 billion) in 2009/2010, with 59% of the costs being indirect (Centre for Mental Health, 2010) and 2.3% of GDP (EUR 44.1 billion) with indirect costs accounting for 48% in France in 2007 (Chevreul, 2009).

Some estimates also exist on the global economic burden of mental illness. Bloom et al. (2011) suggested that indirect costs (USD 1 670 billion) were twice as high compared to the direct costs of mental disorders (USD 823 billion). The difference compared to national estimates from Canada, France, and the United Kingdom is probably attributable to lower levels of direct service intervention (i.e. mental health service provision) in other countries, which are likely to further inflate indirect costs of mental ill health.

In sum, the considerable burden of disease, the multiple vulnerabilities faced by people with complex mental health needs, and the high direct and indirect costs of mental ill health illustrate that no one sector alone can efficiently address the cross-cutting, complex needs of these vulnerable individuals, suggesting that there is scope for an integrated approach.

3.4. Effectively supporting individuals with complex needs requires cross-sectoral co-operation

Finding ways to identify and address the needs of people with mental health needs is an ongoing priority for policy makers in the health and social care sectors. Cross-sectoral co-operation in service delivery is a key aspect to effectively and efficiently supporting individuals with complex needs (OECD, 2012b; OECD, 2014) – though challenges exist.

In addition to the common governance and finance challenges to co-ordinating services, effective delivery of mental health services is further challenged by issues such as stigma, underfunding and neglect. This section discusses recent developments in mental health care towards an integrated community care approach in the general population, and highlights the need for a multisectoral approach in addressing these individuals' complex needs.

Mental health is a national policy priority in many OECD countries

Acknowledging the high costs of mental ill health upon both individuals and societies, governments across the OECD are committed to improving the effectiveness of, and access to mental health care. Mental health is currently a policy priority in several OECD countries: as shown in Table 3.1, 27 OECD countries have ongoing, national-level strategies or policies for mental health in the general population.

The need for a multisectoral approach in providing services for people with mental disorders has also been acknowledged by OECD governments, and the integration of mental health care with other health and social support has grown as part of this move (see, for example Patana, 2014; or Hewlett, 2014). The majority of OECD countries include developing mental health services to cover employment, education or alcohol and substance abuse issue as central elements of their mental health strategies (Table 3.1). In settings where services are often fragmented not only across but also within sectors (for examples see Figure 3.6), however, strong leadership is required by governments to enforce cross-sectional co-operation to promoting mental well-being.

Table 3.1. Mental health is high on the policy agenda, and increasingly takes a multisectoral approach

	National mental health strategy or plan?	Public mental health	Well-being	Prevention	Employment / Disability	Education	Early detection of behavioral problems	Learning disabilities	Alcohol abuse	Substance abuse
Australia	Yes	X	X	X	X	X	X	X	X	X
Austria	Yes	X	X	X	X	X	X	X	X	X
Belgium	Yes	X		X			X		X	X
Canada	Yes		X	X	X	X	X		X	X
Chile	Yes	X	X	X					X	X
Czech Rep.	No									
England	Yes	X	X	X	X	X	X			
Estonia	No									
Finland	Yes	X	X	X	X	X	X	X	X	X
France	Yes	X		X	X		X		X	X
Germany	No									
Hungary	Yes	X	X	X	X	X	X	X	X	X
Iceland	No									
Ireland	Yes	X	X	X					X	X
Israel	Yes				X		X		X	X
Italy	Yes	X	X	X	X	X	X	X	X	X
Japan	Yes	X	X	X	X	X	X	X	X	X
Korea	Yes	X	X	X	X	X	X	X	X	X
Luxembourg	Yes	X	X	X	X	X	X	X	X	X
Mexico	Yes	X	X	X	X	X	X	X	X	X
Netherlands	Yes	/	/	/	/	/	/	/	/	/
New Zealand	Yes	X	X	X	X		X		X	X
Norway	Yes	X	X	X						
Poland	Yes			X	X		X		X	X
Portugal	Yes	X	X	X	X					
Slovak Rep.	Yes	X	X	X	X	X	X	X	X	X
Slovenia	No									
Spain	Yes	X	X	X	X	X	X			
Sweden	Yes	X		X	X					
Switzerland	Yes								X	X
Turkey	Yes	X	X	X	X	X	X	X	X	X
United States	Yes	X	X	X	X	X	X	X	X	X

The table presents the responses to the following questions:

1. Is there a National Mental Health Strategy or Plan in your country?
2. If yes, does the strategy or plan cover/include the following areas: national indicators; public mental health; well-being; prevention; employment/disability; education; early detection of behavioural problems; learning disabilities; alcohol abuse; substance abuse.

“/” corresponds to no answer.

Source: OECD (2012), “OECD Mental Health Questionnaire”, Unpublished Health Policy Questionnaire.

Moving away from hospitals towards integrated community-based care

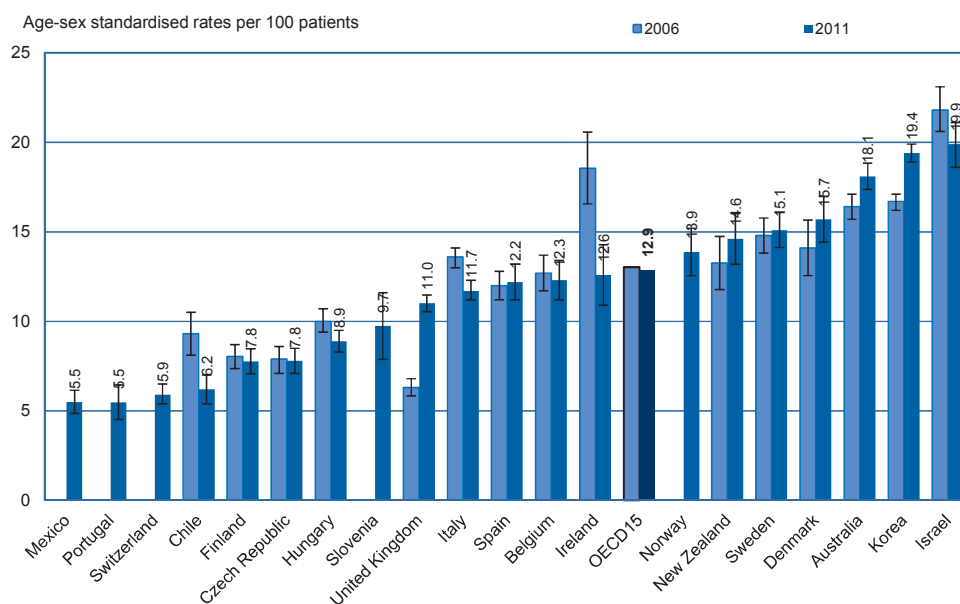
Mental health services across the OECD have undergone significant organisational and structural changes within the past decades. Although to a varying degree, countries are moving away from traditionally separate inpatient care towards community-based integrated services (OECD, 2014). New organisational and delivery models have emerged, which often take a cross-sectoral approach and involve multidisciplinary teams. While these community approaches vary across countries from community outreach with supported employment or housing schemes (e.g. Finland, the United States) to “crisis teams” (e.g. Norway, Italy, the United Kingdom) or interval care protocols (which place unstable patients in hospitals for short periods used in Denmark), patient-centeredness is at the core of community mental health care.

Effective co-ordination of community care remains a challenge

Although integrated approaches to providing mental health care are becoming more common, effective co-ordination within and across sectors remains a challenge. The extent of the challenge can be highlighted using data on unplanned readmissions to hospitals for patients with a mental disorder. High rates of unplanned readmission are an indication of the shortcomings in the co-ordination of outpatient mental health care (well-co-ordinated and effective “outpatient” care should be minimising the use of unplanned emergency or acute care services).

Figure 3.5 illustrates the unplanned readmission rates to the same hospital 2006 and 2011 for schizophrenia patients² in OECD countries with available data from 15 OECD countries. Readmission rates were particularly high in Israel and Korea with approximately 19 per 100 patients readmitted within 30 days. In Korea, this relatively high rate is likely due to poor transition planning and a lack access to effective outpatient care or a low threshold for the decision to hospitalise (OECD, 2014). In Mexico, Portugal and Switzerland, on the other hand, these rates remained relatively low at less than 6 per 100 patients. In addition to limitations in countries’ capacity of distinguishing between planned and unplanned readmissions, differences in care delivery models may also limit the comparability of these rates across countries (OECD Health Statistics, 2014).

Figure 3.5. Schizophrenia re-admissions to the same hospital, 2006 and 2011 (or nearest year)



Note: 95% confidence intervals represented by error bars.

Source: OECD Health Statistics (2013), <http://stats.oecd.org/>.

In some countries, co-ordination issues exist *within* mental health services (Figure 3.6). In Norway and Sweden for example, municipalities are responsible for primary health care, while specialist inpatient and outpatient (mental) health services are governed at the regional level – by counties in Sweden, and health districts in Norway – which has shown to lead to a lack of mental health support at the local level in municipalities. In Norway, for example, municipalities lack mental health specialist staff,

and the use of private services can be costly and therefore restricted to a small number of patients. This has led to long waiting times for treatment (OECD, 2013a).

In Finland, similarly, responsibility for delivering mental health services is divided between municipalities and regions. In addition, child and adolescent psychiatry are divided into *separate* specialities. Child mental health services can be accessed until age 13, while the adolescent services generally can treat patients up to 23 years (Patana, 2014). Waiting times are usually shorter for adolescent services than for adult services, possibly due to the lower take up of services by adolescents. The transition from adolescent to adult services can be difficult and may result in some discontinuities in treatment (Patana, 2014).

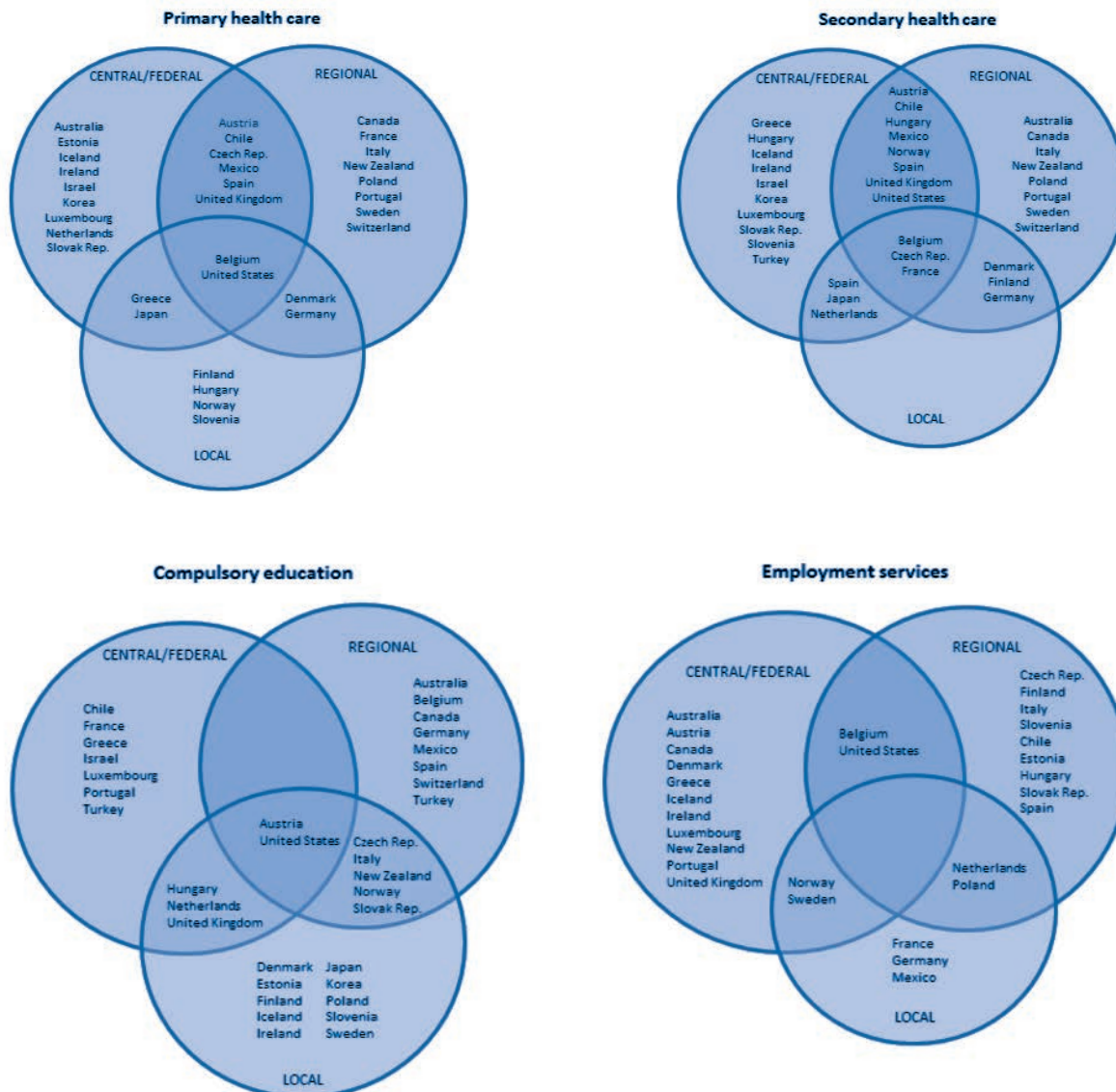
3.5. Links across sectors need strengthening

In addition to improving integration of mental health services vertically *within* the health sector (i.e. within inpatient and outpatient care settings), links *across* different sectors equally need strengthening. Education, health or employment services are often managed at different levels of governance (see Figure 3.6). In the Netherlands, for example, responsibility for youth services is devolved to local governments, compulsory education is split between the central and local governments, while specialist (mental) health services for children and adolescents (as well as the adult population) remain a central government responsibility.

Given the high risks of unemployment, losing a job, or benefit dependency associated with mental illnesses (see Section 3.3), however, the social *and* employment sectors play an important role in supporting individuals with complex needs. While disability benefits are often the primary source of income for people with mental disorders, other public assistance schemes, such as unemployment benefits or social assistance, also play a role, especially for those with mild-to-moderate illnesses. These multiple sources of income have important implications, as the lack of a co-ordinated approach and well-defined responsibilities may create incentives to move these individuals from one public assistance scheme to another for cost-shifting purposes.

At present, social assistance and unemployment systems have little capacity to identify and support individuals with complex health needs (OECD, 2012b). Administrative data on the mental health status of job seekers or unemployment and social assistance recipients is scarce and rarely collected across OECD countries, which hinders employment and social service providers' abilities to take preventative measures and intervene early. Similarly, professionals' in the social sector or in public employment services (PES) often lack in-depth expertise on, or knowledge about available mental health support services.

Figure 3.6. Services for youth with mental health needs are often managed at different levels of governance



Note: **Primary care** services include first contact services for diagnosis and treatment of acute and chronic illnesses, health promotion, disease prevention, health maintenance, counselling, and patient education, in a variety of health care settings. These services can be provided by primary care physicians and nurses or other types of professionals. **Secondary care** refers to medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialised knowledge, skill, or equipment than the primary care physician has. **Compulsory education** refers to primary and secondary schools. **Employment services** refer to job centres and/or training.

Source: OECD (2013), “Questionnaire on Integrated Services Delivery”, Unpublished Social Policy Questionnaire.

Acknowledging these issues, OECD governments are increasingly promoting mental well-being across sectors, especially at earlier stages in the lifecycle. A number of countries are also addressing co-occurring mental health and addiction problems (substance and alcohol abuse) by bringing these services together (Box 3.1).

Box 3.1. Co-ordinating substance abuse and mental health services

Alcohol and substance abuse issues are increasingly incorporated in national strategies for improving mental health services provision. Some 21 of 27 OECD countries with national mental health strategies (see Section 3.1) also cover co-occurring substance and alcohol abuse problems (Table 3.2).

The Netherlands and Canada, for example, have undertaken national reforms to facilitate the integration of mental health and substance abuse services. Lessons from the Dutch the reform “To Score Results” highlighted the following elements as necessary in a co-ordinated system of services: adequate funding; administrators committed to the integrated approach; involving relevant professionals in the implementation process; additional training and supervision to provide professionals with different treatment skills; increased communication and involvement of service users and a sufficiently long timeframe (achieving change requires time) (Schippers, 2011).

In Finland, similarly, the ongoing National Plan for Mental Health and Substance Abuse Work (2009-15) aims to provide co-ordinated substance abuse and health services. The Plan has focussed on the administrative integration of these services to establish 24-hour services, mobile outreach services, and merged mental health and substance abuse outpatient services (Moring et al., 2011).

France also has a far-reaching, co-ordinated governance structure to address substance and alcohol abuse issues. The Inter-departmental Mission for the Fight against Drugs and Drug Addiction (MILDT) has the task of organising and co-ordinating state government activities in the area of drugs and drug addiction. Roles include the monitoring and prevention of drug use, the treatment and reintegration of drug users and finally, the provision of training for those involved in the fight against drugs (MILDT, 2014).

3.6. Tackling complex needs at an early age: Providing integrated support in schools

Children's and adolescents' mental health concerns can have lasting consequences on individuals. Identifying these age groups and intervening early is also likely to reduce costs by reducing future demand for costly inpatient services or disability benefits. Hence, addressing mental health issues must begin at an early stage. Schools provide an ideal, universal setting for reaching children with mental health concerns and their role in providing health support is increasing across the OECD. This section discusses recent and ongoing initiatives integrating mental health services with education systems.

Prioritising child and adolescent mental health services

Responding to the rising concerns about the increasing mental ill health and the shortcomings of available mental health support for children and adolescents, students' mental health has become a policy priority in several OECD countries (see Table 3.1). One of the key areas of the 2011 Budget of Australia's Ten Year Roadmap for Mental Health Reform, for instance, was improving young people's mental health services. Mental health of young people is also a political priority in Korea, given the high incidence of suicide within this age group (Hewlett, 2014). Children and adolescents are equally high on the agenda of the Swedish Mental Illness Action Plan for 2012-16.

While approaches to improving children's and adolescents' mental health services vary across countries, these strategies generally share similar key principles. The role of the education system in promoting mental well-being is increasing, and countries are addressing barriers to improve co-ordination between mental health support, schools and other local services. Despite this increased investment in intervening early, however, in the majority of OECD countries the funding and resources available for child and adolescent mental health are yet far from those dedicated to adult services (OECD, 2014).

Schools play a key role in promoting mental well-being

Schools are ideally placed to promote children's and adolescents mental well-being, and to guide those suffering from disorders to appropriate specialist services when applicable. While in some countries concerns over privacy or parental consent may hinder the integration of (mental) health and education systems (Evans, 1999) many OECD countries have implemented school-based mental health programmes in recent years due to its several benefits. Educational systems reach the vast majority of children and adolescents and provide a non-stigmatising, universal setting for prevention and targeting of children who experience (or risk developing) mental illnesses. Delivering mental health services through the school system can also contribute to solving some major financial and structural barriers that may prevent children from seeking or receiving services due to mental health concerns.

Investing in school-based prevention as a form of early intervention for mental disorders can yield particularly high returns by preventing vulnerability later in the lifecycle and positively affecting children's behavioural and emotional well-being (Wilson et al., 2003). In fact, there is a strong association between achievements in education and mental disorders. Not only do students with emotional or behavioural problems have a high risk of never obtaining an upper-secondary education qualification (Johnston et al., 2011), but evidence also suggests that completing secondary education decreases the risk of adult depression (Chevalier and Feinstein, 2006; Bjelland et al., 2008).

Consequently, investment in school-based programmes to promote mental well-being has increased in recent years. School-based mental health interventions can take a variety of forms, ranging from whole-school programmes to promote mental well-being, initiatives to improve teachers' and school staffs' mental health literacy, co-location of multidisciplinary teams to targeted interventions focussing on at-risk students. Given the strong links between bullying and students' mental well-being, some innovative anti-bullying programmes have also been developed (see Box 3.2).

Box 3.2. Anti-bullying programmes contribute to enhancing students' mental well-being

Bullying is a major cause of mental ill health and school dropouts (Rothon et al., 2011; OECD, 2013b). To prevent the school environment from becoming a source of mental distress itself, bullying and its consequences are therefore issues that must be adequately addressed. Initiatives that integrate anti-bullying programmes in schools are of interest here.

Some promising initiatives to address bullying and the problems associated with it have emerged in the past years. In Finland, for instance, a large-scale programme on bullying, funded by the Finnish Ministry of Education, was launched in 2006. The Kiva-school programme aims to prevent and decrease bullying in schools. The programme consists of general measures where information is disseminated through various means with proactive material (assessment of school environment, classes, online games, booklets for parents, etc.), and targeted measures (discussion with the teacher and the school team), which will be applied once bullying has been detected. The first evaluation of the Kiva-school programme showed that the programme has reduced self- and peer-reported bullying and victimisation. As a result, the Kiva-school model is being progressively implemented in schools within the country (Kärnä et al., 2011).

A meta-analysis on the effects of school-based initiatives to reduce bullying and victimisation (Farrington and Ttofi, 2009) concluded that these programmes produce promising results. Reviewing 53 different anti-bullying school programme evaluations in developed countries, researchers found that the effectiveness of initiatives is generally associated with the intensity and duration of the intervention. Moreover, some programme components were also found more effective than others in reducing bullying, most important being parent involvement, or the use of disciplinary methods (ibid.).

Whole-school approaches to tackle mental ill health

A number of OECD countries have adopted comprehensive, whole-school approaches to tackling mental ill health across children and adolescents in recent years. Whole-school initiatives involve introducing, and integrating, typically non-traditional educational and information services to all actors (teachers, students and support staff) in the school. As broader early intervention and prevention programmes, whole-school initiatives focus on improving mental literacy and mental health awareness among teachers, students and the school staff. These programmes are generally comprised of different elements, including general information or anti-stigma campaigns, mental health literacy courses, and other materials.

The *KidsMatter* and *MindMatters* programmes in Australia, for instance, are two voluntary whole-school approaches funded by the Australian Government. *KidsMatter* targets children in primary schools and early childhood education and care, and aims to increase and improve support for children and families experiencing mental health concerns. By mid-2014, KidsMatter services were delivered in 2 000 schools across the country (KidsMatter, 2013). The *MindMatters* initiative, on the other hand, provides a wide array of support to children and adolescents in secondary schools, including hardcopy resource materials, a website, and professional development and implementation support for teachers and other school personnel (MindMatters, 2013).

In England, the *Targeted Mental Health in Schools* initiative took place from 2008-11 (UK Department of Children, Schools and Families, 2008). First implemented in 25 local pathfinder areas, the programme gradually expanded to reach 150 local communities in 2010. Targeting children aged 5 to 13, this initiative aimed to reform and to improve the effectiveness of the delivery mental health support in schools. The programme relied on strategic integration of all relevant agencies involved in delivering mental health services for this group, and identifying children's needs in the school context. In addition to training teachers, this programme also consisted of social and emotional learning programmes. Parents and community were also involved in the learning and social aspects of the initiative. The importance of teachers' mental health literacy has also been incorporated in the British good care guidelines, which state that "schools and local authorities should make sure teachers and other staff are trained to identify when children at school show signs of anxiety or social and emotional problems" (NICE, 2008).

The evaluation of the English TaMHS produced mixed results. The onset of mental health programmes across children in primary school (5-11 year-olds) decreased. For children in secondary school or experiencing mental health concerns prior to the establishment of the initiative, however, the evaluation showed little or no impact (UK Department for Education, 2011).

In Canada, *Evergreen*, a large-scale mental health campaign targeting children and adolescents has also identified the central role of schools in promoting mental well-being. As part of this national framework, the "Mental Health and High School Curriculum Guide" and "MyHealth Magazine" were implemented to enhance the dissemination of information and mental health literacy amongst students and teachers (Wei et al., 2011). Similarly, the Korean Ministry of Education, Science and Technology has invested in reinforcing the role of schools in dealing with mental illness, by publishing guidance for managing mental distress both in-school and out-school in 2011 (Hewlett, 2014).

In a number of OECD countries, recent efforts to enhance mental well-being in schools have focussed in particular on educating teachers and other professionals working

with children and adolescents. In fact, there is great potential in improving teachers' literacy on mental health problems, as regular intensive contact with students makes them well-placed to identify signs of mental distress. Typically, this type of training provides teachers with information on how to better identify mental distress and disorders across students, and on how raise awareness of mental health conditions and on available support and treatment options. Importantly, such training also has the potential of strengthening links between the education and health systems.

Some countries, such as Denmark, offer courses for teachers to enhance knowledge on, and to facilitate identification of students' mental health concerns. In Austria, the training of youth workers in centres and organisations increasingly encompasses mental health training. In Finland, similarly, mental health forms part of health education, a compulsory subject for upper levels in schools. Teachers are required to complete two years of training to teach health education, which includes providing mental health skills (Patana, 2014).

In the Netherlands, the "Rivierduinen" institute, specialised in children's and adolescents' mental health, offers training for primary and secondary school teachers. The institute's primary aim is to enhance teachers' ability to detect signals of mental distress and to provide them with tools to act appropriately. Rivierduinen also provides an opportunity for individual consultation for schools concerned with students' mental ill health. Additionally, classes for students with parents suffering from mental disorders are also offered (OECD, 2014).

Evidence shows that training teachers and increasing mental health awareness in schools can produce promising outcomes. Such initiatives have been shown to improve teachers' ability to identify psychotic symptoms (OECD, 2013a). Programmes enhancing mental health literacy have also shown to reduce stigma towards mental illness (Pinto-Foltz et al., 2011) and encourage help-seeking behaviours (Anderson and Doyle, 2005).

The effectiveness of these schemes in treating mild- to moderate disorders, on the other hand, remains unclear. In Denmark, although some courses on identifying special education problems are offered, they do not systematically cover pupils with behavioural, social or general well-being concerns. Teachers can, however, guide pupils with such concerns to "special psychological advisory services" for screening and additional support (OECD, 2013d). Some evidence suggests that school engagement in early identification is significantly associated with increased use of mental health services across adolescents with mild to moderate mental health concerns (Green et al., 2013).

Co-located multidisciplinary services in schools

In addition to improving mental health literacy in schools, many OECD countries have expanded their regular school support services to include drug and alcohol prevention, case management, individual and group counselling, and referrals to community health services.

In Sweden, health services are typically delivered by a range of professionals that operate in schools, but their involvement in mental health issues varies. School nurses primarily deal with students' extended absences and study environment. School social workers, on the other hand, tend to focus more on individuals' mental health concerns and preventative measures (e.g. anti-bullying). School psychologists directly deal with pupils with mental health concerns (OECD, 2013b).

In Norway, co-location of health centres in schools is common. Generally, approximately 50%-70% of students use these school-based health centres, often primarily for personal or alcohol-related problems. In the Netherlands, *Special Care and Advice Teams* (SATs) provide care and education professionals and help detect a variety of problems, including mental health problems. SATs are largely used by both primary and secondary schools; in 2011 over 98% of secondary schools and 67% of primary schools had access to SATs (van der Steenhoven and van Veen, 2011).

Co-location of health professionals in schools has a number of benefits. Evidence for Norway, for instance, suggests that school-based health centres can improve health-related quality and increase specialised treatment rates (OECD, 2013a). Moreover, students treated in schools also have fewer hospitalisations and emergency department visits.

Importantly, co-location of health professionals on school grounds can also resolve issues with time/resource allocation. For example, a study shows that community clinicians report “fewer competing responsibilities” while at school compared to school-employed health professionals, who likely deal with other responsibilities or may have to prioritise other tasks in case of a crisis (Langley et al., 2010). External health professionals can ease the time and financial burden to school-employed clinicians and support staff by supporting implementation of health initiatives. School-employed health staff, on the other hand, is generally more capable to factor in the logistical aspects of providing services within the school building and calendar. The findings of this study highlight the opportunities for partnership to aid implementation success.

Child and youth centres play an important role in some countries

External child and youth centres also play an important role in some OECD countries (e.g. Belgium, France or Korea). These centres, which bring together service providers in one place, have the potential to address some of the challenges faced by the education system in terms of dealing with mental ill health. First, despite increased investment in school-based mental health support, available services often lack the capacity to deliver effective and comprehensive responses students’ mental health concerns (see Section 3.5). Moreover, young people are often reluctant to seek help. Child and youth centres have the advantage to both alleviate confidentiality concerns as well as reach young people not attending school.

In Belgium, for example, mainstream schools pay limited attention to students with special needs. A separate special education system is designed for these students (OECD, 2013d). This is also the case in France. The French “therapeutic, educational and pedagogical institutions” (ITEPs) are designed for children with serious behavioural problems, those who have difficulty in school and socialising, but who do not present an intellectual disability or psychosis. ITEPs offer full or partial boarding and provide a combination of education and therapy in varying modalities, from individual sessions to group classes (De Menil and Forti, 2014).

In addition to having an internal school-based support structure, external student guidance units have been created to cover the continuum of care from basic universal to specialised services in the Flemish community in Belgium. The student guidance units (CLBs) offer both universal surveillance and individualised support for students with greater complex needs. CLBs maintain strong links with community services and assist schools in four domains: learning strategies; educational career planning; psychosocial functioning and preventive health care. Given these units’ responsibilities regarding health care (e.g. carrying out check-ups), their role is cross-sectoral, operating

under both the Flemish Department of Education and Welfare and the Flemish Department of Public Health and Families (OECD, 2013d). A similar structure is also in place in the French community, where a number of actors are involved in providing support for students with special needs. The psycho-medical social (PMS) centres have a similar role to the CLB centres, working in a multidisciplinary team. Regular medical check-ups, on the other hand, are carried out by the “school-based health promotion services” (PSE) while school dropout prevention is primarily handled by “school dropout intermediation services” (PMS) and mobile teams (*ibid.*).

In Korea, “Community Youth Safety Nets” for young people and “Suicide Prevention Safety Nets” for high risk groups were also recently established as part of the second National Suicide Prevention Programme in 2012. A national mental health screening was introduced in 2012 and covers all high school students. Follow-up for at-risk students is generally carried out in community centres. CYS-Net includes various institutes and facilities offering counselling services, crisis intervention, medical and legal services and guidance around youth activities. As part of the plan, shelters for at-risk, homeless or runaway adolescents have also been founded (Hewlett, 2014).

Improving identification, monitoring and data collection on early school leavers

To better understand, and effectively respond to the needs of children who leave early, several OECD countries have taken measures to improve the identification, monitoring and data collection of school drop outs.

Norway, for example, has responded to growing concerns about the high number of school drop outs (the third highest in the OECD) by investing in developing measures to improve school-based early intervention and prevention, including better screening, following up and understanding of early school leavers. The Norwegian Labour and Welfare Administration (NAV) in co-operation with the Ministry of Education developed the “New Possibilities” programme, which was established in late 2010. By 2015, the aim is to increase the completion of upper secondary school rate from 70% to 75% (Norwegian Government, 2014). The programme relies on strong partnership between national, regional and local authorities and includes a comprehensive set of indicators which should enable robust recording and measurement of information on secondary education and training.

In Belgium, several measures have been also taken to prevent and monitor school drop-outs. Repeated school absences are monitored on a regular basis and reported to CLB centres in the Flemish community. Since the 1990s, targeted initiatives in the French community and in the Flemish and German communities (such as *Timeout*) are also in place to prevent school drop-outs. These initiatives involve multidisciplinary teams which, in co-ordination with parents, schools and student units, provide support to students with multiple behavioural problems affecting their educational performance.

Denmark, Finland, Luxembourg, the Netherlands and the United Kingdom have also introduced measures to track and monitor inactive early school leavers. Since 2011, municipal outreach workers monitor and follow up with youth dropping out of the education system without obtaining an upper secondary school qualification in Finland. Similarly, the Regional Registration and Co-ordination institutes (RRCs) in the Netherlands have the responsibility to collect data on, and track youth with little or no qualifications and low educational attainment. The RRCs contact and provide assistance to inactive youth seeking training and employment opportunities (Eurofound, 2012).

Barriers to effective multidisciplinary support in schools

Despite considerable efforts in raising mental health awareness in schools, several barriers hinder effective provision of integrated support in schools.

Evidence-base on the effectiveness of school-based programmes remains inconclusive (Wei and Kutcher, 2012). Despite the range of school-based mental health programmes available across the OECD, few countries have evaluated their impact on student outcomes, in particular in the long term. Moreover, schools' capacity to deliver evidence-based practices (EBPs) often remains limited. Some evidence suggests that training in EBP does not necessarily translate into implementing them by the school staff (Swedish Ministry of Health and Social Affairs, 2013; Langley et al., 2010). Guidelines for professionals (e.g. nurses, school psychologists or social workers) should be developed to handle and monitor students' well-being, in particular of those with disability, chronic illness and students from "poor psychosocial risk environments".

Co-ordination of school-based support with other community services also remains a challenge in many OECD countries. Competing responsibilities between, or lack of engagement of any involved parties represent major barriers to providing integrated prevention or intervention services for students with mental health concerns. Joint management responsibilities and clearly defined roles can encourage the establishment of strong links between teachers, school staff, social and health care providers managed at different levels of governance.

- In Sweden, available evidence suggests schools and other local services are inadequately collaborating, which is to a large part due to services being managed at different levels of governance (OECD, 2013b).
- Early intervention, appropriate follow up and the respective roles of health and social care in child mental health services of children and adolescents have also raised concern in Finland. Although co-operation between services has been reinforced and improved in recent years, there is no consistent patient pathway in the delivery of these services. While Finland has a comprehensive system of preventative mental health – child welfare clinics, school health care, student health care and health education in schools reach virtually all age groups up to adulthood – early identification of students' mental health concerns may not automatically translate into early intervention. Despite children being identified at an early stage, there may often be long delays in treatment (Patana, 2014).
- Norway faces obstacles following up on, and rehabilitating students suffering from mental ill health. Further complicating matters, schools and the Educational and Psychological Counselling Services (PPS) are not required to co-operate with centrally managed services targeting students' mental well-being, leading to a lack of collaboration within services managed at different levels of governance (OECD, 2013a).
- In Belgium, limited co-operation between schools and the youth centres has occurred both in the French and the Flemish communities. Schools have reported uncertainties regarding their roles in supporting the students with mental health concerns in the Flemish community. While the CLB centres in the Flemish community are designated to take a leading role in providing mental health support, these roles are not clearly defined in the French community. Several attempts to merge the PSE and PMS centres have also had little success. This is largely due to the fact that PMS are managed at the community level while the PSE

are a regional responsibility. Despite efforts to improve inter-sectoral co-operation, the complexity of the system has prevented well-established co-ordination between sectors yet being achieved.

Lack of funds is an important barrier to effective provision of multidisciplinary support services for children and adolescents. Whereas stable, long-term funding is considered a key element of effective programmes, funds are often provided on a short-term basis, which prevents embedding good-practices or collecting data on students' mental well-being. Funding and access to these services should also be expanded to out-of-school hours to reach children not attending school.

- Lack of resources for school-based mental health support has resulted in long waiting times to see school nurses or psychologists in Sweden (OECD, 2013b). In Norway, similarly, concerns have also been raised about accessing school health care: services may not be co-located or available five days a week.
- Staff needs are also often reported across CLB and PSE and PMS centres in Belgium, resulting in increased demand and pressure at work (Vernault et al., 2009).

3.7. Preventing inactivity and early labour market exit: Integrating services for vulnerable youth

What are the benefits of integrating services for the activation of vulnerable youth? Vulnerable youth are at significant disadvantage in the labour market, and young adults with mental health concerns face multiple obstacles in finding jobs. As mental illnesses are often a major cause and/or a factor of youth vulnerability, mental health support is becoming an increasingly important part of youth activation strategies.

While many OECD countries have sought to tackle inactivity and unemployment within this group,³ few countries have evaluated whether *integrating* services helps young and vulnerable jobseekers' activation. This section provides a review of integration strategies targeting vulnerable youth, and discusses integrated services effects' on youth activation and mental well-being.

Evaluating strategies for integrating vulnerable youth in the labour market

While most countries do not have national strategies for integrating social services for vulnerable youth activation, several countries have piloted initiatives that offer integrated services specifically for vulnerable youth. Levels of integration vary, but the most intensively integrated systems offer multi-service agencies in a single location. These agencies offer assessments, planning (such as individual action plans), referrals, and associated social services (Taylor, 2010). The focus of integrated youth support equally varies. Some programmes offer mental health support as part of integrated services, while others target integrated services *specifically* for youth with more severe mental health concerns. Table 3.2 provides an overview of these initiatives' key features and coverage.

Table 3.2 Integrated services for vulnerable youth

Initiative (country)	Coverage	Common traits and type of integrated services provided
Integrated Services for Young People Framework and Quality Mark (GBR)	National	A self-assessment tool to help localities improve the quality of integrated services across a range of outcomes
Connexions (GBR)	National ¹	Co-located Connexions centres offered support services to young people aged 13-19 (up to age 25 for youths with disabilities) Case managers carry out assessments and offer support and referrals in the areas of education, housing, substance abuse, and money management
Navigator Centres (SWE)	National	Case managers in NCs provide holistic support across sectors and beyond developing mere skill needs with the aim of reintegrating youth to education, training or employment.
Youthreach (IRE)	National	Area-based integrated approaches to increase employment prospects and decrease the risk of unemployment and time seeking for a job. The programme takes a person-centred approach, including personal and social development and increasing self-esteem as a key objective
Project Learning for Young Adults (SLN)	National	Multidisciplinary approach targeting young, "hard-to-employ" adults with weak skill sets and qualifications at risk of social exclusion. The programme is voluntary and offers a bundle of services from the education, health and social sectors, including psychosocial support
BladeRunners (CAN)	Regional	24 hour support, seven days per week, from assigned BladeRunners coordinators.
Voluntary Labour Corps (POL)	National	Co-located centres targeting disadvantaged youth (including those with difficulties in, or dropping out of compulsory education, those seeking vocational training combined with their education and graduates willing to supplement their skills). Services offered include education, on-the-job training, pedagogical and psychological counselling, as well as preventative support in areas such as health, mental health, social behaviour or addiction
NYTKU (FIN)	Local	A small pilot project targeting 58 disadvantaged young people (aged 17-25 years), the majority of who were diagnosed with mental illness. Clients were offered ten-day Rehabilitation Assessment Courses, and at the conclusion of that treatment, were assigned to career advisors at the Employment Services Unit (ESU).
Youth Opportunity (USA)	Local	YO Centre to add a mental health intervention to the YO Centre's employment training programme. Mental health intervention included an on-site mental health clinician, a peer depression prevention curriculum, and mental health training sessions for employment centre staff (who had no formal education in mental health)
TimeOut! Getting Life Back on Track (FIN)	Regional	Young individuals with psychiatric symptoms and suffering from an accumulation of problems, such as alcohol and substance addiction, homelessness or health issues are targeted in particular. Counselling, guidance and support across local services are co-ordinated by a "named person"
HeadSpace (AUS)	National	A national co-ordinated focus on youth mental health and related drug and alcohol problems, aiming to improve access to services for young people aged 12-25 years. Holistic care in four key areas – mental health, physical health, alcohol and other drug use, and social and vocational support.

1. National funding for this programme has been reduced significantly in recent years, though Connexions Centres continue to run in some local areas.

Source: Literature review of integrated services policies for youth and OECD unpublished policy questionnaire (2013), individual sources are cited in the text.

Co-location of youth support services is common

Co-location is a common form of integrating services for vulnerable youth activation. In several OECD countries, including Ireland, Poland, Slovenia, Sweden and the United Kingdom, young and vulnerable individuals can access multidisciplinary services, mental health support included, in one place.

While these co-located services are generally available to all young adults, supporting vulnerable youth is often emphasized as a priority. For example, the United Kingdom's National Youth Agency recently designed an "Integrated Services for Young People (ISfYP) Framework and Quality Mark". This programme's goal is to help local authorities integrate services for young people, especially the most vulnerable (National Youth Agency, 2013). Moreover, although it is no longer running as a comprehensive national programme due to changes in the delivery of career services in United Kingdom, Britain's Connexions programme also offered support services available to all young people. One of its primary goals was to reduce social exclusion, and thus it emphasized its support of vulnerable youth (Watts, 2001).

In Sweden, the Navigator Centres (NCs), in place since 2004, are also a core part of the current national measures targeting 15-24 year-old NEETs, aiming to reintegrate youth to education, training or employment. Between 2008 and 2010, the initial 11 local pilot centres transitioned into a national network. Evaluation carried out by the National Board yielded positive results. 45% to 71% of young people using these services found employment or education opportunities within a year. The evaluation also recorded improvements in confidence and motivation among less successful participants (EMCC, 2013).

The Irish Youthreach programme, a central part of the national programme of second-chance education and training, similarly targets unemployed early school leavers aged between 15-20 years. Youthreach services are generally delivered in local centres generally located in disadvantaged areas, and participants generally attend the programme full-time for one to two years (Eurofound, 2012). Programme evaluations have recorded positive outcomes: in 2010, for instance, following a year of participation in the programme, 15% were employed, 6% in further education, 46% active participants in Youthreach, 4% in a training centre and 11% unemployed (Ireland Department of Education and Skills, 2010 NOT IN THE BIBLIO). Transitioning from the programme into better education or employment opportunities and increasing the number of participants obtaining certification has, however, been seen as a challenge (Forfas, 2010).

Another example of a state-wide initiative to address the complex needs of disadvantaged youth at risk of social exclusion or criminal behaviour (including those with difficulties in, or dropping out of compulsory education, those seeking vocational training combined with their education and graduates willing to supplement their skills) via co-location is the Polish "Voluntary Labour Corps". Youth can be referred to the service by the local social, health, police or education systems or be their guardians, but participation remains voluntary (Voluntary Labour Corps, 2013).

The role of local case management for young disadvantaged jobseekers

Case management, such as that described in the British and Swedish programmes, has been called the "face" of integrated service delivery (Taylor, 2010). Case management is the main mechanism for integration in many programmes targeting vulnerable youth. For instance, a key feature of the Canadian "BladeRunners" programme is a unique system of 24-hour support, seven days per week, from assigned "BladeRunners coordinators."

These co-ordinators help disadvantaged youth (aged 15-30) build careers in construction and related industries in British Columbia. The co-ordinators take youth to work sites, check to confirm satisfaction with the work site, refer clients to social service providers, assist with housing and transportation, and counsel the clients about future training and job opportunities (Travkina, 2012).

Similarly, mentoring by a case worker and individualised approach have been identified as the key success factors for addressing the multifaceted problems of disadvantaged youth taking part in the Slovenian “Project Learning for Young Adults” (PLfYA) initiative. PLfYA is a long-standing, voluntary programme that places special focus on the social, economic and cultural environment of the early school leavers to provide individualised support for successful reintegration into employment or education (European Commission, 2009). Studies illustrate positive results of the programme especially in terms of improvements in motivation and self-esteem. The most recent evaluation recorded a 94% satisfaction rate among participants: 41% continued their education, 15% found part-time, and 9% full-time employment (Dobrovoljc et al., 2003).

Another example of case worker training comes from a low-income neighbourhood in Baltimore, in the United States. Funded by one of 36 national Office of Disability Employment Policy at the Department of Labour (DOL) “Youth Opportunity” (YO) grants, public health researchers worked with Baltimore’s Eastside YO Center to add a mental health intervention to the YO Center’s employment training programme. The mental health intervention included three main components: an on-site mental health clinician, a peer depression prevention curriculum, and mental health training sessions for employment centre staff (who had no formal education in mental health). The pre-test/post-test evaluation found no significant differences in depressive symptoms or coping strategies after jobseekers completed the programme (Tandon et al., 2012).

Targeted interventions for youth with complex mental health concerns

Few countries, including Finland and Australia, have established integrated services that, instead of offering mental health support as part of multidisciplinary services, *specifically* target youth with more severe mental health concerns.

Finland has piloted smaller and larger scale initiatives that target integrated services for vulnerable youth with considerable mental health needs. The “TimeOut! Getting Life Back on Track” programme in Finland, for example, offers psychosocial support for young adults (primarily men exempted from military or civilian service) aged between 15 and 29 years. TimeOut! is currently in place in approximately 150 Finnish municipalities and in fall 2010, the programme reached and was offered to approximately 20 000 men, which accounts for over 60% of men in this age group (Appelqvist-Schmidlechner et al., 2011). Young individuals with psychiatric symptoms and suffering from an accumulation of problems, such as alcohol and substance addiction, homelessness or health issues are targeted in particular (Stengård et al., 2008a). Counselling, guidance and support across local services are co-ordinated by a “named person”, a professional from the municipal social or health sector.

Non-stigmatisation, client-centeredness, prevention and provision of multisectoral, low-threshold support are the stated key principles of the intervention. In a study of the programme’s effects, 67% considered participating in TimeOut had at least some benefits while 58% considered it had improved their life situation. The support programme showed a positive effect on psycho-social distress, but had no impact on problem accumulation, alcohol use, or self-image (Stengård et al., 2008b).

Similarly, Finland's Project for Unemployed Young People with Mental Problems (NYTKU) was a small pilot project targeting 58 disadvantaged young people (aged 17-25 years), the majority of whom were diagnosed with mental illness. Clients were offered ten-day Rehabilitation Assessment Courses, and at the conclusion of that treatment, were assigned to career advisors at the Employment Services Unit (ESU). The ESU advisors worked closely with health care and employment services in an effort to reduce clients' social exclusion (Taylor, 2010). While case management and rehabilitation courses were found to have immediate positive effects, the one-year follow up was deemed too short to determine whether the programme has lasting benefits.

In Australia, the HeadSpace initiative was initiated in 2006 to provide "a national co-ordinated focus on youth mental health and related drug and alcohol problems", aiming to improve access to services for young people aged 12-25 years. The headspace model takes a holistic approach to providing care in the following key areas: "mental health, physical health, alcohol and other drug use, and social and vocational support". In its 2011-12 Budget, the Australian Government provided funding for an expansion of the headspace programme to 90 fully sustainable headspace sites across Australia to be reached by 2014-15. Once all 90 sites are fully established, HeadSpace centres aim to help up to 72 000 young people each year, and HeadSpace services should be accessible to almost every young Australian.

Headspace has been effective in raising community awareness, increasing access to mental health services by young adults or referring clients from headspace to a range of services. This has resulted in better reported mental and physical health and reduced psychological distress (Muir et al., 2009). Approximately half of the clients surveyed also considered that HeadSpace had a positive impact on their willingness to be in education or employment. Some barriers to accessing services were also identified: although being primarily psychological, costs, opening hours or waiting times to see practitioners were perceived as obstacles to using HeadSpace services. On the provider side competition, staff turnover and confidentiality issues were identified as hindering elements to effective services provision. Concerns were also raised about not reaching certain disadvantaged groups, such as youth with lower socio-economic status or those with indigenous backgrounds.

Evaluating the effectiveness of integrated services for young, disadvantaged jobseekers using randomised control trials

Most studies of integrated services have compared participants' symptoms before and after accessing integrated services delivery. These studies have been less successful at evaluating differences in the mental health of young people who are with or without the programme. However, some countries have initiated large randomised control trial (RCT) evaluations of programmes targeting disadvantaged youth. RCTs enable evaluations of programme outcomes by providing a counterfactual to programme participants: a randomised group of comparable individuals who did not receive programme benefits.

These RCTs were piloted locally, often with central government funding, for the purpose of evaluating effectiveness. Two recent programmes are discussed: Australia's "YP4" Programme in Victoria, and the United States' nationwide "Youth Transition Demonstration Project", which both produced mixed or insignificant results.

Australia's YP4

In 2005, Australia initiated a randomised experiment entitled “YP4”,⁴ which sought to integrate the delivery of employment, housing, health, mental health and other services for young homeless jobseekers in the state of Victoria. Participants receiving treatment were assigned a case manager. This case manager met with clients and specifically sought to help “join up” the various social services needed by clients. Control group clients had the standard access to individual service offices.

Evaluators found that YP4's case management had no effect on the employment, well-being, or housing outcomes of disadvantaged youth (Borland et al., 2013). YP4 researchers point to insufficient contact with case managers as one of the programme's failings, suggesting that regular and meaningful contact with professionals is necessary for the programme to reach its full potential.

The United States' Youth Transition Demonstration (YTD)

The United States Social Security Administration (SSA), which administers federal disability benefits, initiated the Youth Transition Demonstration (YTD) in 2005. The YTD aimed to assist youth with disabilities, aged 14 to 25, to transition from school to economic self-sufficiency. The programme also sought to reduce dependence on federal disability benefits, in the hopes of generating public savings. While the initiative targeted youth with both physical and mental impairments, some sites had explicitly focused on those with severe emotional disorders. Case management and social and (mental) health services were also tailored accordingly to participants' needs.

Six YTD programmes in Colorado, New York (the Bronx and Erie), Maryland, Florida, and West Virginia partnered with other agencies to offer an array of transition-related services. These services included individualised work-based experiences; youth empowerment; family support; system linkages; social and health services; and benefits counselling. Service integration across YTD sites took different forms, such as integrated case management and the involvement of related organisations in the community. In Colorado, for instance, the person-centred case management intervention sought to understand each participant's needs and then address these using multiple resources in the existing service system (Fraker et al., 2011a).

One of the more successful programmes, in the Bronx, New York, was identified as having key staff well-integrated in the community. Staff involvement in local organisations helped YTD participants gain access to additional services (Fraker et al., 2011b). And in Erie, New York, the YTD programme established formal partnerships with the involvement of community organisations to provide key services: a legal services corporation, to help with benefits planning; a community employment office, which offered employment preparation assistance; and a parent-led community organisation, which offered support and information to youth with disabilities and their families (Fraker et al., 2011c).

The SSA commissioned an RCT evaluation of YTD. All evaluative work is scheduled to be completed by September 2014, but interim results are available. Of the six project sites, only three (the Bronx, Miami-Dade, and West Virginia) produced statistically significant positive employment results. Positive results corresponded with a greater use of services by the treatment group, as well as larger differences in service opportunities between treatment and control groups (e.g., some communities had better standard services for the control group) (Fraker, 2013). These results suggest the need to

incorporate local conditions such as the availability and quality of existing services fully into programme design.

YTD's mixed and insignificant results correspond with outcomes found in earlier RCTs evaluating integrated programmes for disadvantaged youth. The multi-site JOBSTART programme (1985-1992) and the multi-site School Dropout Assistance Program (1992-1997) are two examples of initiatives that integrate training, employment, and related social services addressing a range of mental and physical health issues, social skills deficits, and personal and family challenges. Results for these programmes were inconsistent across sites, and most employment outcomes were insignificant (Cave et al., 1993; Dynarski et al., 1998).

Notes

1. Indirect costs refer to economic consequences attributable to disease, illness, or injury resulting in lost resources due to situations brought on by mental illness (e.g. reduced activity in the labour market and premature mortality). Direct costs refer to costs associated with health care use and expenditure on treating mental illnesses.
2. Data on within 30-day re-admissions is used as a proxy for unplanned re-admissions as only a few countries have the capacity to differentiate between planned and unplanned re-admissions (*OECD Health Statistics*, 2013).
3. For a comprehensive review of NEETs, school to work transition and social, training and employment initiatives for youth, see Carcillo et al. (2015).
4. YP represents young people. The numeral four is in superscript, signifying “to the power of four”. The four p’s or powers are purpose (meaning a job), place (meaning a home), personal support (denoting the service being offered), and proof (acknowledging YP⁴’s status as a trial and the importance of the evaluation framework underpinning YP⁴).

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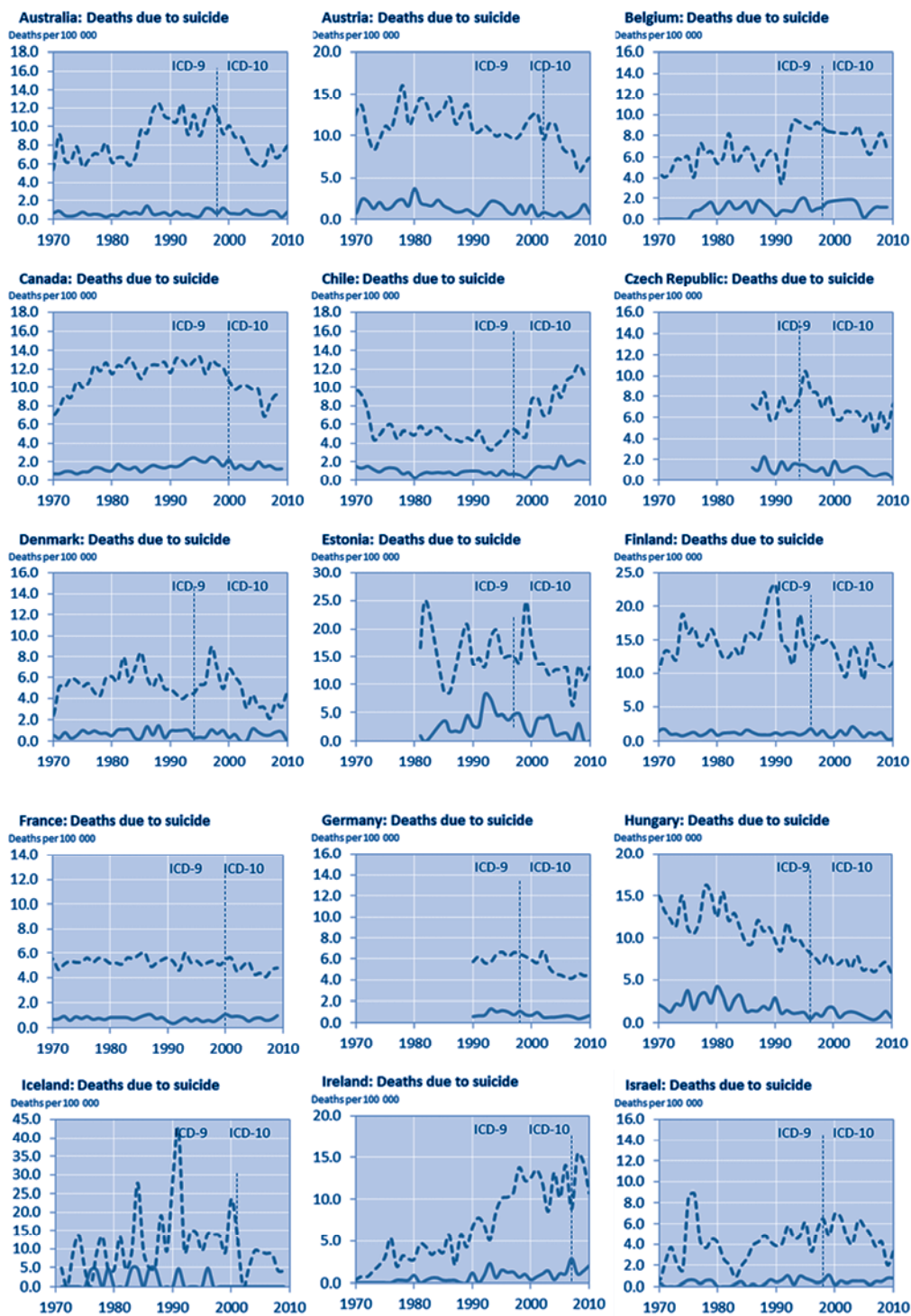
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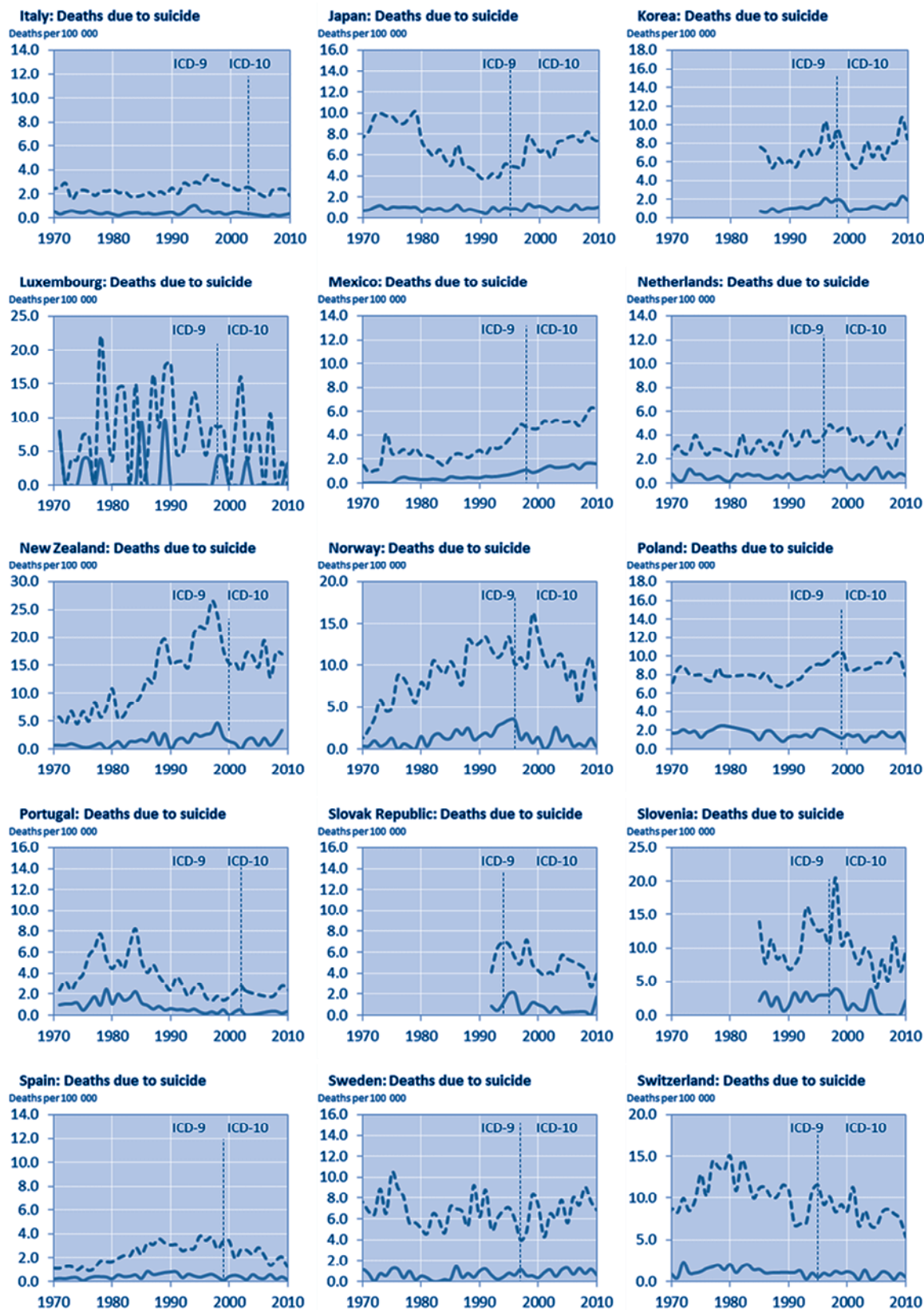
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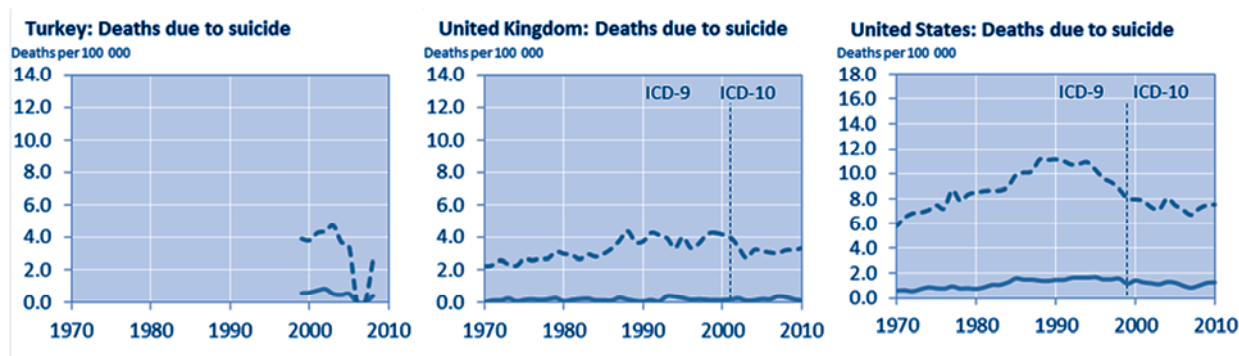
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Annex 3.A1

Suicide rates in children and adolescents







ICD: International Classification of Diseases.

Note: Solid lines represent trends for children aged 0-14 inclusive, dashed lines represent trends for children and youth aged 15-19 inclusive. Later data is available for some countries; trends stop at 2010 for reasons of comparability across all countries.

Source: Author's calculations of WHO Mortality Database (2014).

Mortality data and the International Classification of Diseases (ICD)

Classification of cause of death

Different countries used different WHO coding systems (ICD8, ICD9 and ICD10) at different times. Classification of causes of death under the ICD8, ICD9 and ICD10 systems are broadly similar and comparable in most countries. However, a break in series should be considered when moving from one ICD system to another as data before and after the changeover may not be comparable. Statistics Canada (2005) provides a country specific study of the effects of changing from ICD9 to ICD10 on mortality rates.

The data here are thus drawn from three different databases depending on country and year and the table below presents the codes and categories that have been used to define deaths by suicide.

Table 3.A1.1. Deaths due to maltreatment, accidental injury

ICD8	ICD9	ICD10
A147 (suicide and self-inflicted injury)	B54 (suicide and self-inflicted injury)	X60-Y84 (intentional self-harm)

Country specific issues

All countries

Most countries either use less detailed or more detailed classification system but not both. This is especially true for ICD10. To overcome this problem calculations were done made on both more detailed and less detailed classifications and the larger number is used for this analysis.

Chapter 4

Homelessness, the homeless and integrated social services

Although international comparisons of homelessness require cautious interpretation, OECD-wide evidence suggests that up to 8 in 1 000 working-age adults have no stable accommodation at any one time, and around 8 to 10% of families, on average, have difficulty meeting their housing costs each year. Experiences of homelessness can vary from longer term, chronic forms, to more hidden or transitional experiences. Addressing homeless individuals' needs requires multiple – and often expensive – service interventions, especially when treating the most chronic cases. How and when the needs of the homeless are met will affect human lives and social costs. While several OECD countries are developing innovative “housing first” approaches to address homelessness, temporary shelter and emergency services remain the dominant model of provision, despite their limited capacity to facilitate sustainable exits from homelessness. This chapter addresses the challenges of measuring homelessness across OECD countries and discusses the issues salient to delivering effective housing and social services to those at risk of, or experiencing, homelessness.

4.1. Introduction

Homelessness represents an extreme form of vulnerability, poverty and social exclusion, and is a persistent problem in OECD countries. Homelessness exists in spite of social policy efforts to guarantee minimum living standards and secure housing for all in most OECD countries, and in spite of targeted health and social care interventions for those at high risk. As with other vulnerable groups covered in this report, the homeless are not a homogenous group within and across OECD countries, their situation is not similarly defined country-to-country, and the quality and availability of social services to prevent and treat homelessness varies widely. Beyond the priority of addressing the acute human costs, and human rights, the failure to prevent homelessness is costly for the public service; caring for the chronically homeless can be up to seven times higher than average per capita social spending. The purpose of this chapter is therefore to bring together the available evidence on who is homeless – or at risk of homelessness – in OECD countries, what their needs are, and explore how the integration of housing, health, and social services can better address homelessness, particularly among people with the highest support needs.

The main findings of the chapter follow in Section 4.2. Section 4.3 looks at the definitions and extent of homelessness across the OECD, and the needs for integrated housing supports and services for homeless people. Section 4.4 explores the different homelessness services in use and models of service integration, including case management and Housing First models. Section 4.5 looks at homelessness prevention and the role of service integration. Section 4.6 reviews the governance structures and national strategies involved in homelessness policy making. Section 4.7 concludes with a review of the mix of services needed to tackle homelessness.¹

4.2. Main findings

The main findings of this chapter are as follows:

- *In the majority of OECD countries, homelessness affects between one and eight people in every 1 000 each year* Depending on the definition, as many as one-third of the homeless population can be sleeping rough. The rates of people experiencing housing instability in the OECD are much higher, ranging from around 2% of the population to as high as 25% (the OECD average was 9% in 2012).
- *The needs of the homeless vary depending on their socio-demographics.* The chronically homeless² have higher demand for emergency treatments (e.g. health care) and highly co-ordinated health, housing and social care, whereas lone women heading homeless families tend to have a high need for housing and treatments for depression. Homeless migrants, on the other hand, may require specific interventions to overcome barriers of access to housing and employment.
- *The public service cost of caring for the chronically homeless can be up to seven times higher than average per capita social spending, and three times higher than a supported housing response – where care services are provided in the home – for the same individual.* Preventing homelessness can be very cost effective, with estimates suggesting that the cost of treating a homeless person with complex mental health needs is 18 times higher than the costs of providing preventative at-home service support for these cases.

- *Models that provide housing first and then integrate health and social care support are effective treatments for chronic homelessness (both sustained and repeated experiences).* Emergency shelter and food services often do not specifically aim to rehouse individuals, and so, despite the integration of services in daycentres and elsewhere, they are less successful at reintegrating the homeless back into society.
- *Nearly one-third of OECD countries have committed to integrating social services for the homeless in an official national strategy.* Fourteen OECD countries have active national strategies to combat homelessness, or have legislation which explicitly addresses the problem of homelessness. Of these countries, 12 mention co-operation at the governance level, 12 mention the integration of service delivery, and 11 highlight an active role for civil society.
- All OECD countries yet to integrate horizontally, as well as vertically, face co-ordination challenges when providing homeless support services. Countries where the critical homeless services (social housing, secondary health care, and social assistance) are managed at the same levels of governance, such as Canada and Greece (regional and central levels respectively) may face fewer challenges.

A number of key policy recommendations and cautions stand out:

- *Strategies to house the homeless first, and then provide integrated health and social care supports, show relatively high levels of effectiveness:* in terms of sustained exit from chronic homelessness. Although immediate cost offsets should not be expected in all cases, this approach should be pursued to make better use of current investments.
- *Current evidence on services integration suggests that co-operation between sectors is important, showing similar effects to full systematic integration and collaboration.* Countries without integrated approaches should seek to facilitate communication between key service providers (housing health and social care) in the first instance.
- *Homeless people and their needs differ widely across the OECD.* Countries reforming housing services should provide integrated approaches that are flexible to the needs and characteristics of their populations. For instance, countries with large number of new migrant homeless may focus more on work activation and social services than health integration.
- Finally, *the evidence base on homelessness policies is limited,* and, in particular, no strong evidence exists on associated costs. To properly inform future policies, more evaluations of integrated social services for the homeless are needed, as are reviews of national strategies and their integrated aspects in both governance and service delivery.

4.3. Homelessness and housing instability: Definitions, measurement and social costs

Compared to more homogeneous and visible groups across OECD countries, comparable information on homelessness, and its social costs, is hard to come by. Yet, in many OECD countries, national homelessness statistics and definitions, measures of housing instability, and estimates of the public costs of homelessness exist. But because the available information is broadly incomparable, it is almost impossible to disentangle the national “working” definitions and measurement. Consequently, this section begins with a discussion of what homelessness is, and highlights a recent attempt to consolidate definitional and measurement efforts across OECD countries.

Homelessness in OECD countries: What does it look like?

Stereotypical images of homeless people portray solitary rough sleepers experiencing chronic homelessness. Yet for policy makers working to eradicate homelessness, the stereotypical definition of a homeless rough sleeper is unhelpful for two key reasons (Ryabchuk, 2007). First, the rough sleeper definition misses a number of important people; it does not include those who, although housed, do not have a permanent or adequate residence or who are unlikely to be seen in the streets (often referred to as the “hidden homeless”) or those who may experience recurrent/sustained use of emergency/homelessness services. It also misses people living in temporary accommodation or insecure lodgings with family or friends, as well as families with children who find themselves without secure accommodation.³ Second, and a critical point for service policy evaluation, the stereotypical definition also fails to consider that the behaviour of the homeless may be a necessary response to the conditions in which they find themselves in. By imposing “faulty” identities to the homeless, it infers that they alone are responsible for their current situation without accounting for the frequently “faulty” social structures that enable homelessness.

In reality, homelessness can also be short term or transitional, can be experienced by families with children, and can include someone who has a roof to sleep under, but does not have secure or adequate housing. Homelessness therefore represents forms of housing instability and housing exclusion, and homeless populations include people that *lack* any housing, or are in situations in which they cannot be regarded as *adequately* and/or *sustainably* housed.

Extended definitions of homelessness that include temporary housing and shelter service users are now being used in most homelessness studies and surveys (see Tables 4.1 and 4.2); nonetheless, consistent definitions across countries are still needed for robust international comparisons.

To facilitate consistency in definitions and data collection, the European Federation of National Organisations Working with the Homeless, FEANTSA, has led the development of a typology called the European Typology of Homelessness and Housing Exclusion (ETHOS). Presented in Table 4.1 is the shortened version of ETHOS designed for data collection purposes. ETHOS describes people living in housing which is very insecure, physically unfit and lacking private space for relationships as experiencing “homelessness”. The 2010 EU Consensus Conference on Homelessness recommended ETHOS as the EU standard definition (ECCH, 2011) and ETHOS is widely used as a reference in Europe (e.g. in Northern Ireland, NIHE, 2012) and adapted for use elsewhere (for instance by Australia, Canada, New Zealand; see Amore et al., 2012).

Although ETHOS is gaining attention in a number of OECD countries, and has been recommended for use at the EU level, the following sections show that it is not yet possible to produce robust international comparisons using a shared definition of homelessness across OECD member states.

Table 4.1. ETHOS categorisations of homelessness

Conceptual category	Operational category	Living situation
Roofless	1 People living rough	1.1 Public space or external space
	2 People staying in a night shelter	2.1 Night shelter
Houseless	3 People in accommodation for the homeless	3.1 Homeless hostel
		3.2 Temporary accommodation
		3.3 Transitional supported accommodation
	4 People in Women's Shelter	4.1 Women's shelter accommodation
	5 People in accommodation for immigrants	5.1 Temporary accommodation / reception centres
Migrant workers accommodation		
6 People due to be released from institutions	5.2	
	6.1 Penal institutions	
	6.2 Medical institutions	
7 People receiving longer-term support (due to homelessness)	6.3 Children's institutions / homes	
	7.1 Residential care for older homeless people	
	7.2 Supported accommodation for formerly homeless persons	

Source: FEANTSA, <http://www.feantsa.org/spip.php?article120&lang=en>, November, 2013.

Measuring homelessness and housing instability across the OECD

The following sub-sections introduce the challenges to, and findings of, comparisons of homeless definitions and data collections in OECD countries. Estimates of housing insecurity and how these have changed for different OECD countries since the onset of the economic crisis are also presented.

Estimates of homelessness, and working definitions, in OECD countries

Most definitions used to estimate the size of homeless populations in OECD countries define homeless people as those who are literally roofless and living and sleeping rough and the population living in emergency shelters and supported accommodation *designed* as “homelessness services” (see Table 4.2). Some OECD countries use broader definitions of the homeless (see for instance Australia, Canada, or Sweden) that include persons who are in insecure accommodation, in overcrowded dwellings, or in very poor quality housing.

Definitional differences drive variation in national data collection on homelessness. Some countries, such as Portugal and the United States, combine survey and service administration data to develop a detailed picture of their homeless populations (though in some cases surveys only cover rough sleepers). Other countries rely on either surveys *or* administrative data, while others collect no, or relatively little, data on homelessness. There is also variation in data collection within countries, with some collections being undertaken in specific regions (Belgium) or cities (the Czech Republic or Iceland), and at different times of the year (Table 4.2).

Subsequently, differences data collections create big challenges for international comparisons and understanding real differences in homelessness rates and risks. For instance, Table 4.2 shows that the estimated size of homeless populations vary massively, from 0.1 in 1 000 in Japan to around 5.6 in 1 000 in Sweden. However, rather than suggesting that Sweden has a homelessness epidemic, this table illustrates the difficulties of comparing countries with different measurement strategies. Sweden has one of the most inclusive definitions of homelessness in the OECD, and counts people without stable, permanent, or proper housing. The estimates for Sweden also include people living in institutions. In contrast, Japan only counts rough sleepers and those in emergency shelters.

A similar definition-driven variation is seen for rough sleepers as a proportion of all homeless people, making it very difficult to compare true rates of rough sleeping OECD-wide. The share of homeless people estimated to be sleeping on the streets in OECD countries varies widely from lows of 1% to 5% of the homeless population in the Czech Republic, Finland, Luxembourg, Norway, and Sweden, to around 22 to 25% in Spain, Greece and Korea, and 38% in the United States. The highest rates of rough sleeping as a share of all homeless are seen in countries that do not include people living with friends or acquaintances under temporary arrangements (and cover rough sleepers, those living in places unfit for human habitation, or in homeless services only). Proportions are low in countries that include people who are in institutions without housing options on release, or people in insecure accommodation (or the hidden homeless) in the counts.

Although the results below use national estimates in many cases, it is likely that the homelessness figures derived from city-only surveys are higher than national estimates because of the concentration of housing and social care services in larger cities. Larger cities may attract people who need those services and result in a higher concentration of chronic cases. In London for instance, between one quarter and one third of people using homelessness services were chronically homeless (Cebulla et al., 2009), compared to an OECD national-estimate high of around 25% (see Table 4.2). Regional estimates also require careful interpretation. For example in the United States, there is considerable regional variation in levels of chronic homelessness, ranging from Louisiana's 2011 estimate of 46.8% to New Jersey's figure of 5.3% (Cortes et al., 2011).

Timing and location of surveys can also affect results. Although in the neighbouring countries of Finland, Norway and Sweden, where the former countries collect data in winter and Sweden collects data in summer, do show remarkably similar number of rough sleepers (around 320 to 340 in total). However, geography may play a part. Nordic countries' estimates of rough sleeping are lower than those seen in the warmer climates of Australia and Greece where definitions are similarly broad.

Finally, underreporting and missing data – fundamental flaws in any survey – may also occur in homelessness surveys. For instance, people defined as the hidden homeless may not self-report as being homeless for reasons of stigma, or they may simply not be found to be surveyed.

Table 4.2. Homelessness estimates and definitions across the OECD: Various years

Year (month)	Estimated total	Sleeping rough	Homeless per 1 000 adults	Source	Definition and notes
Australia 2011 (Aug)	105,215	6%	4.9	Australian Bureau of Statistics (2012)	Refers to people who do not have suitable accommodation alternatives and who live in an inadequate dwelling or have no security of tenure in the dwelling, or control of, and access to space for social relations.
Austria 2008	36,980			Correspondence with FEANTSAs (2014)	Refers to people in contact with homeless services. 15,142 people were in contact for consultation to prevent eviction; 13,418 were in contact for consultation services and individual support; 8,400 received support in shared accommodations (stationary services)
Belgium 2010	8,632			FEANTSAs (2012)	The figure refers to homeless people in Flanders only and it includes people staying in hostels and shelters and persons using forms of supported housing for homeless people.
Canada 2009	147,000		4.3	Segaert (2012)	The figure refers to people using emergency shelter at least once in 2009. An estimate including hidden homelessness is available from Gaetz et al. (2013).
Chile 2011 (Aug)	12,255			Ministry of Social Development (2012)	Refers to people who slept rough in public or private places that cannot be qualified as accommodation, people not having a regular or adequate place to sleep, found a night accommodation – paid or free – temporary shelters for homeless people, administered by public or private entities.
Czech Republic 2010	3,300	4.80%		FEANTSAs (2012)	The figure refers to the number of homeless people in Prague only. It includes people sleeping rough or staying in night shelters; people in prison and hospital without housing.
Denmark 2011 (Feb)	5,000		1.38	HesselbergLauritzen, Boje-Kovacs and Benjaminsen (SFI) (2011)	Refers to rough sleepers, hostel users, individuals staying temporarily with friends and family or living in temporary supported accommodation, as well as in institutions or prisons from which they are due to be released within a short period (three months).
Estonia 2007	1,346			Ministry of Social Affairs (2014)	Refers to homeless people making use of night shelters.
Finland 2013 (Nov)	7500 single, 417 families	4.40%	1.71	Housing Finance and Development Centre of Finland (2014)	Refers to people living outdoors, on staircases, night shelters or hostels and various institutions for homeless people; released prisoners without housing and people living temporarily with relatives or friends.
France 2012	141,500	9.00%	3.47	Yaouancq, Lebrère, Marpsat, Régnier (Insee), Legleye, Quaglia (Ined) (2012)	Refers to people staying in homeless shelters or sleeping somewhere not intended for habitation in metropolitan France.
Germany 2012	284,000	8.50%	4.6	FEANTSAs (2014)	Refers to the main legal provision in Germany that defines homeless people as those having nowhere to live at all. The figure is an annual estimate of the national prevalence of homeless.
Greece 2009	7,720	23.30%	1.02	FEANTSAs (2012)	Refers to people living in the street or shelters, people living temporarily in institutions or living in inadequate conditions. These figures are challenged both by the Ministry of Health (which conducted the survey) and other social partners due to methodological constraints. The United Nations Human Rights Council reports that "there are 21,216 cases of people who live, in various forms, outside the home" in Greece.
Hungary 2012 (Feb)	30-50,000		4.41-7.36	FEANTSAs (2012)	Refers to people staying in homeless shelters and rough sleepers.
Iceland 2012 (March through May)	179	12.30%	0.84	Sigurðardóttir (2012)	Refers to people defined as homeless using services in Reykjavík (Service Centres of Reykjavík, the Icelandic Red Cross Reykjavík, and interacting with police or the prison service). Homeless people are those without conventional housing, living in sheltered accommodation, or with others (unpaid and insecure), or those leaving institutional accommodation (prisons etc.) with a history of housing issues and without guaranteed accommodation in the months preceding release.
Ireland 2011	2,348 households			Housing Needs Assessment (2011)	The data are collected from all local authorities and include those in need of local authority intervention and registered as homeless. Therefore, those not on the local authority list and people in transitional housing are excluded.
Italy 2011 (Nov-Dec)	47,648		1.21	ISTAT (2011)	Refers to people living in public spaces, people living in night shelters and/or obliged to spend several hours during the day in a public space, people living in hostels for homeless people or in accommodations provided by the social support system.

Table 4.2 Homelessness estimates and definitions across the OECD: Various years (cont.)

Country	Year (month)	Estimated total	Sleeping rough	Homeless per 1 000 adults	Source	Definition and notes
Japan	2014 (Jan)	7,508		0.1	MHLW, Japan (2014)	Collected via a street count of people living their day-to-day lives in city parks, or by rivers and roads.
Korea	2006	4,856	26.60%	0.14	Mizuuchi and Jeon, URP Working Paper (2009)	Refers to people sleeping rough and staying in homeless shelters.
Luxembourg	2006 (Feb)	715	4.20%	2.24	FEANTSA (2012)	Refers to people sleeping rough, staying in a night shelter or a homeless hostel; people staying in supported housing, in hospital or prison and people who were housed by family or friends.
Netherlands	2012	27,000		2.43	National Statistics Office (CBS) (2012)	Refers to people sleeping rough or staying in homeless shelters, people staying in short-term accommodations or staying on an irregular basis with friends, acquaintances or relatives.
New Zealand						Definition by the National Statistical Institute (2009): homelessness is defined as the living situation of people without shelter, in temporary accommodation, sharing accommodation with a household or living in uninhabitable housing. There is no precise current measure of homelessness, although the Housing New Zealand waiting list is usually considered as a measure. The total number in the A and B categories is currently 3,811; about 250 people are considered as currently homeless. Housing New Zealand housed 200 people in June, or about 40 high-need families per day (2013) (www.parliament.nz).
Norway	2012 (Nov-Dec)	6,259	5.00%	1.26	Norwegian Institute for Urban and Regional Research (NIBR) (2013)	Refers to people who live rough, stay in night shelters and spend the whole or parts of the day outside; people living with friends, acquaintances and relatives on a temporary basis or living in temporary accommodation (shelters and housing provided specifically for homeless people, caravan sites, hotels and bed and breakfasts).
Poland	2012/2013	30,712	27.90%		FEANTSA (2014)	Refers to people living in night shelters and homeless hostels and people who were provided with a shelter.
Portugal	2010	3,000		0.43	FEANTSA (2012)	Individuals who, regardless of nationality, age, sex, socio-economic status and mental and physical health, are roofless and living in a public space or insecure form of shelter or accommodated in an emergency shelter, or are houseless and living in temporary accommodation for the homeless.
Slovenia					FEANTSA (2012)	There is no established strategy for collecting data on homelessness in Slovenia. Data are collected in Ljubljana for rough sleepers, houseless and inadequate housing. The approximate number of people staying in overnight shelters from May 2009 until August 2010 is 110; the approximate number of people living in emergency housing in 2009 is 486, while the approximate number of people on waiting list for emergency housing in the same year is 258.
Spain	2005 (Dec)	21,900	22.00%	0.5	FEANTSA (2012)	People living rough, in emergency accommodation, people staying in long-stay group accommodation, people living in buildings unsuitable for human habitation or in temporary accommodation.
Sweden	2011 (May)	34,000	1.00%	5.56	The National Board of Health and Welfare (2011)	This figure includes people in "acute" homelessness (people sleeping rough, living in tents, staying in shelters or homeless hostels); people receiving institutional care or living in different forms of category housing; people living in long-term housing solutions (the secondary housing market); persons living in short-term insecure housing solutions that they have organized themselves.
United Kingdom	2013 (Oct-Nov)		2,414 (absolute figure)		DCLG, UK (2014)	The figure is for rough sleepers in England only.
United States	2012 (Jan)	633,782	38.40%		Homelessness Research Institute (2013)	Refers to the definition set by the U.S. Department of Housing and Urban Development (HUD), which considers an individual homeless if he or she lives in an emergency shelter, transitional housing programme, safe haven, or a place not meant for human habitation, such as a car, abandoned buildings, or on the street.

Note: Data is missing for Israel, Mexico, Slovak Republic, Switzerland, and Turkey. Homeless rates are calculated where national total estimates exist, using OECD population estimates. Estimates for Canada and Chile include both adults and under 18-year-olds.

Source: See references listed in the table.

Trend changes to homeless in recent years

Limitations in cross-national homelessness data make it difficult to compare OECD countries at a point in time. However, comparing homelessness *trends* by country is possible, and allows for a comparison of changes to homelessness risks across countries.

Evidence from Seoul in Korea, New York City in the United States, and England in the United Kingdom, shows that the financial crisis corresponded with large increases in homelessness. The homeless population in Seoul, for instance, increased by 67% in two years⁴ (Chosun, 2012), compared to a rise of 24% of children in homeless shelters in New York from 2011 to 2012 (Gabbatt, 2012). The number of rough sleepers in England rose by 23% from 2011 to 2012 (Ramesh, 2012), whilst the number of homeless families in “bed and breakfast” temporary accommodation also increased by 44% in the United Kingdom between 2009/10 and 2011/12 (National Housing Federation, 2012).

In some other countries, homelessness has fallen. The Japanese national count of homeless people, which uses a definition of people living rough, reported that there were 13 124 homeless people in Japan in 2010, falling to 8 265 in 2013 and then to 7 508 in 2014 (Ministry of Health, Labour and Welfare of Japan, 2014). The United States has tracked a relative decline in estimated chronic homelessness from a peak of 18.7% of all homeless people in 2008 to 16.8% of all homeless people in 2011.

Unlike cross-sectional cross-national comparisons, where measurement choices explain many of the differences, differences in homelessness trends cross-nationally are more likely to be meaningfully explained by factors such as the Great Recession. Equally public service provision may play a role in differences between rough sleeper rates and hidden homelessness rates in the trends. The size of the homeless shelter and hostel sector, and the higher the number of shelter beds available, the bigger the recorded homeless population tends to be, and the smaller the share of rough sleepers.

Estimates of housing insecurity

Another measure of homelessness risk, collected for the purpose of international comparison, measures people at-risk of housing insecurity: specifically, here defined as the rates of households unable to afford housing costs at any point in a given year.⁵

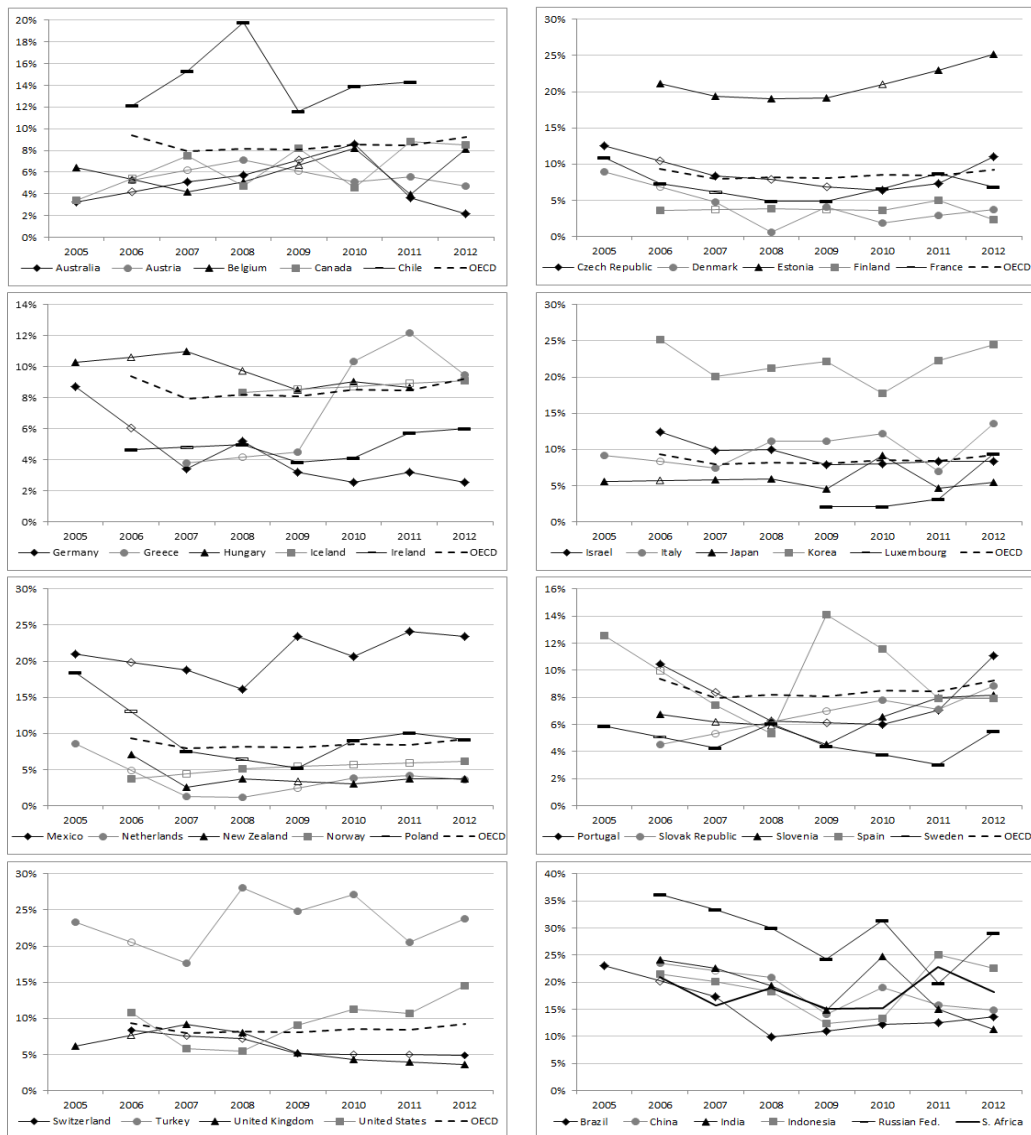
Figure 4.1 shows the trends in people’s reported ability to meet the costs of housing between the years of 2005 and 2012 where data is available (solid points in the trends denote where there is observed data for each country). Between 2006 and 2012, on average between eight and 10% of people in OECD countries report not having enough money for housing in the past year. The low point of this trend was around the beginning of the economic crisis, and the average has been creeping up since. The figures are somewhat higher than those found in homelessness statistics, but better represent those people who are at risk of homelessness in its broadest definition.

The highest levels of housing insecurity are seen in Estonia, Korea, Mexico and Turkey, where trends fluctuate from one-in-five to one-in-four respondents reporting housing insecurity. The lowest rates of housing insecurity are found in Australia, Denmark, Finland, Germany, and the Netherlands where rates can be as low as 2% of the population.

In most countries the trends in housing insecurity are reasonably stable, with the exceptions of Chile, Greece and Spain: the latter two countries notably having experienced deep economic recessions and austerity. The United States and Luxembourg

also report upward trends moving from below the OECD average immediately pre-crisis to above or around the OECD average in 2012. Germany and Poland are the only countries with notable downward trends over the period: German rates fall by two thirds, and Polish rates fall by almost half.

Figure 4.1. People reporting insufficient money for adequate shelter or housing in the past year, trends from 2005 to latest available year



Note: The Gallup World Poll was conducted by telephone in approximately 140 countries in total, and all OECD countries, using a common questionnaire translated into the main national languages. Samples are nationally representative of the resident population aged 15 and over in the entire country, including rural areas in most cases. Sample sizes are limited to around 1 000 persons in most countries (exceptions include Iceland and Luxembourg [c. 500]; Japan and New Zealand [c. 750]). Data for Germany and Japan are the average of four quarterly samples. Observed data points on each trend line are “filled”, estimates are “empty”. The figure records the proportion of respondents who answered “Yes” to the question “Have there been times in the past 12 months when you did not have enough money to provide adequate shelter or housing for you or your family?”.

Source: Gallup World Poll (2014), www.gallup.com/strategicconsulting/en-us/worldpoll.aspx.

Caution is required when interpreting the results. The depth and persistence of unaffordable housing conditions in the previous year is not clear from these figures, and neither is housing quality. Both factors drive homelessness risks; for an international trend comparison of these factors see Annex Figure 4.A1.1. Furthermore, price and supply variations in housing markets within and between countries suggests that unaffordable housing may not reflect absolute levels of poverty related to the disposable income available for these purchases.

Which homeless people can benefit from integrated housing and services?

The evidence above shows that homeless populations vary widely across the OECD. In considering the role of integrated housing and services, it is useful to identify homeless by support needs.

Although homeless populations are counted and defined in different ways, there is growing evidence that there is a *minority* within the homeless population who have very high support needs and who may benefit from intensive integrated housing and services (Fitzpatrick et al., 2012). This group has been described in various ways, but is most frequently described as those *chronically homeless or experiencing sustained homelessness*. Evidence suggests that people with multiple high-support needs have a higher likelihood of experiencing chronic homelessness, particularly if they experience two, three or all of the following traits (Culhane and Kuhn, 1998; Kemp et al., 2006; Culhane and Byrne, 2010; Fitzpatrick et al., 2011): problematic drug and alcohol use; severe mental illness; a history of low-level criminality and imprisonment; and a history of institutional care.

There is also a “*transitionally*” *homeless group* of people with lower support needs whose homelessness is shorter in length and associated with factors such as: loss of employment, loss of affordable housing, transitions for institutional or social care, and relationship breakdown. Some groups in society may be particularly vulnerable to transitional homelessness, such as: lone parents and lone women whose homelessness has resulted from domestic violence, young people transitioning from social care, and unemployed evictees. This group is a good target for preventative policy action. At any one point in time this “transitionally” homeless group appears to outnumber chronically homeless people (Busch-Geertsema et al., 2010).

Chronic homelessness is often associated with poor access to services such as mainstream health, social work and housing services (Quilgars and Pleace, 2003) – and a lack of appropriate access that can exacerbate social costs. The barriers that can be faced by chronically homeless people include:

- *Administrative barriers*: such as lacking a fixed address, complex forms and bureaucracy, or welfare systems that prioritise household supports over provisions for single men and women (see Baptista, 2010).
- *Attitudinal barriers*: providers or employers reluctant to engage with a “challenging” group of people (see Kemp et al., 2006; Pleace and Minton, 2009).
- *Attitudinal barriers* from chronically homeless people themselves: problems related to (mental) health.
- *A focus on mainstream provisions in the public health, welfare and housing agencies and not homelessness provisions*, reflecting the relatively small scale, if not the high financial and social cost, of homelessness (e.g. Housing Ministries will spend the majority of their time on affordable housing and regeneration concerns – see Pleace et al., 2011).

Offering greater access to services and service integration could result in cost savings if sporadic and repeated emergency service use is reduced. The type and timing of access to service will inevitably have a say in prevention also: for instance protecting or facilitating employment will reduce the risk of individuals entering a negative spiral of falling income, housing loss, no fixed address, administrative “invisibility”, and no access to mainstream benefits or services.

Until the 1990s, extensive cross-sectional (single-day) survey research suggested that US homelessness was very closely associated with very high support needs. Longitudinal analysis, looking at the population using homelessness services over time, then began to show that this was not accurate. The new longitudinal data showed two distinct groups of homeless people (Culhane and Kuhn, 1998). There was a small group of “chronically homeless people”, which was made up of people with very high needs living in emergency accommodation for *prolonged* periods and people with very high needs who were making *frequent stays* in emergency accommodation. There was also a much larger group of “transitionally” homeless people with *low* support needs who used emergency accommodation for a few days and then left, never to return. US homelessness services were spending a lot of time and resources on a relatively *small*, high need group who were staying repeatedly or staying for long periods (Culhane and Kuhn, 1998; O’Sullivan, 2008).

Work in some other OECD member countries has broadly – though not conclusively – supported the patterns identified in the United States. In the United Kingdom, research has found high support needs among young lone homeless people and low support needs among homeless families (Pleace et al., 2008), and, overall, a small proportion of homeless people with very high support needs (Fitzpatrick et al., 2011). French research on homelessness also found past experience of homelessness was associated with low incomes and job insecurity; it was not just associated with someone having high support needs (Brousse, 2009). When looking at the highly gendered problem of family homelessness, research in the United States⁶ showed high rates of depression among lone homeless mothers. However, the bulk of lone women heading homeless families did *not* have the high rates of severe mental illness or problematic drug and alcohol use hitherto closely associated with homelessness (Shinn et al., 1998; Metraux and Culhane, 1999).

There is some evidence that a small group of homeless people with high needs, who are frequently homeless or homeless for sustained periods, is present in many OECD member states. However, it is important to note that the pattern is not universal. Homelessness in Japan, for example, appears to be less clearly associated with very high support needs than in some other OECD countries (Okamoto and Bretherton, 2012).

Homeless migrants: an example of different risks and service needs

A particular group of homeless people worth closer scrutiny are homeless migrants. Immigrants can be at a greater risk of homelessness than non-migrants for reasons which can include: access or eligibility to social security benefits available in the host country when they become unemployed or experience poverty; lack of appropriate documentation; lack of family, extended family or other social support in the country when they experience poverty; discrimination in housing and employment markets; lack of information regarding the services and support available in the host country; language; and pre-existing vulnerabilities that may have led them to leave their country of origin.

Homelessness among immigrants in Europe has grown during the past decade (FEANTSA, 2012). This phenomenon affects both non-EU migrants and EU citizens. Immigrant homelessness is a particular concern in France, Italy, Spain and Greece, which

experience increasing migration pressures in particular from African asylum seekers and refugees (see Box 4.1 for details of the experiences of Italy and homeless migrants). Evidence suggests that refugees represent an increasing proportion of homeless service users in some countries (ibid.). Inadequate asylum services are also becoming a major issue: France, for instance, has annual availability for 35 000 applicants, while the number of applications in 2012 was 50 000.

France, Denmark, Ireland and the United Kingdom record the highest share of EU citizens amongst homeless immigrants. Voluntary repatriation measures have been introduced for example in Denmark, Ireland, and the United Kingdom to address the issue of mobile EU citizen homelessness; however, there are concerns as to how these measures may infringe people's social and human rights.

Homeless migrants represent an example of what makes people vulnerable to homelessness, and how treatments might differ between groups. In some cases, homelessness experienced by migrants can be more readily explained by economic exclusions, financial destitution, and social exclusion (lack of extended family and social supports) (see Box 4.1). Homelessness in migrant populations should therefore require different treatments, including support in accessing appropriate documentation and more activation and formalisation policies. Mainstream social policies could also reduce the risk of homelessness among migrants (see Box 4.2).

Box 4.1. Homeless migrants and service use: The experience of Italy

In 2011 the Italian National Institute of Statistics (ISTAT) conducted the first national census on homeless people in Italy. ISTAT estimated that between 43 425 and 51 872 people were homeless in 2011, amounting to between seven and nine in every 10 000 people living in Italy. The ISTAT estimate defines homeless people who have visited a canteen and have slept in a shelter, but does not include people under the age of 18 years, Roma people (who are considered as travellers) and people temporarily staying with friends or relatives.

Half of all homeless people are foreign born men

Homeless people in Italy are mostly men (86.9%), the majority of whom are foreign nationals (57.9%). Romanians (11.5%), Moroccans (9.1%) and Tunisians (5.7%) are the most common groups amongst men, and among women, the main countries of origin are Romania (36.6%), Ukraine, Bulgaria and Poland. Homeless immigrants are on average ten years younger than Italian homeless (the average age is 36.9 years compared to 49.9 for Italian homeless), they are more educated, and they are generally homeless for a shorter time (1.6 years compared to 3.9 years for Italian homeless).

Just 20% of the foreign homeless in Italy were homeless both before and after migration; 41.4% were not homeless before moving to Italy, and the remaining 38.6% had homes on arriving in Italy. Of the latter group, half were housed in a different Italian municipality to where they were homeless.

The main reasons for becoming homeless were loss of secure job, family breakdown (separation from spouse and/or children) and poor health. Overall, among the foreign homeless, 55.9% experienced job-loss, 54.4% experienced family breakdown, and 13.7% reported poor health as a cause of their homelessness.

Very few homeless people are involved in paid work. At the time of the survey, 72.2% of the foreign homeless and 70.8% of Italian homeless were not engaged in any kind of paid work, but 40.8% of the interviewed immigrants and 36.8% of Italian homeless declared to have engaged in occasional paid work since becoming homeless. Difficulty in finding paid work is the biggest barrier for homeless immigrants (57.8%), and 4.6% of those interviewed declared that the lack of appropriate documentation was also an issue. On average, a homeless person in Italy works 12 days per month, and for the majority of working foreign homeless (47.2%) earnings are in the range of EUR 100 and EUR 499 per month. Around one-quarter of foreign born homeless in Italy earn less than EUR 100 per month, or around EUR 3 per day.

Box 4.1. Homeless migrants and service use: The experience of Italy (*cont.*)

Earnings are not the only source of income for homeless immigrants. The main source of income for homeless immigrants is charity from strangers or volunteers, followed by help from relatives or friends. Only 6.1% receive financial help from municipalities or public entities (this is likely to be related to residency rules by municipality). For Italian homeless, the situation is similar, but they receive less financial help from relatives and friends.

Almost all the homeless immigrants stated to have used a food and shelter service at least once in the last 12 months (99.8%). Food services were most commonly used (canteens, by 91.3% of respondents), around two-thirds used shelter services or hygienic services (showers/toilets), and 61.4% participated in at least one clothes distribution. Immigrants visit canteens and hygienic services more often than Italian homeless, probably because they are more likely to sleep rough (in public spaces).

More homeless people live in Milan and Rome than in other Italian cities (ISTAT, 2012), though other large Italian cities have a high concentration of homeless people (Palermo, Florence, Turin and Bologna). What is notable is that despite similarly high numbers of homeless, both populations and demand for services differ between these cities (for instance the number of immigrant homeless using canteen services in Milan is much higher than in Rome – 78.3% in Milan versus 46.7% in Rome).

A recent survey of homeless people conducted in Milan (Fondazione Rodolfo de Benedetti, Bocconi University, & Comune di Milano, 2013) found that the incidence of homeless people has almost doubled in the year 2012, increasing from 0.12% to 0.21% of Milan's total population. Both among rough sleepers and those who sleep in shelters, the incidence of immigrant homeless is striking: the figures are 83% and 76% respectively.

Most immigrant homeless in Milan are from Africa [Burkina Faso, Ghana, Mali, Ivory Coast (10% altogether), Egypt and Tunisia (8% altogether), Morocco (8%), and Somalia, Ethiopia, Eritrea (6% altogether)] and eastern Europe [Romania (15%), Ukraine and Bulgaria (4%)]. About 7% of the people come from Asia, in particular India, Bangladesh, Pakistan and Sri Lanka. As with the findings of the national census, immigrant homeless in Milan are on average around ten years younger than Italians (38.6 years versus 48.5 years) and are more educated.

The main reasons for immigrants' homelessness are loss of secure employment (48%) and issues associated with immigration itself (17%), whereas issues related to alcohol, drugs or justice are more frequent among Italians. On average, homeless immigrants in Milan were homeless for 2.5 years, while the duration of homelessness condition is twice as high for Italians (5.1 years) – in both cases these durations are longer than those reported in the national census.

Just over one in ten homeless people in Milan were engaged in paid work at the time of the interview, the vast majority of which (70.4%) was irregular employment. The average income for homeless people in Milan is EUR 146 per month.

Services for the homeless in Milan, Italy

In 2013, about 66% of homeless Milanese had visited a municipality-run social service centre at least once (for instance, a social assistance centre or employment centre). When surveyed, two-thirds of homeless people who did not visit any services said that they were not aware that these services existed. Fifty-nine per cent of the homeless people interviewed in Milan reported ill-health in the month preceding the interview, and 67% of whom had sought care from a public hospital. Compared to migrants, homeless Italians in Milan, and those who sleep in shelters, are more likely to access other municipal support services (canteens, hygienic services, food supplies, and services that distribute clothes, medicines and blankets).

Overall, in Milan, 2 700 beds in 31 shelters are available to homeless people, and 112 000 meals in 12 canteens are provided every day. Canteen services are mainly offered to any needy person by faith-based NGOs, for instance *Opera San Francesco Onlus*, *Associazione Cenadell'Amicizia*, *Centro Francescano Maria della Passione*. NGOs also distribute small meals, clothes and blankets in several areas of the city. Throughout the year, the municipality and NGOs offer shelter services to Italian and documented migrants, with the municipality also providing help to immigrants seeking for political asylum through a help centres (*Centro dell'Accoglienza*) operating in five different locations.

Box 4.1. Homeless migrants and service use: The experience of Italy (cont.)

During the winter season, Milan activates a special plan to provide shelter services to homeless people. Access to these services is provided through a Help Centre located in the central railway station, but possession of regular documents is required in order to access these services. Moreover, as part of the "winter" plan, teams of six people (the so-called "*Unita' Mobili*") operate along the underground lines and tramway lines; the teams include a nurse, an interpreter, an educator and a co-ordinator. The main services of this unit include food and medical services and the provision of blankets and clothes.

Shower services are offered by the municipality to all Italian citizens at the cost of EUR 0.5; the same service is also provided by NGOs, and requires the possession of regular documents and a member card. Clothes and blankets are distributed to homeless people all year long by NGOs; but a free subscription to the service is often required. In order to access the health care services provided by public hospitals, the possession of appropriate documentation (such as a visa, or residency permit) is required; however, those without regular documents can access to emergency health services (maternity services, health care to minors, vaccinations and treatment of infectious diseases). Special services reserved for foreigners only are also provided by NGOs. For instance, Caritas Milan offers orientation services for shelters, job search and legal advice, as well as night shelter services for homeless immigrants.

The social costs of homelessness in different OECD countries

Estimating the full cost of homelessness to OECD countries is a complex task. To assess the full extent of social costs of homelessness in a country it is necessary to understand the size and needs of the population, the services they may receive (both direct homelessness services and non-homeless services) when homeless and when housed, and the potential of these interventions for creating or reducing social costs over time.

The depth of housing exclusion and persistence of homelessness also matters. There are some costs associated with transitional homelessness, such as short-term emergency accommodation use. However, US research suggests that transitional homelessness does not generate the high financial costs of chronic homelessness, because it is neither enduring nor associated with high support needs (Culhane, 2008; Culhane and Byrne, 2010). Direct public costs of chronic homelessness can be generated through several paths. These include risks to health and well-being through heightened infection, stress, drug abuse, and poor diets (Kemp et al., 2006; Johnson and Chamberlain, 2008; Pleace, 2008); sustained contact with relatively expensive "emergency" public services (Culhane, 2008), including accommodation, medical, mental health, drug and alcohol services, and the criminal justice system; long-term unemployment and associated losses in economic productivity; and, in some cases, increased cash benefit spending.

When homeless people are housed they may use more services than they would have otherwise used while living on the streets. Housing the homeless (i.e. investing in housing supply) can also entail considerable costs itself. Thus some short-term service costs may actually *increase* when homelessness falls (whether or not long-term savings are expected), which complicates the cost saving discussion and can raise the need for closer scrutiny of social investment on homelessness treatment and prevention. If the burden of social protection increases when addressing homelessness, initial spending may rise; and homelessness may have been cheaper in some instances. Homeless people, who are continuously living rough or in shelters with drug addictions and/or health problems, may have the highest costs and lowest potential for full reintegration into society. In these cases, the discussion of public cost savings, or social investment, will need to be side-lined in favour of quality of life and human rights (see reference to Culhane, 2008, below).

It is also difficult to evaluate costs associated with changes in service use over time, because services have relatively high fixed costs and spending is not readily shifted between public services (such as buildings, specialised equipment or staff). Thus per capita spending can increase while the numbers of users fall, despite no qualitative change in the service provision or user outcomes. Equally, the marginal cost associated with providing a service for an additional homeless person in high-fixed cost settings is non-linear.

Estimating the direct costs of homelessness using case studies

A lack of quality evidence limits our ability to gauge the true costs of homelessness. Pleace et al. (2013) asked experts in 13 European OECD countries about evidence of the costs of homelessness in terms of productivity loss, city tourism, transport and infrastructure, criminal justice, social work, welfare benefits, drug and alcohol services, mental health, and emergency hospital use. All national experts reported that the evidence base was limited or weak, and no strong evidence on associated costs existed.

Pleace et al. (2013) collate information on the costs of social services in 13 countries for three “model” homelessness cases over one year. These cases include a chronic homeless person, a single mother with two young children, and a person with mental health needs at risk of homelessness. For each model case they cost two scenarios – the service use when homeless and the service use when “treated” for homelessness or risk of homelessness – and present a “cost offset” ratio representing how much more “untreated” homelessness costs, relative to “treated” homelessness (reported in Table 4.3).

The data in Table 4.3 have been standardised to represent a proportion of the total per capita social expenditure in the working age population in each country (minus pensions), and allows for a direct comparison with the cost of providing social protection for an average person of working age. In the case of Vignette 1, for instance, the cost of a providing social protection to a chronic homeless person in the Czech Republic is 293% of the cost of the average person of working age (or is 2.93 times higher). Because most working age people receive few benefits, or do not receive benefits, these figures are likely to underrepresent the average benefit recipient, but do show that:

- In many countries the estimated cost of caring for the chronic homeless can be up to seven times higher than supporting the average person and three times higher than a supported housing response (see the “Ratio” column).
- A homeless single mother with two young children can cost up to 6 times more than the average support levels, and twice as much as supporting the same family in a house with support worker visits.
- The biggest potential savings can be made from preventing and/or rapidly intervening in the costly homelessness of persons with complex needs (in this case with mental health needs). In some countries, costs for treating homelessness in this group are 17 to 18 times as high as prevention treatment.

Table 4.3. Preventing homelessness represents the best value for money, and treating even the most chronically homeless produces savings

Costs of homeless and alternative treatments per person as a proportion of average social protection spending per working-age person, for three model cases, 2013

	Vignette 1: Chronic homeless			Vignette 2: Homeless family			Vignette 3: Prevention		
	Situation 1: Homeless (chronic)	Situation 2: Supported housing	Ratio	Situation 1: Homeless (family)	Situation 2: Housed with mobile support	Ratio	Situation 1: Homeless (preventable)	Situation 2: Mobile support (euros)	Ratio
Czech Republic	293.3	92.6	3.2	281.4	126.6	2.2	272.2	20.9	13
Denmark	708.4	284.9	2.5	...	...	...	652.5	108.6	6
Finland	663.6	235	2.8	610.2	375.1	1.6	792.6	106.5	7.4
France	477.6	221.9	2.2	...	...	...	...	...	...
Germany	...	...	...	367	295	1.2	...	...	...
Hungary	110.5	114.8	1	...	...	...	...	...	...
Netherlands	761.4	245.4	3.1	554.4	382.3	1.5	731.2	42.9	17
Poland	183.8	111.3	1.7	...	...	...	...	...	...
Portugal	240	152.7	1.6	...	...	...	...	...	...
Sweden	779.1	239.3	3.3	526.7	314.3	1.7	838.2	130.8	6.4
United Kingdom	666	452	1.5	460.2	424.7	1.1	1057	58.9	17.9

Note: Values represent the percentage change from the average social cost per typical service user. All vignettes compare services use over one year. Vignette 1 compares arrest and imprisonment of one month, three emergency hospital uses, a four-night admission to hospital, admission to mental health ward for two months, daycentre support for 150 days, and emergency shelter for 200 days (situation 1) with a year of supported housing where emergency or inpatient services use is replaced by primary health care and mental health treatment, and there is no daycentre use (situation 2). Vignette 2 compares cash benefit receipt, four emergency health visits, emergency accommodation (two months), temporary accommodation in a hotel then the private rental sector (situation 1) with rehousing and mobile social support replacing emergency accommodation, and GP visits replacing hospital visits (situation 2). Vignette 3 compares police intervention (five arrests and short custody stay), inpatient mental health for three months, resettlement with three months specialist social worker support, emergency accommodation, and daycentre use for 150 days (situation 1) with mobile support service to help sustain independence, and prevent homelessness (situation 2). The authors stress that experts had challenges in producing precise data on costs, and results provide only “reasonable estimates” for four of the 13 countries across all vignettes (Pleace et al., 2013, p. 16). Social protection estimates for 2013 use observed 2009 data social spending (minus pensions) for the working age-population. Mobile support refers to visits from a support worker to the place of residence.

Source: Pleace, N., I. Baptista, L. Benjaminsen, V. Busch-Geertsema (2013), *The Costs of Homelessness in Europe: An Assessment of the Current Evidence Base*, EOH Comparative Studies on Homelessness, Brussels, December 2013.

The United States also offers evidence on rehousing costs. A large-scale cost exercise was undertaken in New York using longitudinal administrative data from a range of service providers in the early 2000s. It explored total service use by chronically homeless people before and after housing. The study reported a fall from an average of USD 40 500 per year in total service costs for someone who was homeless with severe mental illness to an average of USD 24 300 following housing,⁷ a drop of 66% (Culhane, 2008). This calculation included health, criminal justice and emergency accommodation costs. The cost of providing this homeless group with integrated support and housing was however USD 17 200. This meant that average financial cost of a rehoused, supported, chronically homeless person was actually marginally higher than allowing them to remain on the street and in emergency shelters, at USD 41 500. However Culhane argues that the human value of the intervention, in terms of improved living standards and other outcomes, justifies the difference (ibid.).

Cost benefit evaluations of shelter based services, Housing First and Housing-led services are further elaborated in Section 4.4.

Box 4.2. Mainstream policy efforts to help with housing insecurity

Much of this chapter addresses policies to treat homelessness. These policies exist in the context of mainstream social protection and housing policies which help reduce the risk of homelessness by preventing housing insecurity through cash supports – including social assistance benefits, specific rental supports and housing allowances, fiscal supports such as – mortgage relief, and in-kind support such as social rental housing (particularly programmes prioritising the vulnerable) and emergency accommodation. Tenancy legislation and mediation can also help. However, reducing housing insecurity is generally not the only goal of housing policy. Forthcoming OECD work provides an overview of the main policy goals and tools in promoting promote access to affordable good-quality housing in OECD countries (Salvi del Pero et al., 2015, forthcoming).

- *Housing benefits* and minimum income benefits that include increments for housing costs are available in most OECD countries (30 of 32 OECD countries reviewed in 2010 had such benefits, see OECD, 2014). These cash benefits are paid most often to individuals and/or families for the purposes of paying rents, but can also cover costs associated with heating or the up-keep of the home for both renters and owner-occupants. Housing benefits serve to reduce homelessness risks by providing income to cover housing costs or other basic needs during spells of unemployment or for those living on low incomes (ibid.).
- *Mortgage relief* is available in 16 of 30 OECD countries for which data is available (OECD Crisis Questionnaire, 2011). Mortgage relief can take the form of cash supports to cover interest payments (e.g. the United Kingdom) or the mortgage payments themselves (e.g. Poland), or temporary postponements of mortgage payments (e.g. Norway). In some cases countries have debt settlement legislation protecting the householder from eviction whilst debts are repaid over a set period of time or banks provide private agreements for individuals with distressed mortgages. These agreements can include restructuring or re-financing, or temporary postponements of mortgage payments – ibid.).
- *Social housing* refers to residential rental accommodation provided at below-market prices and allocated by eligibility criteria. Social rental housing is usually owned by the state, co-operatives or not-for-profit landlords, but in some cases it is also provided by for-profit investors who rent their dwelling under special contracts with state subsidisation (Fitzpatrick and Pawson, 2013; Salvi del Pero et al., 2015, forthcoming). Social rental housing exists in twenty-six of 28 OECD countries for which data is available (OECD Crisis Questionnaire, 2011). In most OECD countries social housing is provided to low income families and/or individuals based on pre-determined eligibility criteria (in federal countries eligibility can vary by state, e.g. Australia). At least half of the countries with social housing provisions (14 out of 26 with social housing stock) have an active waiting list, meaning the demand for social housing is commonly higher than the supply (OECD Crisis Questionnaire, 2011). On some occasions, regional and local authorities can acquire emergency housing for homelessness, including through the requisition of idle property (as in Switzerland). In some countries, social housing is part of a broader system of social and housing policies rather than solely a public segment of the housing sector (for example in the Czech Republic). Although significant barriers to access for the homeless exist (Pleace et al., 2011), social housing has an important role to play in homelessness prevention as it provides low-cost solutions to housing insecurity for the poorest members of societies, including the rehousing of the homeless, and generally offers a level of security not found in the private rental market.
- *Tenancy law* in OECD is used to regulate the rental market, providing clear rights and responsibilities for both tenants and landlords. Such laws can protect tenants from unaffordable rent increases or unexpected evictions. Legislation that supports landlords' basic rights can serve to incentivize rentals to lower-income group by making it more attractive for landlords to put property on the market. Tenancy law can protect against homelessness best when it strikes a balance between the interests of tenants and landlords. Related to tenancy law is the availability of *mediation* between the private landlords housing market and problematic tenants (to cope with rent arrears, anti-social behaviours, etc.). Mediation services help assure private landlords and facilitate access to housing for persons systematically excluded from private tenancies, or prevent families from being forced to leave their homes.

Mainstream social policies could reduce the risk of homelessness not only generally but also among migrants. Evidence from the Italian case (see Box 4.1) suggests that reducing restrictions on residency eligibility for social transfers can reduce migrants' risks of poverty, housing insecurity and homelessness. Any savings made on homelessness and health services, or productivity gains, may help fund these changes. Portability of social benefits from the country of origin, even transitionally, would contribute to the same goal.

4.4. Integrated housing and services for homeless people with high support needs

Homelessness services across OECD countries exist in what can be described as four main “types” of services. These four types are: emergency accommodation services, outreach and food provision for people living rough (including via daycentre services); permanent supported housing (in some cases providing supported or sheltered employment); accommodation-based transitional services; and “Housing First” and case-management models.

How these different homeless services vary in terms of quality of care can be most meaningfully expressed through historical reforms. Pleace (2012b) uses the evolution of elderly care in the United Kingdom to express how developments in the provision of similar human services have been driven by progressive ideals about quality of life, arguing that elderly care policies shifted from “dehumanising” and “marginalising” long-stay hospital and institutional care in the 1960s to sheltered housing services with choice and personal control in following decades. In the 1990s, community care reforms sought to allow older people to remain in their own homes as long as possible. Pleace notes that although reforms were driven partly by progressive ideals about elderly quality of life, financial incentives also played a role: lower-level support to maximise independence and reduce hospital and emergency room admissions represented major cost savings (Sinclair et al., 1990).

Homelessness services providing food and emergency accommodation

Barriers to existing services, welfare systems, employment and the housing market led to the development of homelessness services providing emergency accommodation and food in many OECD countries. These services are often supported or commissioned by the public sector or by NGOs, in several countries particularly faith-based organisations. These emergency services can be characterised as “low threshold” in that they ask few questions, do not undertake assessments and, while they may take referrals from other agencies, often operate on a “first come, first served” basis: homeless people who need help simply present themselves to the provider. These basic services remain important in the majority of OECD countries and often include emergency accommodation that provides a bed and food; daycentre services that provide daytime food and shelter; and soup runs or soup kitchens that provide food during the day or night.

While these services still exist in all OECD countries, countries with relatively extensive welfare systems have tended to *modify* or *replace existing services* with the service models that are discussed below (Anderson, 2010). In Finland, emergency accommodation has been almost entirely replaced by “housing first” solutions and basic emergency accommodation has also become a relative rarity in the United Kingdom (Kaakinen, 2012; Fitzpatrick et al., 2010).

However, these still widely-used models date from a time when responses to homelessness did not directly involve housing but instead used specific, often communal, emergency accommodation or were designed primarily to provide people with food and/or a bed. Traditional emergency accommodation, daycentres and soup kitchens are forms of integrated services (as they combine food, shelter, etc.), but they do not directly provide, or systematically seek to arrange, housing or support services for the homeless people using them. Unsurprisingly, these services have long been criticised as failing to resettle and reintegrate homeless people into society (MacGregor-Wood, 1976; Dant and Deacon, 1989).

Permanent supported housing

As the link between very high support needs and sustained homelessness became more apparent, some countries started providing permanent supported housing for homeless people. It is important to be careful about terminology here. In United States terms, “supported housing” is ordinary housing in which an individual receives assistance from mobile support teams. The definition of supported housing used in this report refers to supported housing means purpose-built, communal or congregate accommodation with on-site staffing. Permanent supported housing is a separate, self-contained response to homelessness that provides a settled environment for homeless people with support needs (see Box 4.3 for an example of Korea’s homeless women’s shelter). These services do not operate in total isolation, but they can be characterised as largely discrete rather than as examples of integrated housing and services.

Box 4.3. Integrating services in sheltered accommodation: Seoul’s Homeless Women’s shelter, Korea

Seoul’s homeless women’s shelter in Gangnam-gu, Korea offers an example of integrated social services in shelter accommodation. Seoul’s homeless women’s shelter is a large, detached, and purpose-built accommodation, with gardens and a cafe accessible to the residents and medical equipment available to staff.

There are approximately 200 women in the shelter, most of whom are middle aged (between 40-60 years of age – similar to age ranges of the homeless in other OECD countries). The women have a range of needs, including physical and mental disabilities, mental health needs, addictions, and extreme poverty. The women can enter the shelter by referral (from police), by outreach (the centre staff go into the Seoul city centre to find women), or they can present themselves at the centre to be admitted directly.

The cost of running the centre is USD 2.6 million per year, funded by the Ministry for Health and Welfare, Korea, the local government of Seoul (2.2 million in total, split 50-50 centrally and locally), and by charitable donations (the remaining USD 400 000).

The centre is managed and mostly staffed by the “Caritas Seoul” charity. The thirty-nine staff at the centre are social workers, carers, medical staff, counsellors, and a mental health specialist, as well as administrators and caretaking staff. One part-time medical doctor is also contracted to the service. The broad range of service providers on site can meet the multiple needs of the women are well cared for at the centre, however when the medical doctor staff is not on site, the staff report having to take the resident to the local hospital emergency room, at additional costs to the public budget and the client and service provider. Additional central government support to increase the working hours of the doctor (paid for by savings made to the hospital budget from reduced emergency visits) would be a cost effective solution to this problem.

A goal of the centre is to help the women return to society and reunite them with their families. To this end, multiple services are integrated at the centre. For instance, various therapies are offered, from speech and music therapy to social skills training. The women can also earn money at the centre by contributing to work organised by the centre (a sheltered employment scheme). Efforts to re-house the women are also made, and include using finger-printing to identify the women to reunite them with family members. However, in practice the success rate of this method is low; an estimate was that this was successful in about 13% of cases overall.

One limitation to the centre’s rehousing initiative is that the staff have few opportunities to offer mobile support to families rehousing the homeless women. Staff report that they are not able to visit the home or families rehousing the women in order to facilitate the transition. Mobile support is a common practice among other OECD countries when rehousing the homeless, and evidence suggests it is a cost-effective way to lower the risk of repeat homelessness (see below).

Permanent supported housing services tend to be small and used for groups like older chronically homeless people who cannot live independently (Fitzpatrick et al., 2010). Referral to permanent supported housing can come from emergency accommodation, health and social work services. Permanent supported housing is unusual in some OECD countries, but is used in Denmark and the Netherlands, which employ the SkaeveHuse model. SkaeveHuse is, in effect, not unlike small⁸ sheltered housing models for older people: there is a member of staff on site who monitors the well-being of residents and can summon help if needed, but it is a low-level “monitoring” service, not a service model offering intensive support (Meert, 2005).

Accommodation-based transitional services

The next type of homelessness services, accommodation-based transitional services are designed to re-house and re-settle homeless people into ordinary housing. Once the basic needs of a homeless person are met by putting a roof over their head and feeding them, these accommodation-based transitional services seek to move homeless people by making them “housing ready” and meeting their care and support needs. These services can use communal accommodation (shared living space) and congregate accommodation (blocks of self-contained apartments).

There are two basic models of service: a *single-site transitional service* and a *staircase model*. Both models are mainly targeted towards lone homeless people with high support needs, including chronically homeless people. Homeless people enter these programmes via referrals from emergency accommodation, hospitals, social work services, and the criminal justice system, or from homeless people directly approaching a service for help.

Single-site transitional models focus on ensuring that an individual is “housing ready”, i.e. is effectively educated to live independently in their own home using their own resources (Dant and Deacon, 1989; Pleace, 1997 and 2008). These models coordinate with health, social work and other services in order to address health and care needs that *might threaten housing sustainment*. For example, someone with a severe mental illness may have issues with their neighbours or paying their rent if they are resettled without proper treatment of their health needs (Pleace, 1997 and 2008). These single-site transitional services use a key-worker system (a regular case-worker that supports the service user), sometimes combined with a resettlement function that provides mobile on-going support to follow formerly homeless people when they move into ordinary housing (Pleace, 2008).

“Staircase” services, also known as Linear Treatment Models and Continuum services, take a more structured and self-contained approach. Staircase services are specifically designed to work with chronically homeless people, and like single-site transitional housing, are designed to make people “housing ready”. The staircase seeks to ensure that chronically homeless people abstain from drugs and alcohol and comply with physical and mental health treatments as part of being housing ready. Participants advance through a series of steps: first, emergency accommodation; second, moving into supported communal housing; third, living in less supported housing; and, finally, eventually living independently. The different “steps” on the staircase, which vary in number, can also involve physically moving between different forms of accommodation, each of which is closer to ordinary housing than the preceding step (Busch-Geertsema and Sahlin, 2007; Rosenheck, 2010).

Staircase services can sometimes be characterised by their strict and sometimes arguably harsh regimes, as they insist on abstinence from drugs and alcohol and treatment compliance. The US version of this service, the Continuum model, has been subject to sustained criticism in the past decade, and there is increasing criticism directed at European examples of this approach (Busch-Geertsema and Sahlin, 2007; Pleace, 2008). The criticisms have been threefold:

- These programmes have high rates of service user attrition; with chronically homeless people either abandoning, or being ejected, from staircase services at high rates. Some projects report losses of between 50 to 70% of service users before resettlement has occurred (Pleace, 2008).
- Chronically homeless people often become “stuck” on specific steps, unable to meet the criteria required to progress to the next step (such as non-adherence to treatment, severe mental health problems, abstinence from drugs and alcohol), and become perpetual residents in staircase services (Sahlin, 2005).
- Researchers have argued that some staircase services with harsh regimes have dehumanised, and in some respects, mistreated chronically homeless people. Of course, this is not necessarily a feature of all staircase services, some of which are more “forgiving” of lapses in behaviour than others (Pleace, 2008; Tsemberis, 2010b).

Evaluations of accommodation-based transitional services

Accommodation-based transitional services have seen some success, with between 30 to 50% of service users successfully completing the staircase (Pleace, 2008; Rosenheck, 2010). They continue to form a core component of homelessness service provision in many OECD countries. When successful, staircase services can produce housing-ready individuals whose support needs have been met, giving them a good chance of a sustained or even permanent exit from chronic homelessness (Rosenheck, 2010). Many of the recent homelessness policies have focused on services that are designed to help chronically homeless people become “housing ready” and be able to live independently.

“Housing First” and Case-management service models

Housing First and case management services differ from older service models (Section 4.4) in five key respects (Tsemberis, 2010a and 2010b):

- The services use a combination of *permanent* accommodation, support workers and case management services; they are an *integrated response* combining housing and support services to meet the needs of homeless people.
- There is no requirement to undertake a series of steps to be made “housing ready” prior to accessing permanent accommodation. Permanent accommodation is provided immediately, or as rapidly as possible, and homeless people are moved in as quickly as possible. In other words, “housing” is provided “first”. Some Housing First services offer choices of accommodation.
- Access to accommodation is not conditional on abstinence from drugs and alcohol and there is no requirement to comply with treatment for mental or physical health problems. Service users choose for themselves whether or not to use these services without affecting their access to accommodation and being allowed to remain in accommodation.

- Services follow a harm reduction approach with a recovery orientation.
- There is an explicit emphasis on treating homeless people with compassion, warmth and respect and on recognising that access to suitable housing is a human right.

Since the adoption of Housing First as federal homelessness policy in the United States (USICH, 2010), an increasing number of OECD countries are incorporating, piloting and developing Housing First services. Housing First is being explored in Australia, Austria, Belgium, Germany, Italy, the Netherlands, New Zealand, Poland, Portugal, Sweden and the United Kingdom. In Canada, Denmark, Finland, France, Ireland, Norway and the United States, Housing First approaches are at the core of national homelessness strategies. Housing First services have also become central to local and regional homelessness strategies in many economically developed countries. The EU-wide Consensus Conference on Homelessness held in late 2010 has recommended the use of what it termed “housing led” approaches (i.e. Housing First) (ECCH, 2011).

Housing First and case-management services exist in several forms. Although there is considerable variation in the details of operation, Housing First services can be broadly categorised as following the Scattered Housing First, Communal Housing First, or a Housing-led approach (Pleace and Bretherton, 2013b).

Scattered Housing First

Housing First was initially developed by the Pathways to Housing, a non-governmental organisation in New York. This innovative service was based on a mental health service model that placed service users immediately into ordinary housing, across communities – or in a “scattered-site” approach to housing rather than a “single-site” approach (ibid.) – and provided mobile support which was designed to enable and sustain resettlement into the community (Tsemberis, 2010a).

Following the Pathways model, the Scattered Housing First (SHF) strategy, mainly uses ordinary private rented housing which it secures by offering private landlords a complete housing management service (the same service assures the adequacy of the housing conditions for the service users). The service also provides 24-hour assistance through a telephone support line.

SHF uses two forms of integrated service support: an assertive community treatment (ACT) team and an intensive case management (ICM) team. The ACT team *directly supports* chronically homeless people with the highest levels of need. A ten-person ACT team would be responsible for 70 formerly chronically homeless people and is comprised of (Tsemberis, 2010a): a team leader who co-ordinates the services provided (with support from an administrative assistant); a psychiatrist (usually a part-time post); a doctor or a nurse-practitioner⁹ (usually a part-time post); a full time nurse; a qualified social worker, usually with mental health training; a specialist in supported employment; a drug and alcohol specialist; a “peer specialist” (a qualified team member who has been through the experience of chronic homelessness themselves); and in some cases a “family specialist” or a “wellness specialist” support workers whose role centres on positive reconnection with family or the development of positive relationships and healthy lifestyles.

The ICM team performs case management and works with formerly chronically homeless people with lower levels of need. The ICM enables a homeless person to connect with any services they need, including social work services, drug and alcohol

services, mental health and medical services and the welfare systems. The ICM provides some direct support itself, though its main role is focused on case management. ICM staff are each assigned up to 20 service users (Tsemberis, 2010a).

Formerly chronically homeless people using SHF have to accept the following three conditions to access the service (Tsemberis, 2010a): a weekly home visit from SHF staff; signing a tenancy or sub-tenancy, which gives them some housing rights alongside responsibilities for the apartment they live in; and, sign an agreement guaranteeing that 30% of their available income will help pay the rent.

Evaluations, costs and critiques of Scattered Housing First services

SHF was evaluated rigorously in a randomised control trial (RCT) and was found to produce a very high success rate in delivering sustained exits from homelessness. Sustained exits from homelessness occurred among 88% of the people using SHF over five years in New York. In contrast, only 47% of formerly homeless people in the comparable control group – which used staircase services – experienced a sustained exit from homelessness. This finding has been echoed in a large number of subsequent studies (Tsemberis, 2010b). A recent observational study of an Amsterdam-based service modelled on SHF reported a 77% housing sustainment rate over the course of one year (Wewerinke et al., 2012). The strength of the RCT evidence on SHF as a means of stopping sustained and recurrent chronic homelessness led the US Federal Government to recognise Housing First as “evidence-based” social policy (USICH, 2010).

SHF is dependent on a supply of adequate, affordable housing which can offer some security of tenure. Johnson et al. (2012) have noted that although much attention has been paid to the support offered by SHF, part of SHF’s success will be driven by the efficiency with which it secures suitable housing. Equally, the ICM component of SHF is dependent on good working relationships with and sufficient access to externally provided health, social work and other support and welfare services (Tsemberis, 2010a).

SHF found Housing First costs to be 28% less than maintaining a chronically homeless person in emergency accommodation (USD 57 a night for SHF compared to USD 71 a night in emergency accommodation).¹⁰ SHF also claims significant cost offsets, centring on reductions in use of emergency medical services and mental health services and a reduction in arrests and short term imprisonment. The “stabilising” effect of housing has been associated with less severe mental illness, stabilising problematic alcohol use, and reducing the use of emergency medical services (Padgett, 2007; Pearson et al., 2009).

Critics of the SHF strategy present three main arguments. The first is that SHF cannot always meet the needs of chronically homeless people who need continuous monitoring, because the strategy uses dispersed housing and mobile support workers (Kertesz et al., 2009). The second criticism is that while SHF can enhance well-being and mental health problems, rehoused homeless people may still suffer from social and economic exclusion and problematic drug and alcohol use (Stanhope and Dunn, 2011; Johnson et al., 2012). The third criticism is that SHF models are less ambitious than staircase models, which seek to address user needs comprehensively in order to make chronically homeless people “housing ready” (Edens et al., 2011). These criticisms highlight some practical limits to what even integrated responses can reasonably be expected to do for chronically homeless people. Chronically homeless people are a high-need group, and some failures and set backs are likely. A strategic or service-level response that fully addresses the

needs of very vulnerable people – like the chronically homeless – has yet to be devised (Busch-Geertsema, 2005; Richardson, 2009; Pleace, 2012a).

Communal Housing First

Communal Housing First (CHF) services follow the same philosophy as SHF with one key difference. The CHF services provide *permanent* accommodation in dedicated communal or congregate buildings with single rooms or self-contained apartments with on-site staffing (a single-site model) – there is no staircase, and no expectation for the residents to move. Security of tenure is offered, but there is effectively no choice in where to live.

CHF may directly provide psychiatric, drug and alcohol services and medical services and may use case management to arrange access to externally provided services. CHF services follow a harm reduction approach, and, as with SHF, there is no requirement to stop drinking, taking drugs¹¹ or to comply with drug and alcohol or mental health treatment in order to access and remain within the provided accommodation. The permanent communal and congregate accommodation directly provided by CHF only has the same sort of requirements attached to a normal tenancy or lease agreement i.e. agreeing not to behave in an anti-social way and make an agreed financial contribution to the rent.

CHF exists in several forms in different OECD countries. Some of the Housing First service models that can be described as CHF include:

- “Project-based” Housing First services were developed in the United States for very high need groups of chronic homeless people. Such services have been deliberately targeted on chronically homeless people who make the most extensive and expensive use of emergency medical services, and/or have frequent contact with the criminal justice system (Larimer et al., 2009).
- The Finnish “Name of the Door” Programme has seen a large scale conversion of hostels and emergency accommodation into what is referred to as a “Housing First” model using congregate self-contained flats with on-site staffing (Busch-Geertsema, 2010a; Kaakinen, 2012; Kettunen and Granfelt, 2011; Tainio and Fredriksson, 2009; Tsemberis, 2011).
- Some examples of “Common Ground” services provide permanent housing with support within a harm reduction framework¹² (Jost et al., 2011). Some Common Ground services combine permanent housing for formerly homeless people with low cost housing for working households in the same accommodation block.¹³ The Common Ground approach has been influential in Australian policy responses to chronic homelessness (Parsell and Jones, 2012).¹⁴

Evaluations, costs, and critiques of Communal Housing First services

The evidence base for CHF services is less developed than for SHF. Some US research shows CHF produced sustained exit from chronic homelessness (Larimer et al., 2009; Collins et al., 2011; Collins et al., 2012). In Finland, CHF services are regarded as successful at reducing chronic homelessness although this success is sometimes expressed in terms of a reduction in visible chronic homelessness (Busch-Geertsema, 2010a; Kettunen and Granfelt, 2011; Luomanen, 2010). Recent Finnish figures suggest a 32 % fall in long-term homelessness from 3 600 in 2008 to 2 730 in 2011 (Kaakinen, 2012). While there is some evidence that the Common Ground model can provide

sustained exits from chronic homelessness (Jost et al., 2011), the Common Ground approach has not yet been subjected to the same level of evaluation as other forms of Housing First (Parsell and Jones, 2012).

Data on the cost effectiveness of CHF are confined to the United States. One study estimated that there was an annual gross saving of USD 12 million for emergency and criminal justice services by stably housing 95 very “high cost” chronically homeless people. However, the net saving appears less spectacular given that the CHF project had itself cost close to USD 11 million to develop. That said, social outcomes also improved, the chronically homeless people using CHF experienced improvements in well-being, and the city in which CHF was based experienced a reduction in chronic homelessness (Larimer et al., 2009).

Other studies have reported significant reductions in alcohol use among CHF participants, which could reduce emergency health and possibly criminal justice costs, although this has yet to be evaluated (Collins et al., 2011; Collins et al., 2012). Common Ground itself estimates that the annual cost of housing a formerly chronically homeless person in a Common Ground scheme is currently some USD 24 190, less than half the estimated cost of the emergency accommodation, medical, homelessness shelter and other services that Common Ground calculates they would use on average if they remained homeless for one year.¹⁵

CHF models have a considerable capital cost, giving CHF services higher start-up costs than those of SHF (Larimer et al., 2009; Tsemberis, 2010a). A CHF service is also visible in a way that SHF is not, because it is a block containing apartments. It does not “scatter” chronically homeless people across a community in ordinary housing like SHF does. This means CHF developments may have to deal with NIMBY attitudes.¹⁶ Like SHF, CHF services may be partially or largely reliant on case management and effective joint working with externally provided health, mental health, drug and alcohol and other health and welfare services. Similar to SHF, CHF may be adversely affected if external services are difficult to access.

Criticisms of the CHF model are fourfold. First, CHF services are criticised for not following a consistent operational model, which is part of the general criticism that the range of services calling themselves “Housing First” are actually rather diverse. It is possible to argue that the CHF model is less clear and consistent model than SHF is. Consequently, one must understand which features of a specific CHF model make it effective before replicating the programme (Tabol et al., 2009). Though this is a valid critique, the success of the Housing First approaches arguably lies in their *general philosophy*. Housing First appears to be successful because the provision of accommodation is *not* conditional on treatment compliance with drug and alcohol and/or mental health services, and this harm reduction approach gives choices and control to homeless people who are treated with respect and compassion (Pleace, 2012a).

The second criticism of CHF is that service users have little control over where they live. While SHF can offer at least a constrained choice of locations and types of housing sponsored by the project, CHF offers just one accommodation option. This choice constraint limits homeless people from choosing where they live, which may make a sustainable exit from homelessness more challenging (Tsemberis, 2011). This criticism can be countered by pointing to the high rates at which formerly chronically homeless people elect to remain in CHF services, whereas chronically homeless people abandoned or were ejected from some staircase services at a high rate (Pleace, 2008).

The third criticism is that CHF models separate formerly chronically homeless people from the communities in which they live (Tsemberis, 2011). In contrast, the SHF model houses homeless people across the community in order to facilitate social inclusion. As CHF models provide permanent but also *separate*, communal and congregate accommodation, some programmes are sometimes criticised as keeping service users “apart” from the community rather than placing them within the community. However, even in the SHF model, homeless people can become isolated or remain in toxic local neighbourhoods (Pleace, 2012a). The Common Ground approach of using a mix of other resident groups within the same block of permanent congregate housing is designed to facilitate a sense of community and social inclusion.

The fourth criticism of the CHF model focuses on the presence of several formerly chronically homeless people living in the same environment. Critics argue that CHF can become an environment in which many people use drugs and drink alcohol, and is not an ideal place to overcome substance abuse or other issues (Kettunen and Granfelt, 2011). CHF services that are well run and which carefully consider the “balance” of residents’ needs may be able to avoid these issues. However, this might mean some of the most complex people with the highest needs may be unsuitable for a CHF environment.

Following the Housing First philosophy

The existing evidence base indicates that services following the *philosophy* of Housing First are generally more effective than other forms of homelessness service. This suggests there should be a concern with assessing *fidelity* or commitment across service providers to the Housing First philosophy (Tsemberis, 2011a). Without what Tsemberis, the originator of SHF model, has defined as a “fidelity test” (Tsemberis, 2011a) being applied, it cannot be clear that Housing First services are *actually* being implemented. The first test that should be applied to “Housing First” services and strategies should therefore be centred on ensuring the right kind of services are in place, before then moving on to consider outcomes and costs. Three examples can be used to illustrate the risk of not using a fidelity test:

- classifying time-limited mobile support services that expect homeless people to be “resettled” to a set timetable – a model that is unlikely to work – as “Housing First”,
- defining services in which the staff team look upon service users as “deviant” individuals whose behaviour needs to be “corrected” – again a service model that is unlikely to work – as “Housing First”,
- replacing existing dedicated homelessness services with a very low-cost system of mobile generic support workers who lack specific training and who have very little contact with service users, in effect diluting the “Housing First” concept to an extent where it is unlikely to be effective.

Beyond the fidelity test, the key indicators of success of a Housing First-based strategy centre on the extent to which the numbers of chronically homeless people, and the financial and other costs of chronic homelessness, are reduced. This is the test of effectiveness of Housing First and related policies that has been applied in Finland and the United States, the two countries that are furthest ahead in using Housing First models as a core element in their responses to homelessness. Both countries track both their *overall* levels of homelessness and the element of chronic homelessness¹⁷ within overall homelessness and both have reported what they have interpreted as falls in their levels of chronic homelessness (Kaakinen, 2012; SAMSHA, 2011).

Sustainably ending chronic homelessness does not end all the support needs or necessarily improve the living situation of a formerly chronically homeless person to an acceptable level. This raises questions around assessing the gains to well-being associated with Housing First over the medium to long term, and also about the evaluation of co-ordination and joint working between Housing First and other welfare and social policies. Housing First is only likely to see its largest returns if it achieves economic integration of the homeless through paid employment, but for this to work co-ordination with education, training and employment-related services will be needed. Over time, the successful co-ordination of Housing First and other services to provide sustainable inclusion in the community and in paid work is a further area where programmes, and evaluations, could be introduced (recent discussion in the field has moved on to post-homeless social integration – see Pleace and Quilgars, 2013).

Housing-led models

Housing-led models (see Pleace and Bretherton, 2013b) have the same basic operation as SHF, employing mobile workers and immediately re-housing homeless people into ordinary housing dispersed across a community:

- Housing-led models include relatively *low intensity* services that use *case management* to support formerly homeless people in ordinary housing. These services can differ from distinct from SHF services in three ways:
 - Housing-led services do not necessarily employ an ACT team and there is no direct provision of health care or personal care by a Housing-led service. Access to mental health, medical, drug and alcohol and other health and support services, is only secured through case management.
 - Housing-led services are low intensity. The main function of the Housing-led team is to case manage a package of services and ensure that sufficient supports are in place to facilitate tenancy sustainment. The Housing-led team will provide little or no direct support to someone using a Housing-led service.
 - Housing-led services can be used for homeless people with moderate support needs as well as chronically homeless people because the packages of support arranged via case management can be adjusted to meet different levels of need.
- Case management models are a form of Housing-led models that were originally developed without reference to the SHF model. These services reflect many of the same operating assumptions and the wider philosophy of SHF but did not derive these ideas from SHF. Case management services again offer low intensity support service using mobile support services.

Housing-led services – which for the purposes of this chapter *include* case management service models – share a number of core operating principles with the SHF model. Housing-led services resemble SHF through design and because they were developed in contexts in which some of the core ideas of Housing First were already present in homelessness and social policy (Johnsen and Teixeira, 2012).

Alongside being low intensity case-management services, Housing-led differs from SHF and CHF approaches insofar as Housing-led models work with both chronically homeless people and homeless people with more moderate support needs. The low intensity case management model used by Housing-led models can be “scaled” to

differing levels of need, drawing together both high intensity and lower intensity packages of support for homeless people as necessary (Pleace, 1997; Franklin, 1999; Pleace and Quilgars, 2003; Bowpitt and Harding, 2008; Lomax and Netto, 2008; Tsai et al., 2010; Waagemakers-Schiff and Rook, 2012).

Housing-led services are therefore distinct from SHF and CHF models in that they have the potential to support homeless people whose needs cannot be met simply through access to adequate and affordable housing and who require some support during the initial stages of resettlement. The Housing-led model might be used for homeless people whose support needs are not ongoing or which only occur sporadically, whereas SHF and CHF are designed for high-need chronically homeless people who are likely to need at least some ongoing support to sustain an exit from homelessness.

Homelessness services using mobile workers who resettle formerly homeless people in ordinary housing as the final “step” within a staircase service are *not* Housing First or Housing-led models. Mobile resettlement services attached to staircase services are part of an approach that is centred on making homeless people “housing ready” through a series of largely institution-based steps are also *not* Housing First or Housing-led models. By contrast, Housing First or Housing-led approaches *immediately* provide housing with no requirement to be “housing ready” and *separate* provision of housing and support.

A Housing-led service must also have some capacity to provide on-going support. A mobile support service that sets a fixed one or two-year timetable within which a formerly homeless person must be living entirely independently is *not* “Housing-led”. Housing-led services may scale back the level of support they provide as someone becomes more confident and capable in living independently, just as SHF services have the capacity to do, but must also have the capacity to re-engage if needed. Some Housing-led models operate on the basis that they become “dormant” when the team and a formerly homeless person agree that independent living is possible, but can be called upon if needed on an ongoing basis (Lomax and Netto, 2008).

Evaluations, costs and critiques of Housing-led services

There is some evidence that Housing-led services can promote sustainable exits from chronic homelessness. In one US study, a Housing-led service providing subsidised access to adequate and affordable housing alongside low intensity case management increased housing stability, reporting a 65% housing sustainment rate¹⁸ among chronically homeless veterans (Rosenheck, 2010). This level of housing sustainment is lower than, though comparable with that achieved by SHF and CHF models. But it should be noted that evidence on Housing-led models is less extensive and robust than for SHF or CHF and available data are sometimes cross-sectional and qualitative (Goldfinger et al., 1999; Pleace, 1997; Lipton et al., 2000).

The costs of Housing-led services are relatively low in terms of direct service delivery. Costs are lower than SHF because there is no ACT or similar direct delivery of mental health, health and drug and alcohol services, and lower than CHF services because there is no purpose-built accommodation. The wider costs of a Housing-led service may be relatively high, however. A Housing-led service may *increase* short-term costs when it connects formerly homeless people with mainstream health and welfare services that they need, but could hitherto not access. Over the medium and long term, a Housing-led service should, as with other integrated housing and support services (Culhane, 2008) generate cost benefits by reducing sustained and recurrent chronic homelessness.

The financial benefits of Housing First strategies are most obvious when working with chronically homeless people with very high support needs. The financial “pay off” from using SHF and CHF would become smaller or non-existent if working with homeless people with moderate support needs who do not frequently use emergency services or the criminal justice system (Kertesz and Weiner, 2009; Stanhope and Dunn, 2011). Of course, SHF and CHF services are *only* designed for chronically homeless people and are not intended as a “global” response to homelessness. Thus, arguments supporting the cost effectiveness of SHF and CHF are made on the basis that these services are for chronically homeless people (Tsemberis, 2010b; Larimer et al., 2009). Housing-led models, by contrast, can work with chronically homeless people with less pronounced needs (Rosenheck, 2010).

Like SHF services, the Housing-led approach depends on securing a sufficient, adequate and affordable housing supply. Equally, like other forms of Housing First which rely on case management, Housing-led models must reliably access health, social work, drug and alcohol and other external services in order to function well.

4.5. Using integrated housing and services for homelessness prevention

Homelessness prevention refers to intercepting homelessness before it occurs. The United Kingdom has led policy developments on homelessness prevention, focusing specific services to people who are at risk of living rough and other forms of homelessness. An emphasis on prevention can also be seen in Germany and the United States (Pawson et al., 2007; Busch-Geertsema and Fitzpatrick, 2008; Culhane et al., 2011).

As described earlier in this chapter, homelessness exists in multiple forms that can be broadly divided into a low need population who become homeless for short periods of time and a smaller, higher need, chronically homeless population. Prevention can happen on two levels. The first level is targeted on transitional homelessness that is associated with loss of income, loss of affordable housing, and relationship breakdown among people with low support needs. While this population often self-exits from homelessness, preventative services can avoid transitional homelessness among people who have *temporarily* lost the resources to house themselves, through provision of advice and support to secure replacement affordable housing, welfare safety nets, help getting into paid work and through housing subsidies (Pawson et al., 2007).

The second level of prevention is stop chronic homelessness from occurring. In this second level of prevention there is a role for Housing First models in working with high need groups who are at potential risk of chronic homelessness. As noted above, people with *multiple categories of high support need* do appear to have a higher likelihood of experiencing chronic homelessness, particularly if they experience one or more of the following: problematic drug and alcohol use; severe mental illness; a history of low-level criminality and imprisonment; a history of institutional care (Culhane and Kuhn, 1998; Kemp et al., 2006; Culhane and Byrne, 2010; Fitzpatrick et al., 2011).

Housing First can take referrals from service providers working with people with a history of, or a heightened risk of, chronic homelessness. SHF services for example take referrals both from homelessness services and from psychiatric hospitals and prisons (Tsemberis, 2010a). The United Kingdom uses Housing-led services that are specifically designed to prevent chronic homelessness among high risk groups including 16-18 year-olds leaving the care of social work services and people leaving prison (Quilgars et al., 2009; Pleace and Minton, 2009; Quilgars et al., 2008).

In a wider sense, all Housing First services have a preventative function because they are specifically designed to prevent a recurrence of homelessness. The same risk factors and needs that are important in preventing recurrence of chronic homelessness are often the same as those which need to be addressed to prevent chronic homelessness from occurring in the first instance. If chronic homelessness can, in effect, be “intercepted” by Housing First services before it actually occurs, the potential gains for individuals and society are considerable (Culhane et al., 2011).

4.6. National homelessness strategies and integration: Commitments and key challenges

To effectively integrate key public services for the homeless, national strategies have been put in place that require links across policy sectors to be made.

National strategies for the homeless: Efforts to integrate services and their evaluations

Nearly one-third of OECD countries have committed to integrating social services for the homeless in an official national strategy (see Annex Table 4.A1.1). Fourteen OECD countries have active national strategies to combat homeless, or have legislation that explicitly addresses the problem of homelessness. Of these countries, 12 mention co-operation at the governance level, 12 mention the integration of service delivery, and 11 highlight an active role for civil society.

National strategies for ending homelessness are reasonably recent developments. Some northern European countries (Finland, the Netherlands, Norway, and Sweden) and Canada have had strategies for addressing homelessness in place since before the financial crisis (pre-2008), while in the other OECD countries homelessness plans were developed later (for example Australia, France, Ireland, and United States). The most recent developments included Prague’s (Czech Republic) city-wide strategy – and the national strategy led by the Ministry of Labour and Social Affairs – to address homelessness, the piloting of Housing First in Vienna, Austria, Spain’s development of a homelessness strategy as part of its national inclusion strategy (2013-16). In the remaining OECD countries, however, a national strategy to end homelessness is missing (although anti-homelessness legislation has existed in Japan since 1992 – see Annex Table 4.A1.1).

National strategies are often implemented by multiple levels of governance and with the delivery of a broad mix of services for homeless people. In some cases, however, integration functions only at the national level, with ministries co-operating through inter-ministerial delegations or cross-departmental teams [France, Ireland, Luxembourg, United Kingdom (Northern Ireland, Scotland and Wales) and United States (though actual policy is city and state-level led)]. While for some national strategies, central or regional governments, local communities and the private and voluntary sectors co-operate through collaboration platforms and collaboration agreements (Australia, Canada, Denmark, Finland, Luxembourg, the Netherlands, Norway, and Sweden).

In almost all countries, a broad mix of services is offered in addition to housing (such as physical and mental health supports, drug rehabilitation, or training opportunities), as national strategies often focus on integrating housing and support systems. The housing component of the strategies is delivered under Housing First principles in some countries (for example in Canada, Denmark, Finland, and France).

Evidence from available evaluations of the national strategies suggests that both vertical and horizontal integration of services constitutes a meaningful response to the complex needs of homeless people. In Canada and the United States, for instance, cooperation between different levels of governance created strategic alignment of goals and priorities deemed critical in achieving the targeted goals most efficiently. In the United States, the three state agencies involved have created “Solving Veterans Homelessness as One” (SVHO), a joint strategic planning and decision-making framework to address issues that require an interagency response. In Norway, an evaluation of the national strategy proposes greater co-ordinated action through “multi-level governance” in order to provide all stakeholders with “ownership” of the national strategy, in order to improve information sharing among the different service providers (Dyb et al., 2008). In Finland, the evaluation of the effect of the national programme to end homelessness in Tampere suggested that significant savings could be generated from a nationally defined integrated approach (it was estimated that in Tampere the total annual savings for 15 residents in the unit in question amounted to around EUR 220 000; Busch-Geertsema, 2010a).

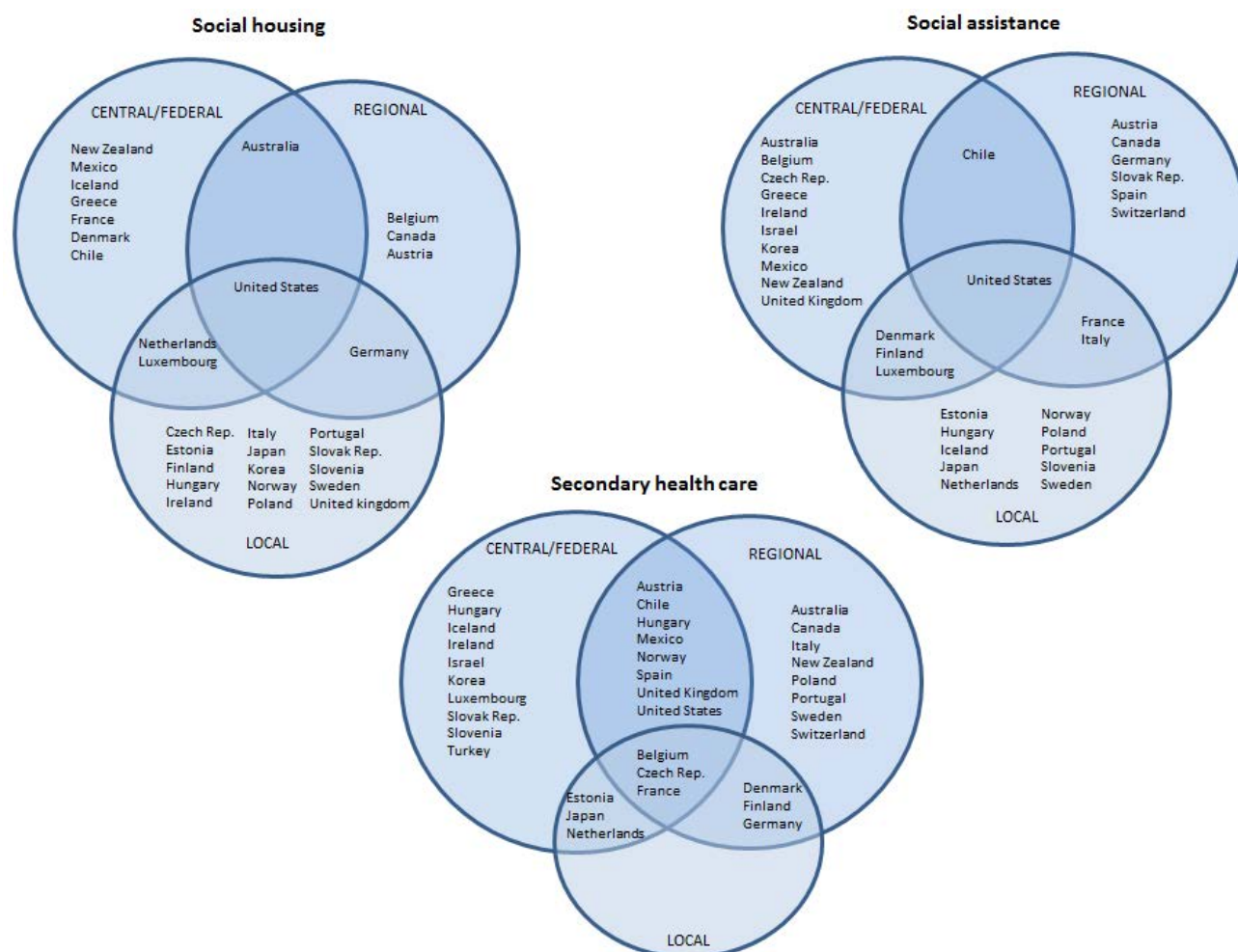
Finally, Housing First approaches, as part of national strategies, have proved to be successful at housing the homeless in Denmark, Finland, and the Netherlands. However, the experience of Ireland cautions that Housing First approaches should make-up one part of a wider mix of service responses to long-term homelessness, as the housing-led approach cannot address the needs of all homeless persons (Pleace and Bretherton, 2013a).

Links across sectors with homeless services

Key services for the homeless, such as social housing provision, social protection supports, and specialist and emergency health interventions, are managed and financed at different levels of governance across most of the OECD (see Figure 4.2). With the exceptions of Canada and Greece, where three of the critical homeless services are managed at the central and regional levels respectively, all OECD countries face a challenge to integrate horizontally, as well as vertically, when providing co-ordinated homeless support services. Challenges, however, persist even when different services are managed at the same level of governance. In Canada, for example, horizontal integration remains a challenge; however, several provinces are working towards improving horizontal integration. For example, the province of Alberta has created an Interagency Council on Homelessness to address horizontal integration at the provincial level.

No OECD country entirely devolves responsibility for secondary health care to local governments, whereas 15 social housing systems and ten social assistance systems are delivered at the local level. Moreover, five countries in the provision social housing, six countries in social assistance and 17 countries in secondary health care provision, already contend with degrees of vertical integration in the provision of these independent services.

Figure 4.2. Key services for the homeless are often split between central, regional and local governments



Note: **Social housing** refers to housing services allocated and managed by a public body, often delivered using targeting strategies to ensure those in most need are housed. **Social assistance** refers to cash social protection policies providing cash supports via minimum income or social insurance schemes. **Secondary health care** refers to medical care provided by a specialist or facility upon referral by a primary care physician or emergency service hospital services.

Source: OECD (2013), “Questionnaire on Integrated Services Delivery”, Unpublished Social Policy Questionnaire.

All of these services play an important role in supporting homeless individuals, but some have a comparative advantage in identification or leading treatment.

Social housing and assistance systems should take a lead role in identifying people at risk of homelessness; similarly, the secondary health care system should be used to identify people who are already homeless. Because the chronic homeless will have limited access to social security supports in many countries, it is unlikely that social assistance systems will identify individuals who are homeless. The same may be said of social housing systems that do not provide shelter services, or do not systematically monitor the reason for exit from the social housing system. It is more likely that either service will be able to identify persons at a homelessness risk (and could be trained to do so as a matter of course). Secondary health systems care systems, however, are probably

the best able to identify people who are sleeping rough, or are homeless as they present to emergency services.

For treating the homeless, the accumulated evidence above suggests that housing ministries – or ministries managing housing benefits, and associated social protection, where there is limited access to social housing provisions – should take the lead in providing housing in advance of medical interventions and general social welfare supports. This provides stability. Social protection services and mental health services, as well as housing services, are all key to identifying homelessness risks and therefore contributing to prevention. The education system and early childhood services also play an important role in addressing the needs of vulnerable children and youth who may be at risk of homelessness (for further discussion, see Chapter 3). Social protection services will be able to contribute to reducing the proportion of the population experiencing housing insecurity.

4.7. The need for a service mix in responding to homelessness

The available evidence suggests that many OECD countries have relatively large transitionally homeless populations with low support needs whose homelessness is best addressed through a range of existing economic, welfare and housing policies. Financial or low-level practical assistance from NGOs or governments, ranging from support for securing employment to help in paying the rent, can minimise and prevent transitional homelessness (Shinn, 1998). Co-ordination of mainstream social, health and housing services can also be beneficial to address vulnerabilities that exacerbate the risk of homelessness.

In contrast, chronically homeless people require specifically tailored support to exit homelessness, and people with multiple sets of needs require support to avoid becoming homeless in the first place (Busch-Geertsema et al., 2010; Fitzpatrick et al., 2012). Several OECD countries have a range of resettlement, staircase services and Housing-led services focused on *specific* groups of homeless people (Anderson, 2010; Homeless Link, 2012). The following groups are examples of people with high support needs that are likely to need specifically tailored services:

- young people with a history of care by social work departments who are about to leave that care,
- lone women and lone parents who are women with dependent children whose homelessness has resulted from domestic/gender-based violence from a male partner,
- people with health needs that are associated with uniquely military experiences centred around having been in combat,
- people who exhibit persistent low level criminality and who require specific support to stop offending behaviour,
- people from cultural backgrounds whose situations and belief systems make it difficult for them to use mainstream homelessness services, or who might encounter prejudice from other service users (for example, homeless people who have Roma origins (Pleace, 2011a).

Finally, there is scope for innovation in service development. For example, recent research has highlighted widespread policy neglect of women's experiences of

homelessness and the interplay between gender-based violence and the causation of homelessness (Baptista, 2010; Mayock and Sheridan, 2012). Relatively little attention has been paid to the role of Housing First services in specifically supporting women and what role Housing First might take among lone women parents who have higher support needs and dependent children.

Notes

1. With the permission of the author, this chapter largely draws from Pleace (2012a) prepared for the OECD Consultation on Integrated Services and Housing in November of 2012.
2. Various definitions are used to describe people with high support needs who experience sustained and repeated homelessness. When referring to chronic homelessness or “chronically homeless people” this chapter draws from the American definition of those with sustained or repeated homelessness associated with high or very high support needs. The US federal government’s definition is “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years”. Rough sleepers are distinguished from chronically homeless people, as the former term includes people living and sleeping rough (on the street, etc.), but not necessarily for extended or repeated periods.
3. In the review of international surveys of homelessness by Fitzpatrick and Stephens (2007), the authors show that the majority of homeless are indeed unemployed single middle-aged males, often from indigenous or foreign populations, and in some cases with health (mental and physical) problems. Females and families with children are also visible in the statistics of the hidden and transitional forms of homeless (2007, pp. 54-55).
4. It must be noted that more surveyors were used in Seoul to conduct a more comprehensive investigation.
5. This chapter broadly defines housing insecurity as households unable to afford housing costs at any point in a given year. It should be noted, however, that as for homelessness, definitions of housing insecurity vary, and can encompass aspects such as being threatened with severe exclusion due to insecure tenancies; eviction, or domestic violence.
6. US family homelessness is disproportionately experienced by lone women with children, whose homelessness is linked to relationship breakdown, often involving male domestic violence.
7. 1998 prices.
8. 6-10 residents.
9. A nurse practitioner shares some training with doctors and can prescribe some drugs.
10. www.pathwaystohousing.org/content/our_model.
11. CHF services would not in any way facilitate drug use and would often remove someone who was selling drugs or committing any other criminal offence.
12. www.commonground.org/mission-model/why-common-ground-works/.
13. www.commonground.org/.

14. However, it should be noted that some Common Ground services use a *transitional* service model, a kind of “tolerant” staircase approach and it is only the *permanent housing* provided by “Common Ground” that might be seen as a form of CHF. Common Ground also operates short term supported accommodation services that might be termed a form of *staircase*, albeit without the strict regimes of some earlier models. These services offer *transitional* housing with support from which chronically homeless people are expected to move on into more independent living and, while they are not a staircase service in the orthodox sense, these services are *not* a form of Housing First.
15. www.commonground.org/mission-model/why-common-ground-works/.
16. “Not in My Back Yard”, i.e. local resistance to the physical placement of a new service provider.
17. “Long-term” homeless people with support needs in Finland.
18. Based on a specific measure of staying in their housing for 65% of the nights covered by a longitudinal evaluation, a higher rate than for comparison groups getting time limited case management.

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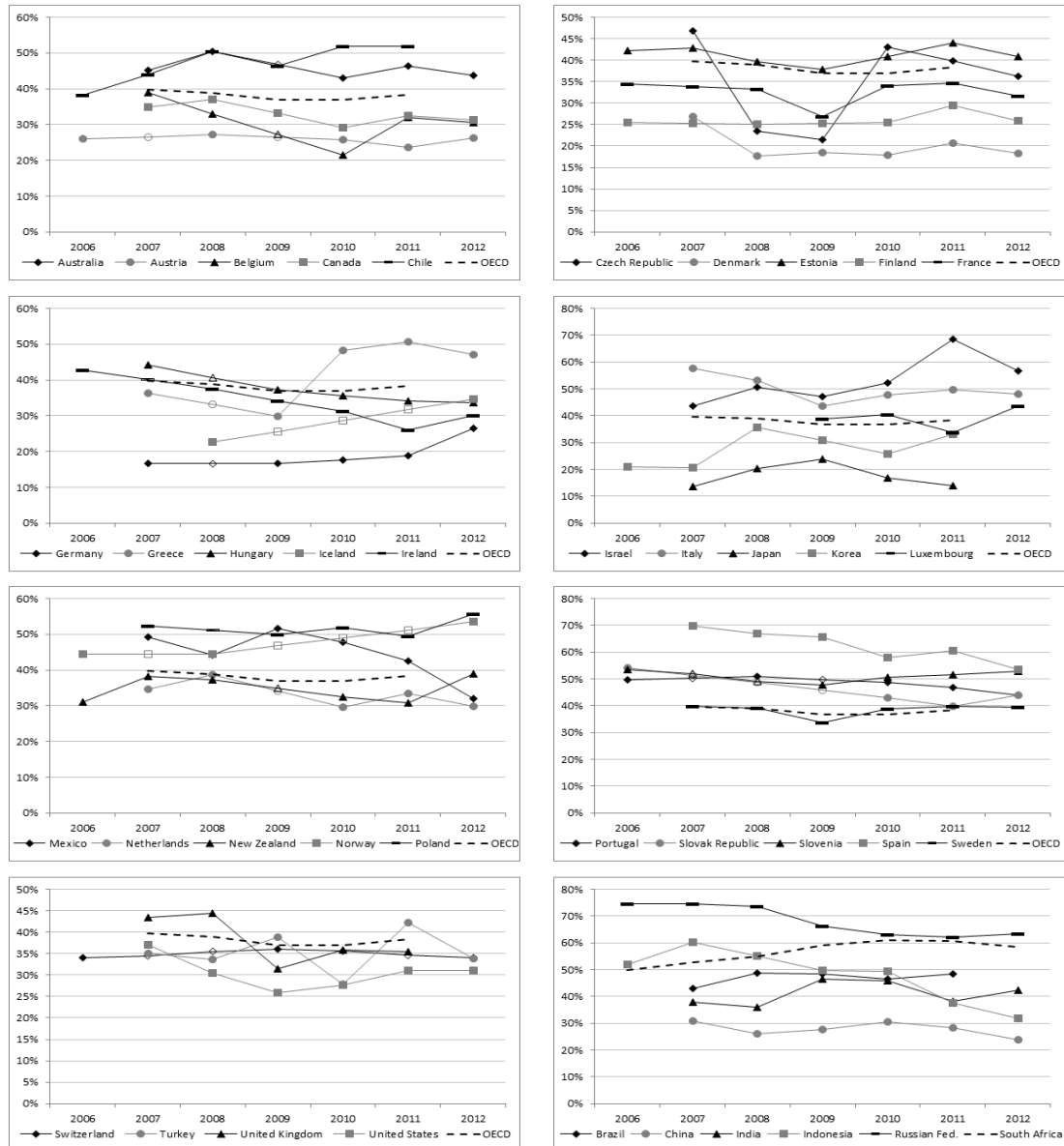
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Annex 4.A1

Supporting figures and tables

Figure 4.A1.1. People reporting being dissatisfied with the level of good quality affordable housing in the city or area where they live, trends from 2005 to 2012 (or latest available year)



Note: The Gallup World Poll was conducted by telephone in approximately 140 countries in total, and all OECD countries, using a common questionnaire translated into the main national languages. Samples are nationally representative of the resident population aged 15 and over in the entire country, including rural areas in most cases. Sample sizes are limited to around 1 000 persons in most countries (exceptions include Iceland and Luxembourg [c. 500]; Japan and New Zealand [c. 750]). Data for Germany and Japan are the average of four quarterly samples. Observed data points on each trend line are “filled”, estimates are “empty”.

Source: Gallup World Poll (2014), www.gallup.com/strategicconsulting/en-us/worldpoll.aspx.

Table 4.A1.1. National strategies for combatting homelessness and their “social integration” commitments

Country	Source	Description of main national strategies	More than one ministry/ level of governance	Multiple services delivered (in addition to housing)	Involvement of private actors
Australia	Commonwealth of Australia (2008)	To substantially reduce homelessness and achieve the high level outcomes agreed to by all governments under the National Affordable Housing Agreement, services available to homeless must all work better together (i.e. state and territory housing authorities, universal employment services, schools, health services, including hospitals, mental health and drug and alcohol services, family and children’s services, aged care services. The COAG Reform Council monitors progress against the outcomes and performance indicators in the NAHA.	No	Yes	Yes
Austria		There is no national homelessness strategy. In 2013 Vienna introduced a pilot for a Vienna Housing First Initiative to provide care for the homeless in homes provided by the Viennese government with the purpose of facilitating sustainable community integration and addressing homeless persons’ deprivation.	No	No	No
Belgium	FEANTSA (2012)	Most competencies relating to homelessness are at the level of the regions. In Flanders, work is ongoing on a regional strategy. At Federal level, homelessness was included in the National Action Plans against poverty and social exclusion. There is an Inter-ministerial committee on social inclusion and the social economy (CIM) which brings together different ministries of the Federal Government, the Communities and the Regions. One of its five working groups is dedicated to homelessness. A temporary, federal, inter-ministerial group on homelessness was created in 2011 to focus on the crisis in winter shelter capacity. Homelessness was also a major priority for the Belgian Presidency of the EU Council in 2010. The Federal Government has now introduced a small scale pilot programme to test Housing First in five cities: www.housingfirstbelgium.be/	Yes	No	No
Canada	FEANTSA (2012)	On April 1, 2007, the Government of Canada introduced the Homelessness Partnering Strategy (HPS), a strategy aimed at preventing and reducing homelessness in Canada. The HPS provides direct financial support to 61 urban communities, as well as Aboriginal, and rural and remote communities across Canada, to help them address their local homelessness needs. This approach provides communities with the flexibility to invest in proven approaches that reduce homelessness at the local level. The HPS funds local priorities identified by communities through a comprehensive community planning process involving officials from all levels of government, community stakeholders, and the private and voluntary sectors. The Government of Canada recognises that the provision of safe, stable housing and related supports is an important element to addressing homelessness and helping individuals achieve greater self-sufficiency and improved quality of life. The HPS therefore focuses communities to adopt longer-term solutions, such as the Housing First approach, as a cornerstone of their plan to address homelessness. The Government of Canada’s Economic Action Plan 2013 announced nearly \$600 million over five years (2014–2019) to the HPS focused primarily on a Housing First approach.	Yes	Yes	Yes

Table 4.A1.1. National strategies for combatting homelessness and their “social integration” commitments
(cont.)

Country	Source	Description of main national strategies	More than one ministry/ level of governance	Multiple services delivered (in addition to housing)	Involvement of private actors
Chile	Ministry of Social Development (2014)	<p>The Ministry of Social Development (Ministerio de Desarrollo Social or MDS) has lead responsibility for homelessness, being the Ministry that targets and coordinates the social programs directed to the most vulnerable people. In addition, this Ministry elaborated and implemented the two registries of homeless people realized in Chile. In practice the Ministry of Social Development maintains, through the National Office of Homeless People (translation for Oficina Nacional de Calle), periodical communication with other ministries, services and private institution that work with homeless people, coordinating the design and implementation of the different policies targeted on homeless.</p> <p>Currently, Chile has six social programmes that focus, directly or indirectly, on homeless people (for further information on these programs, use the filter “Condición de beneficiarios” à “personas en situación de calle” in www.programassociales.cl). The strategy has different levels of interventions and goals, the more urgent being to offer shelter, health protection and other services to homeless people during winter. The strategy also aim to reintegrate these persons to society, offering them assistance in areas like housing, health, job training and search, drug and alcohol treatment, etc. Several social programs, including “ Apoyo a personal en situacion de calle”, “Plan de invierno noche digna”, and “ Centros para la superacion” offer integrated support in the form of multidisciplinary temas or multiagency working across sectors (e.g. health, labour, education and social services).</p>	Yes	Yes	Yes
Czech Republic	FEANTSA (2012)	The “Concept of Preventing and Tackling Homelessness Issues in the Czech Republic until 2020” was adopted by the government in August 2013. In order to develop the Concept, an Expert Group on Tackling Homelessness was created, attached to the The Ministry of Labour and Social Affairs (MoLSA) Commission for Social Inclusion. NGOs working on homelessness, experts from relevant ministries and academics are represented among the members of the expert group. Since the Concept’s adoption, the Expert Group supervises and monitors the implementation of particular measures. The whole system of proposed solutions in the Concept is based on the definition of four trajectories describing routes into homelessness. The strategy is also based on economic analysis calculations of the costs of homelessness and of various solutions. The City of Prague has also adopted its own local homelessness strategy.	No	No	No
Denmark	FEANTSA (2012), Ministry of Social Affairs (2009), Kenneth Hansen (2010)	The Danish Government developed a national homelessness strategy for the period 2009-2012. The objective is to reduce homelessness and to help as many homeless citizens as possible to exit homelessness and live worthwhile and stable lives in their own homes. Initially, eight municipalities co-operated with the Ministry of the Interior and Social Affairs to transform the Homelessness Strategy into specific initiatives to tackle homelessness. Local social authorities have considerable room to develop modes of interventions in homelessness services and policies. Although they are almost entirely publicly funded, NGOs are often involved in running the services. The Homelessness Strategy takes its starting point in a “Housing First” approach. Approximately DKK 500 million (EUR 67 million) were earmarked for the strategy in the period.	Yes	Yes	Yes
Estonia	FEANTSA (2012)	No national strategy to tackle homelessness is in place in Estonia. A strategy for social inclusion follows the common objectives of the European Union to decrease poverty and social exclusion. The basis for the strategy is the Joint Inclusion Memorandum (JIM, 2003) which analyses the causes of poverty and social exclusion, assesses the influence of current policies on decreasing poverty and exclusion and defines the most important challenges and fields of activity to increase social inclusion.	No	No	No

Table 4.A1.1. National strategies for combatting homelessness and their “social integration” commitments
(cont.)

Country	Source	Description of main national strategies	More than one ministry/ level of governance	Multiple services delivered (in addition to housing)	Involvement of private actors
Finland	FEANTSA (2012)	Programme to reduce long term homelessness (2008-2011) and to end long term homelessness (2011-2015). The Ministry of Environment coordinates the program, in close cooperation with The Ministry of Social Affairs and Health, the Ministry of Justice, the Housing Finance and Development Centre of Finland (ARA) and Finland's Slot Machine Association (RAY), which partly funds the programme. The first phase (2008-2011) aimed at providing 1,250 new dwellings, housing units or places in care facilities; the second phase (2011-2015) aims at providing further 1,250 flats and flexible support services, in line with the 'Housing First' principle. The NGO for homeless people, Vaillavakinaistaasuntoary (No Fixed Abode), has been actively involved in the implementation of the reduction programme. Homeless people will be involved and their expertise harnessed systematically in projects already at the planning stage. Approximately EUR 200 million were allocated for the funding of the programme.	Yes	Yes	Yes
France	FEANTSA (2012)	National strategy for homeless and poorly housed people, 2009-2012. The aim is to reduce homelessness by improving the monitoring of needs and emergency responses and by prioritising housing solutions based on the "Housing First" principles. An inter-ministerial General Delegation (DIHAL) was created in 2010 to develop, coordinate and monitor the implementation of policies on homelessness. DIHAL leads the national strategy; responsibility for implementation is shared with regional and local authorities.	Yes	Yes	No
Germany	FEANTSA (2012)	There is no national strategy in the sense of a federal programme defined in a strategic document. Service provision for homeless people, however, is relatively extensive and provided for by a legislative framework. National legislation sets out the obligations of municipalities in terms of provision of social services. Since the Mid-1990s, the Social Code stipulates that all persons who are at risk of losing their homes are entitled to assistance - either in the form of loans or allowances for rental debts. Police laws in the Bundesländer (regional states) strictly oblige municipalities to provide shelter for roofless people. In 2013, BAG W laid down principles for a National Strategy in a <i>Call for a National Strategy against Homelessness and Poverty</i> , published in September 2013. It will follow up this call in the coming years. North-Rhine Westphalia, the most populous region, has a regional action plan on homelessness. The budget for the Programme is 1.12 million Euros a year. Its aim is to develop innovative approaches and support municipalities to tackle homelessness. The main focus is the prevention of homelessness and access to housing. Specific target groups include migrants and older homeless people	No	No	No
Greece	FEANTSA (2012)	There is no integrated homelessness strategy. Homelessness is framed within the context of social policies and addressed in an indirect way. The increase in the number of homeless people due to the economic crisis has brought the issue onto the policy agenda. A Committee on Homelessness was established in January 2012 with the aim of drafting a legislative proposal and an action plan. The Committee is composed of several stakeholders including ministries, academics and NGOs and it has developed the first legal recognition of homelessness and a definition.	No	No	No
Hungary	FEANTSA (2012)	There is currently no national strategy in Hungary. Regular consultations occur between the Government and social service providers through a consultative committee.	No	No	No
Iceland	Benjaminssen and Dyb (2008)	There is no national strategy for homeless people in Iceland.	No	No	No

Table 4.A1.1. National strategies for combatting homelessness and their “social integration” commitments
(cont.)

Country	Source	Description of main national strategies	More than one ministry/ level of governance	Multiple services delivered (in addition to housing)	Involvement of private actors
Ireland	DEHLG (2008), FEANTSA (2012)	<p>Strategy to address adult homeless in Ireland, 2008-2013. The Department of Environment, Community and Local Government (The Department) has overall responsibility for the strategy. A Cross Departmental Team on Homelessness was set up in 2000, chaired by the Department. A National Homelessness Consultative Committee was established in 2007 to provide ongoing input into the development and monitoring of homelessness policy from stakeholders. Local authorities have a statutory duty to produce three-year action plans on homelessness in accordance with the strategy and for implementing Homeless Consultative Forums. Main goals of the strategy are, for instance, to prevent homelessness, eliminate the need to sleep rough, meeting long-term housing needs and ensuring the effectiveness of services for homeless people (i.e. homeless services will operate as part of a coordinated system delivering an integrated response to homeless' needs). A Homeless Policy Statement was published by the Department of Environment in March 2013, updating the objectives of the Strategy, setting a new target for ending Long-term Homelessness of 2016 and establishing a Homeless Oversight Group.</p> <p>The Homelessness Oversight Group issued its first report in December 2013, stating that the 2016 target could only be met if certain policies were put in place. These included greater access to housing and a new Homeless Policy Implementation Team be established to drive the Strategy. This report is due to be considered by Cabinet in early 2014.</p>	Yes	Yes	Yes
Italy	FEANTSA (2012)	There is no integrated national homelessness strategy. Competence for social policy lies at regional level. There is a high degree of diversity between regions with some areas (Northern and metropolitan urban areas in general) having more comprehensive and adequate homeless services than others.	No	No	No
Japan	MHLW, Japan (2014)	Japan enacted a law for the independence of the homeless in 1992. The law covers various provisions including providing, where necessary, lifestyle guidance, health provisions, accommodation, social assistance and employment supports. A large decline in the number of homeless has been recorded in the past 5 years (from over 15,000 in 2009 to 8,265 in 2013).	No	No	No
Korea		See Box 4.3 for an example of homelessness services in Seoul, Korea.			
Luxembourg	FEANTSA (2012)	<p>In March 2013, the Luxembourg Family and Integration Minister announced and explained the national homelessness strategy. The strategy:</p> <ul style="list-style-type: none"> • was adopted on the 18th January 2013 by the Government; • provides a framework for all the governmental activities to fight homelessness an exclusion from housing; • requires the collaboration of all governmental bodies and the NGOs working in this field; • is based on the Housing First approach; <p>The strategy has four main objectives:</p> <ol style="list-style-type: none"> 1. Provide homeless people with decent and stable dwellings; 2. React rapidly and adequately to urgent situations; 3. Prevent homelessness; 4. Boost the existing measures and consolidate governance; <ul style="list-style-type: none"> • will be implemented through 14 concrete actions; • will run from 2013 to 2020. 	Yes	Yes	Yes
Netherlands	FEANTSA (2012)	Strategic plan for social relief, 2006-2010 and 2011-2014. The plan is coordinated by the Ministry of Health, Welfare and Sports (VWS) and the National Association of Local Authorities (VNG). VWS has overall responsibility for the development and monitoring of the policy. The municipalities are responsible for developing local policies in line with the national framework, by producing a strategy known as "City Compass" or "Strategic Relief Plan". The cities will have to agree contracts with their local partners regarding the delivery of care and the supply of accommodations. The aim is to ensure that all homeless have incomes, accommodation, a non-optional care program and a feasible working activity. In 2011, the annual budget was EUR 307,228,114.	Yes	Yes	Yes
New Zealand		There is no national homelessness strategy in New Zealand. The "New Zealand Coalition to End Homelessness," an incorporated society whose aim it is to end homelessness in New Zealand by 2020, calls on the government and private actors in New Zealand to make homelessness a priority on the political agenda.	No	No	No

Table 4.A1.1. National strategies for combatting homelessness and their “social integration” commitments
(*cont.*)

Country	Source	Description of main national strategies	More than one ministry/ level of governance	Multiple services delivered (in addition to housing)	Involvement of private actors
Norway	FEANTSA (2012)	Strategy to prevent and combat homelessness, 2005-2007. A collaboration agreement was signed by the Norwegian Association of Local and Regional Authorities, the Ministry of Local Government and Regional Development, the former Ministry of Labour and Social Affairs, the Ministry of Health and Care Services, and the Ministry of Justice and the Police. The Norwegian State Housing Bank also coordinated municipal networks. Municipalities have a statutory duty to assist the less advantaged into housing and to provide social services and were the main actors in the implementation of the strategy. Main goals were, for instance, reducing eviction petitions by 50% and the number of evictions by 30%, making it easier for people to move from prison and treatment institutions to own home, reducing the number of people staying longer than three months on temporary housing. Since 2008, Norway began to focus on combating youth homelessness. Since 2009, there has been a specific focus on the development of social housing.	Yes	Yes	Yes
Poland	FEANTSA (2012)	There is no national integrated homelessness strategy in Poland. Between 2008 and 2010, work on such a strategy was undertaken by the Ministry of Labour and Social Policy. NGO service providers were invited to provide input through a working group. In May 2008, the working group presented a proposal which was discussed at a conference hosted by the Ministry. Unfortunately, cooperation on the strategy broke down and in January 2009 a less ambitious document was presented by the Ministry, focusing on regulation of specific elements of homeless services and lacking strategic objectives to reduce homelessness over the longer term. Eventually, this less ambitious initiative has been shelved with the financial crisis as a justification. Primary responsibility for providing homeless and social assistance services lies at the local level (municipalities and communes). Services for the homeless are either provided by local authorities (social assistance centres) or outsourced to NGOs. Some Housing First services have been piloted, but they are currently small-scale projects and only available at the local level. At the current time NGO homeless service providers are working on proposals for a homelessness strategy entitled “National Programme for Combating Homelessness and Housing Exclusion 2014-2020”. This work is taking place in the framework of an ESF project “Creation and Improvement of Standards of Social Welfare and Integration Services”. The document was submitted to the Ministry of Labour and Social Policy in December 2013. Five key priorities have been developed: needs diagnosis, prevention, intervention, inclusion and quality of services. The Ministry prepared a separate, more comprehensive, strategic document aimed at combating poverty, which mentions homeless people among other groups in need of support, called the National Programme for Combating Poverty and Social Exclusion 2014-2020.	No	No	No
Portugal	FEANTSA (2012)	A national strategy for prevention, intervention and follow-up was launched for the years 2009-2015. However, the progress that was made on implementation in the early phase has been largely halted in the context of the economic crisis. The strategy would be coordinated by the Institute of Social Security. An Inter-Institutional Group was formed (GIMAE), with representatives from public and non-profit social service providers. At local level, implementation groups called NPISA were also established. According to the plan, 1.80% of homeless should have a “case manager” and no one should stay overnight on the street for more than 24 hours due to the lack of alternative.	No	No	No
Slovenia	FEANTSA (2012)	There is no specific integrated strategy on homelessness at national or regional level. Homelessness is usually dealt with within the broader sector of “social issues”. Since 2000, homelessness has increasingly become a mainstream part of social policy. In 2010, the University of Ljubljana and the Ministry of Labour organised a conference in the context of the European Year against Poverty and Social Exclusion. The aim was to start developing a national strategy by engaging all the relevant stakeholders. This initiative has been rather weakly followed up by the different ministries.	No	No	No
Spain	FEANTSA (2012)	There is no national strategy in Spain. This reflects a highly devolved structure government where social policy is the competence of each of the Autonomous Communities (17 in total) and responsibility for the homeless is divided between the region and the local level. The Spanish government recently included the development of a homelessness strategy in the Plan Nacional de Acción para la Inclusión Social 2013-2016.	No	No	No

Table 4.A1.1. National strategies for combatting homelessness and their “social integration” commitments
(*cont.*)

Country	Source	Description of main national strategies	More than one ministry/ level of governance	Multiple services delivered (in addition to housing)	Involvement of private actors
Sweden	FEANTSA (2012), Swedish Government Office (2007)	<p>There is no up-to-date national strategy. The previous strategy was implemented for the period 2007-2009. Since 2002 the National Board of Health and Welfare has been responsible for developing knowledge and understanding of homelessness. The Board was commissioned to lead and coordinate the implementation of the Government's strategy in consultation with the National Board of Housing, Building and Planning, the Swedish Prison and Probation Service, the Swedish Enforcement Authority and other relevant agencies, including the Swedish Association of Local Authorities and Regions. The Ministry of Health and Social Affairs coordinated an interdepartmental group on the strategy. Local authorities were responsible for implementation at the local level. The National Board of Health and Welfare carried out monitoring at national level in cooperation with the other relevant agencies. According to the strategy, municipalities had to cooperate with and support nonprofit actors for the achievement of the plan's goals. The strategy's main priorities were to guarantee a shelter to everybody, reducing in the number of women and men who are in prison or at a treatment unit, facilitating entry into the ordinary housing market.</p> <p>A Homeless Coordinator was appointed in January 2012 for two years by the Social Affairs Ministry. His mission is to disseminate knowledge and understanding generated from the former strategy, as well as by the National Board of Health and Welfare, and to monitor municipal action. A budget of 1 million Euros was earmarked to support this mission until July 2014. A final report is expected in June 2014, detailing experiences and proposals such as a new national homeless strategy.</p>	Yes	Yes	Yes
United Kingdom	DCLG, UK (2014)	<p>Homeless policies are underpinned by a strong legislative basis in the United Kingdom. In England, the main legal provisions are contained in the 1996 Housing Act, the Homelessness Act 2002, and the Homelessness Order 2002. The current government has introduced a new national strategy focused only on rough sleeping: "Vision to end rough sleeping: No Second Night Out nationwide". This policy has been developed by a Ministerial Working Group on Homelessness, which brings together relevant government departments to tackle homelessness. The strategy calls on collective action from government, councils, charities and communities to ensure that people do not spend more than one night on the streets.</p> <p>In Scotland a right to settled accommodation for all unintentionally homeless households was implemented in 2012 and a right to housing support for homeless households who require it was implemented from June 2013.</p> <p>In Wales, new housing legislation came into force in 2014, which improves rights to homeless people including a focus on prevention.</p>	Yes	Yes	Yes
United States	Homelessness Research Institute (2013)	<p>The President and Congress charged USICH to develop "a national strategic plan" to end homelessness with enactment of the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act in May 2009. USICH members include a total of 19 Departments and Offices, such as the Department of Agriculture, the Department of Defence, the Department of Education, and the Office of Management and Budget. Main goals of the strategy include ending chronic homelessness in 5 years, preventing and ending homelessness among veterans in 5 years, preventing and ending homelessness for families, youth, and children in 10 years, integrating primary and behavioural health care services with homeless assistance programs and housing to reduce people's vulnerability to and the impacts of homelessness (by encouraging partnerships between housing providers and health and behavioural health care providers to co-locate or coordinate health, behavioural health, safety, and wellness services with housing and create better resources for providers to connect patients to housing resources).</p>	Yes	Yes	Yes

Source: See references in Column 2 of the table.

Chapter 5

Integrating care for the frail elderly

As their populations age, all OECD governments are confronted with increasing demand for health and social services. The inefficient (over)use of services by the frail elderly, who suffer from physical and functional disabilities, puts additional pressure on scarce public resources. Drawing from evidence on integrated models of care across OECD countries, this chapter examines the potential of these innovative service delivery methods to provide effective and cost-efficient care for frail elderly individuals. The chapter also discusses barriers and perverse incentives to effective implementation created by traditional service delivery structures. Whilst highlighting the need for better measurement and further evaluation of integrated care, findings illustrate the potential of integrated service delivery models to respond to the frail elderly's complex needs, and offer some promising ways to promote integration at both the governance and delivery levels.

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

5.1. Introduction

People across OECD countries are living longer. Consequently, the number of *frail* elderly people with multiple chronic conditions and complex health and social needs will grow in the coming decades. Whilst integrated models of care hold the potential to meet the economic, health and social care challenges of ageing populations in the next decades, effective co-ordination of care remains a challenge for many countries across the OECD.

This chapter examines the challenges and opportunities of integrating care for the frail elderly, where the rationale for integrated social services for this group differs from that of other vulnerable groups. The integration of services for vulnerable families, the homeless, or people with complex health needs aim to reduce the demand for social services and facilitate reintegration into society, whereas the primary goal of integrated care for the frail elderly is to provide good quality end-of-life care.

This chapter is organised as follows: Section 5.2 summarises the main findings of this review. Section 5.3 discusses how ageing populations put strain on health and social care systems. Section 5.4 defines the framework for integrating care for the elderly. Section 5.5 offers an overview of different approaches and available evidence on integration of care across OECD countries. Section 5.6 then examines the challenges of integrated care in the context of current financing and governance arrangements of service delivery structures. Section 5.7 concludes with lessons for transferability of policies and delivery methods.

5.2. Main findings

Because there is great variation in services governance and delivery methods, there is no one optimal way to integrate elderly care. Moreover, it is not fully clear which integrated care strategies – and in which context – produce best outcomes. However, the following findings stand out:

- Although there is limited cross-country comparative information on the number of *frail* elderly, their share is set to grow in the coming years. Consequently, *the demand for health and social care by the frail elderly will increase, even when care is provided in an integrated setting.*
- *Services should be integrated from a patient, not a provider perspective.* This allows service users to make informed choices about their care. Carefully defining the target population and their particular needs enables a holistic, patient-centred approach to integrating care. Depending on the frail elderly's care need, *community care provided in a home setting* appears to be the optimal delivery method in this context, both in terms of cost effectiveness and patient satisfaction (see, for example, OECD, 2010; Chan et al., 2008; Verté, 2012).
- *Outcomes-oriented strategies, as well as evidence-based guidelines and protocols,* facilitate effective delivery of integrated elderly care. Engaging primary care physicians (PCPs) – acting as case managers and/or gatekeepers – can also improve outcomes. For instance, involving PCPs in the integrated care process can relieve pressure on secondary and acute services.
- *Workplace development and training initiatives are critical* when implementing integrated delivery methods, a finding specifically noted for integrating health and social care for the frail elderly. This contributes to developing a common vision and

- culture that is essential in settings which bring together traditionally hierarchical professional statuses and cultures.
- *Efforts are needed to embed integrated care policies within traditionally fragmented service delivery structures.*
 - The frail elderly’s health and social services are often managed at different levels of government and/or by different government entities/departments with separate budgets, which can create disincentives to integrating care. Some promising practices to overcome this division have, however, emerged, such as *enforcing central steering power* or *legislation to support the provision of integrated care*.
 - In countries where service provision is decentralised, *attention should be paid to regional differences in the provision of effective integrated care*. These disparities have important implications. For instance, elderly people who live in rural areas have generally fewer health and social care resources. They also face a greater risk of social exclusion. *Tele-home care* (and other ICT developments) has great potential in reaching the elderly in remote areas.
 - *Financial integration is necessary to prevent cost shifting when multiple sectors are involved in services delivery.* Good-practice examples of bringing together financial resources include, for example, *pooling together budgets or resources under a single funding envelope* or *integrating budgets for defined care services*.
 - *The quality of care co-ordination needs to be measured more accurately.* Currently, only a few countries measure patient experiences on care co-ordination. User surveys and administrative data (e.g. hospital admissions) offer potential for developing more robust indicators on the state and quality of care co-ordination. Other methods, such as linking the payment of block grants to performance targets in Sweden, has also shown some success in improving data collection on elderly individuals’ service use.

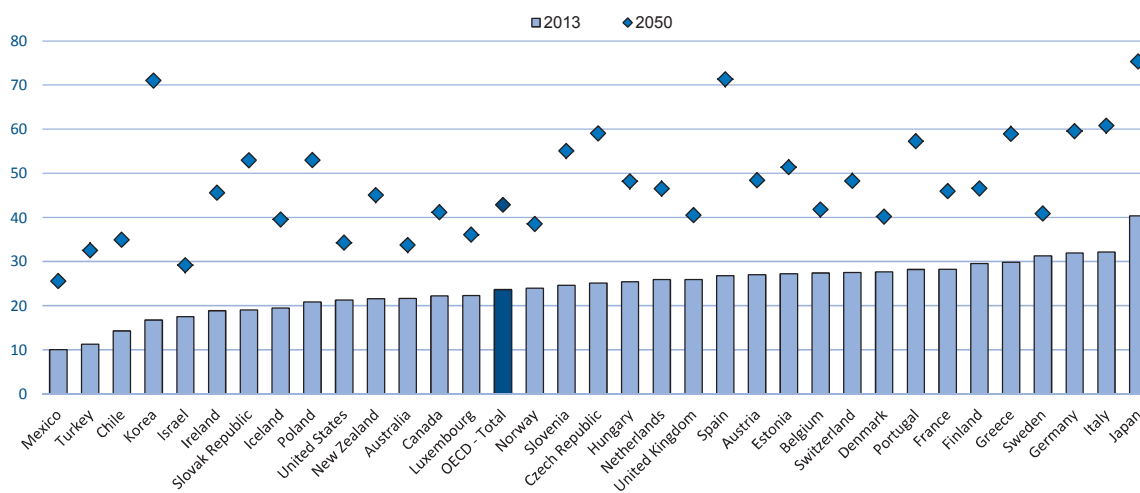
5.3. Ageing populations will strain public health and social care resources

All OECD countries are confronted with a growing need to provide efficient care to the frail elderly. The size of the elderly population, which is more likely to suffer from multiple chronic conditions, will grow rapidly over the next decades. This growth is projected to increase the demand for, and the expenditure in social, health, and long-term care services. This section explores the nature, the extent, and the costs of frailty in old age today and in the coming decades, and discusses the rationale behind delivering integrated care across sectors to this group.

Who are the frail elderly?

Before attempting to define the frail elderly, it is useful to look at the current proportion and anticipated rise of the elderly population. Although not all elderly people will require *intensive* care services, the use of standard social and health care services increases in old age. Hence, the increasing share of the older population will place significant pressure in the existing health and social care resources in the coming years (Colombo et al., 2011; OECD, 2012). By 2050, the old-age dependency ratio is projected to increase in all OECD countries (Figure 5.1). In the majority of OECD countries the dependent elderly population is likely to rise to over 40% of the total population, and reach levels as high as 70% in Korea, Spain and Japan.

Figure 5.1. Old-age dependency ratio, 2011 and 2050



Note: No 2050 projections available for Turkey or Israel or OECD average.

Source: OECD (2015) “Demography and Population Data”.

The term “frail elderly” encompasses several aspects related to health and social service needs in old age. In this chapter, frail elderly is broadly defined as older individuals suffering from both acute and (multiple) chronic conditions which require continuous long-term care and support. Functional and physical disabilities and incapacities are also common (Chan et al., 2008).

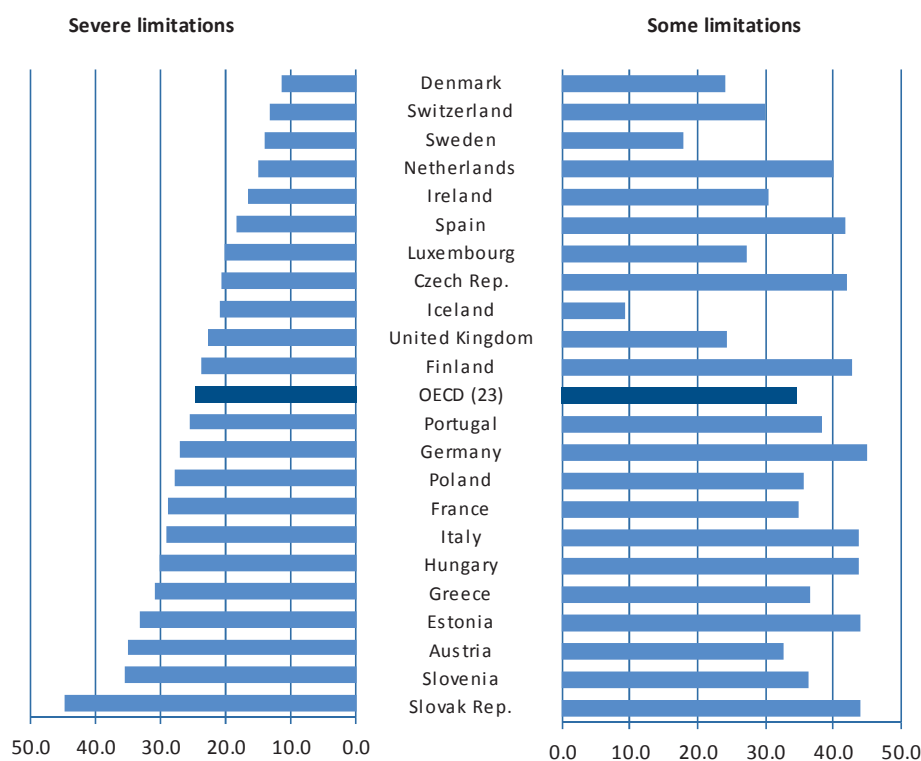
The use of multiple coexisting conditions to identify frailty, including conditions such as disability in old age which are difficult to measure with certainty (Lafortune and Balestat, 2007), makes estimating the extent of the frail elderly population across the OECD challenging. For European OECD countries, the *European Survey of Income and Living Conditions* offers some comparable, self-reported, information on the proportion of the frail elderly. However, since EU-SILC is conducted as a household survey, these results do not survey elderly people living in institutions (e.g. nursing homes).

Almost 35% of people living at home aged 75 and above reported having some long-term restrictions in daily activities due to a health problem, whilst 25% experienced severe limitations in 2011 (Figure 5.2). The proportion of people aged 75 and over with severe limitations was highest in Slovakia at around 45%, followed by Austria, Estonia, Greece, Hungary and Slovenia all reporting shares over 30%. Denmark, Switzerland and Sweden, on the other hand, recorded the lowest shares at below 14%. In terms of some limitations in daily activities, the shares ranged from 45% in Germany to 9% in Iceland.

The incidence of *elderly falls* is also an indicator of frailty in old age. Falling is one of the leading causes for hospitalisation for the elderly, and often due to physical or functional frailties. Due to differences in definitions, however, opportunities for cross-national comparisons remain limited. However, some national estimates are available: a study from the United Kingdom, for instance, found that approximately 32% to 42% of people aged 75 and above experience a fall each year (Royal College of Physicians, 2011). In the United States, on the other hand, some evidence suggests that in nursing homes, 34% of residents had fallen at least once within a half-year period, and 9% within

the past month (Jones et al., 2009). Finally, data from Finland also indicates that 2.8 persons aged 65 or above per 1 000 population of the same age received hospital care for injuries or other preventable accidents in 2011 (Sotkanet, 2013). In sum, available evidence on frailty in old age combined with the rising share of the elderly population suggests a demand for effective services delivery solutions responding to their needs.

Figure 5.2. Self-reported limitations in daily activities, population aged 75 and above, 2011, selected OECD countries



Note: Proportion of people who answer “yes strongly limited” or “yes limited” to EU-SILC question: For at least the past six months, to what extent you have been limited because of a health problem in activities people usually do? (Answering categories; yes strongly limited, yes limited, no not limited).

Source: Eurostat (2013), “Health Status Statistics”, available at http://epp.eurostat.ed.europa.eu/statistics_explained/index.php/Health_status_statistics.

Effective delivery of services to the frail elderly: A growing policy priority

Policy makers across the OECD are increasingly concerned about improving services delivery for elderly patients. It is easy to identify the public and private consequences of care systems that inadequately meet these populations’ needs. Indeed, the physical and functional frailties of the elderly often result in inefficient (over)use of services. Whilst many seniors without intensive support needs can be well-served within the existing care delivery structures (Nolte and McKee, 2008), patients with complex chronic conditions need to navigate through complex care settings with multiple providers and sectors, which traditionally have been separate (Bird et al., 2007).

The frail conditions of some older people can, for instance, limit their ability to communicate and share information with several service providers, or to express

treatment preferences (OECD, 2012). In a setting with little or no care co-ordination, there is a risk these patients end up seeking care from a higher intensity setting than needed – such as the emergency services. This in turn leads to unnecessary hospital admissions and acute presentations to emergency departments, which often serve as the first point of contact for these individuals (Bird et al., 2007). Finally, there are also risks regarding accessing the right service at the right time, duplication of tests, and medical errors when health and social services fail to effectively address multiple needs (MedPad, 2012).

The cost of providing services to the frail elderly

The shortcomings of the existing care structures for the frail elderly come at a high cost to the health sectors, social services sectors, and elderly well-being. Lengthy hospital stays, institutional care, and emergency department visits are very expensive and strain the already scarce resources of the health systems (Chan et al., 2008; Hofmarcher et al., 2007).

In the context of the on-going economic recession and public budget constraints, there is a need to find better value for money in terms of public spending on health and social services, and services for the elderly in particular (OECD, 2010). The share of spending on the elderly will increase significantly in the coming decades: compared to people aged 65 and under, the proportion of total health care expenditure on the elderly is projected to increase from 40% in 2010 to 60% in 2060 (De la Maisonneuve and Oliveira, 2013).

The average OECD expenditure on health and long-term care as a percentage of GDP is also set to increase in the coming decades: in a cost-containment scenario, which assumes that “policies act more strongly than in the past to rein” in some of the expenditure growth, this share is projected to increase from 6.5% in 2010 to 9.5% in 2060. In a cost-pressure scenario, where no stepped-up policy action in terms of spending is taken, spending might rise as high as to 14% of GDP (De la Maisonneuve and Oliveira, 2013).

Costs, and concerns over care co-ordination

High levels of health expenditure and concerns about health and social care co-ordination are linked. An OECD survey on care co-ordination found that countries with health expenditures above the OECD average are also those most concerned about poor co-ordination and efficiency of health and social care (Hofmarcher et al., 2007). Consequently, as a means of enhancing cost efficiency and quality of care, these countries tend to show a greater commitment to better integration health and social care by improving care co-ordination.

Although countries with higher levels of health spending are concerned about co-ordination, it is unclear whether lower levels of co-ordination (and consequent inefficiencies) in fact cause higher than necessary spending. In fact, whilst countries with higher levels of health expenditure tend to be more concerned about poor co-ordination of care, they also report fewer actual problems with care co-ordination than countries that spend less on health care. While these high spender countries generally pay more attention to efficiency issues, greater financial resources can also contribute to resolving some supply-side issues, such as long waiting times to nursing homes or tertiary care (Hofmarcher et al., 2007).

5.4. Integrating care: Improving value for money and effectiveness in services delivery to the frail elderly?

Integrated care for the frail elderly holds promise in two ways: by reducing the cost of acute and institutional care and by improving the service users' satisfaction by enabling them to stay in their community. This section defines the framework and goals of integrated care and discusses the importance of making services available at home.

The importance of providing services at home

Over the past decade, service provision to the frail elderly has increasingly shifted from institutional care settings to less costly, community-based care (OECD, 2010). In addition to reducing costs, community care also offers other advantages. Evidence suggests that community care improves patient experiences, service use outcomes, and the quality of life of the frail service users (Chan et al., 2008). Long waiting times for admission to nursing homes can also be addressed when services are made available at home.

Notwithstanding the complex health and social needs that put the elderly individuals' autonomy at risk, the vast majority of this group highly prefers to stay and be treated in their home environment (Verté, 2012). The ageing-in-place approach has encouraged an emphasis on patient-centred care in the OECD (Nolte and McKee, 2008). Canada, for example, has established an “Age-Friendly Community” (AFC) – model, which facilitates healthy and supportive environments for older Canadians. One of the domains of AFC is community support and health services, and the model is being implemented in more than 850 Canadian communities as well as in other countries.

In line with patient-centeredness, innovative provider-payments methods such as personal budgets have emerged in recent years, aiming to enhance patient choice and consequently service quality and co-ordination (Box 5.1). The recent progress and potential of information and communication technology (ICT) in health and social services delivery (e.g. tele-home care) also present new opportunities for better organisation of long-term care at home, especially in rural areas (for further discussion on ICT, see OECD/European Commission, 2013).

Although community care's benefits are widely acknowledged, most health care delivery systems continue to focus primarily on treating acute illnesses and are less responsive to the long-term support needs of the frail elderly with multiple chronic conditions (Nolte and McKee, 2008). The global burden of disease is shifting from acute illnesses towards chronic conditions and long-term conditions, which can often be treated in a less-costly community setting (OECD, 2010). Developing community and home care for the frail elderly is of particular importance in rural areas, which traditionally have “below average health outcomes and larger health inequalities” (Weatherly et al., 2010).

Box 5.1. Enhancing the quality of community care – Increasing patient choice

An emerging approach to improve care quality for the elderly is self-directed care, where service users have the freedom to administer their own care through personal budgets and direct payments. This method has been implemented in several OECD countries (e.g. Austria, Germany, the Netherlands, the Nordic countries, the United Kingdom and the United States). It was first piloted in the 1980s in the United States in the form of Medicaid “cash and counselling” programmes, which aimed to empower patients by increasing choice for patients using home and community care. Although these cash schemes vary across countries, patients can generally choose and pay for the type of services and support they consider they need. The cash benefits can also be used to pay for personal carers (e.g. family members).

Available evidence on the effectiveness of these schemes largely support the use of these schemes, although some evidence suggests that the impact may vary across different population groups (Glendinning et al., 2008). The “cash and counselling” programmes and personal budgets in the United States and the United Kingdom, for instance, have showed positive results, such as increased patient satisfaction and fewer unmet care needs (Carlson et al., 2007; Glasby and Duffy, 2007). Despite these promising results, the use of personal budgets has faced some criticism. Although patients have shown to value choice over their care, managing individual budgets can increase the administrative burden for elderly individuals and their carers, who also need to assume the risk. It also remains unclear whether personal budgets reduce costs of services to the elderly or produce economies of scale. Moreover, there is uncertainty regarding the quality of care and in some cases patients may be incentivised to underuse necessary, but expensive services (Poole, 2006).

What is integrated care for the frail elderly?

Integrated care for the elderly has been defined as “a coherent set of products and services, delivered by collaborating local and regional health care agencies through securing liaison or linkages within and between the health and social care systems” (Hardy et al., 1999). Indeed, differing from integrated models of service delivery targeting other vulnerable groups, integrated care for the frail elderly primarily seeks to “link cure with care” to provide good quality end-of life care. In the context of ageing populations with longer life expectancies and professional careers, however, employers and public employment agencies are also likely to play an increasingly important role in providing preventative and rehabilitative health services for older workers (see Box 5.2).

Box 5.2. Providing services for older workers – The potential of the employment sector

Demographic changes have led to prolonged working careers and the greater use of older workers (OECD, 2006). Consequently, the role of public employment services in providing support for elderly employees is likely to grow in the future. In addition to providing training and counselling opportunities to this target group, it is also important to focus on preventative health measures that help maintain employability of older workers, particularly those with physical or functional frailties.

Public employment services offer the opportunity for health promotion. Currently, few such programmes exist. The Fit2Work programme implemented in three Austrian provinces in 2011, for instance, aims to promote the employability of workers with health conditions that often require taking sick leave. The programme offers health, education and training advice; dissemination of information and liaison with different institutions; occupational health diagnosis and individual support (European Commission, 2012) (for further discussion on older workers, see OECD, 2006).

In reality, many terms are used to describe integrated care, reflecting different national or subnational service delivery structures in which they have been implemented (see Section 5.4). Case management, patient-centred care, continuity of care, transmurial

care, or managed care, for instance, all reflect policy initiatives that aim to provide services efficiently in an integrated setting, either horizontally or vertically. However, these terms often do not reveal the types of integration and interaction between service providers (Nolte and McKee, 2008).

Given the widespread differences in the health and social service structures, *the notion of care* also varies across countries. There is, for instance, a clear difference between publicly funded systems (e.g. the Nordic countries or the United Kingdom) and cases like the United States. In the United States, integrated care generally entails a form of managed care to a defined population, such as the frail elderly suffering from a specific chronic condition, leaving the majority of chronically ill out of the scope of these services. In the United States, a co-ordinated continuum of care is also generally organised by providers who are “willing to be held clinically and fiscally responsible for the outcomes” (Nolte and McKee, 2008). Integrated care also tends to have a different focus in Europe, bringing together sectors as opposed to functions (see Section 5.5) which is more the case in the United States (ibid.).

Types and degrees of integration

The literature on integrated care for the frail elderly makes clear distinctions between different degrees of integration (for broader definitions on integrated services, such as those used for other populations in this report, see Chapter 1). Leutz (1999), arguing that only a small proportion of the elderly population requires integrated care, differentiates between full integration, co-ordination and linkage.

- The highest degree, *full integration*, refers to pooling together organisational and financial resources from different sectors within one managed structure or contractual agreements to create a new programme with agreed objectives.
- *Co-ordination* refers to explicit structures created to facilitate care provision (e.g. discharge planning, case management or the sharing of information) across separate sectors.
- Finally, *linkage* involves very little integration between separately existing health and social services with distinct responsibilities, funding, and operational rules. These systems can effectively provide care for the elderly with merely mild or moderate social and health service needs.

Policies integrating care for the frail elderly also have different levels and types of integration. At the delivery, or *macro-level*, there are two levels of integration:

- *functional or system integration*, which includes (though not exclusively) financial management, strategic planning, or quality improvement,
- *organisational integration*, which concerns the co-ordination and management of activities across different sectors (OECD, 2012).

Integration at the delivery or *micro-level*, on the other hand, refers to:

- *professional or service integration*, such as joint working or group practices,
- *clinical integration*, which concerns the delivery, direct care, and support provided to older people by their direct caregivers (e.g. case management) (MacAdam, 2008; OECD, 2012).

These different levels of integration are interrelated (MacAdam, 2008). Fragmentation at one level likely impedes integration at other levels. Indeed, the effectiveness of integrated care at the direct service delivery level is likely to depend on the extent of integration at the macro-level, and vice-versa. For instance, fragmented strategic planning or financial management will impede efforts to deliver health and social services together.

Is there an optimal way to finance integrated care for the elderly?

Integrated care models also require careful consideration of financing arrangements. The disincentives to integration and the interdependence of different sectors in providing care in an integrated setting raise an important question: who should fund these services?

At the organisational and structural levels, there are several forms and degrees of financial integration (Weatherly et al., 2010). *Pooled funding* is perhaps the most commonly used form of financing integrated care. In a pooled funding scheme, each body involved in service delivery makes contributions to a common fund to be spent on pooled functions or agreed services. The highest degree of both financial and organisational integration, pooled funding combined with integrated management, has been shown to prevent some negative effects of integrated models of care. Many well-established initiatives of integrated care for the elderly (e.g. *SIPA* and *PRISMA* in Canada; *On Lok* and *PACE* in the United States; and *Co-ordinated Care Trials* in Australia) rely on this model. Services delivery can also be jointly managed without pooled funding (e.g. *Rovereto* and *Vittorio Veneto*) (see Section 5.5).

There can also be joint funding arrangements in which the organisation and management of health and social services remain separate. By *aligning budgets*, for instance, the different actors involved in the delivery of integrated care align resources, identify their own contribution, and meet agreed aims. Whilst the management of, and accountability for, different services remains separate, spending and performance within the service are monitored. This is common, for example, in England. *Lead commissioning*, on the other hand, refers to a service when one actor takes “the lead in commissioning services on behalf of another to achieve a jointly agreed set of aims” (Weatherly et al., 2010).

Finally, there exist financing arrangements that aim to improve a particular service with little integration across different sectors. These strategies include *cross-charging* and *grants transfers*. Cross-charging, which has been implemented in England, Denmark and Sweden, is “a system of mandatory daily penalties made by social care bodies to health bodies to compensate for delayed discharges in acute care when the social care body is solely responsible” (ibid.). Grant transfers involve no pooling of function or partnership and are merely payments by one sector to another with the aim of enhancing a particular social or health service (e.g. Scotland). Further discussion on financing methods of integrated services delivery is included in Chapter 1.

5.5. Integrating care for the frail elderly: Policies and their evaluations

The number of integrated care models targeting the frail elderly has grown in recent years. Although these policies share broadly similar goals and methods of integration, the design and scope of each model is unique. These models reflect the existing care culture and the responsibilities for services in the given OECD country.

The following tables present an overview of the current and/or recent policies to integrate care for the frail elderly in OECD countries (for a snapshot summary of formal evaluations of integrated care policies at the delivery level, see Annex 5.A1). A literature review identified relevant, horizontally integrated models of care across health and social services sectors. This review draws on work undertaken by the OECD Health Division (OECD, 2012; OECD/European Commission, 2013), evidence from journal repositories, and official government websites. Any initiatives integrating care without a stated focus on the frail elderly, or which solely focused on one chronic condition, were excluded from this review. To complement the review, a policy questionnaire was sent to OECD country delegates. The initiatives are categorised by the level and the type of integration.

Enhancing integration of care at the national governance-level

To enhance integration of care for the elderly at the national level countries can apply financial or legislative-based initiatives. These initiatives provide budgetary and legal frameworks within which a range of services for the elderly are managed and paid for (see Table 5.1).

Table 5.1. Financial or legislative initiatives to improve care co-ordination for the frail elderly

Policy	Country	Coverage	Common traits and type of integrated care provided	Period
Elderly Care Act	Finland	National	Statutory care co-ordination prescribed in the new Elderly Care Act	2013-present
Long-term Care Insurance	Japan	National	Financial incentive scheme that encourages greater co-ordination by sharing information regarding the patient's treatment	2000-present
Government Subsidies for Nursing Homes	Norway	National	A subsidy to municipalities who link their nursing homes to NOKLUS (The Norwegian Quality Improvement of Primary Care Laboratories)	n.a.
National Network for Integrated Continuous care	Portugal	National	Integrated home care teams; assessment and care planning by multidisciplinary teams; pooled funding across health and social care; online web-based data management systems	2006-present
Government programme targeting the most frail elderly	Sweden	National	Payment of block grants has been linked to performance targets such as avoidable hospitalisations for chronic conditions and quality targets	2011-present
Reshaping Care for Older People	The United Kingdom	Regional (Scotland)	Increasing funding for home-care services; partnership across local and central governments, local communities, services providers and services users; Multi-professional and multi-agency assessment; outcome indicators which use data collected and reported at the national level; local measures collected to inform local improvement	2011-present

Source: OECD (2013), "OECD Questionnaire on Integrated Social Services Delivery, Part 2, Frail Elderly", unpublished Social Policy Questionnaire; OECD/European Commission (2013), *A Good Life in Old Age? Monitoring and Improving Quality in Long-term Care*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/9789264194564-en>.

Strong steering at the national level is likely to enhance health and long-term care integration (Mur-Veeman et al., 2008). Furthermore, literature looking at service integration for the general population suggests that proactive, national-level commitment does facilitate the establishment of integrated models of care at the delivery level (OECD, 2013a).

In Norway, to enhance quality measurement and co-ordination, subsidies are provided to municipalities which link their nursing homes to the Norwegian Quality Improvement of Primary Care Laboratories (NOKLUS) (OECD/European Commission, 2013). In Japan, moreover, the *Long-Term Care Insurance* was established in 2000. Japan has the highest projected elderly population (in the share of total population; see Figure 5.1), and

this financial incentive scheme was implemented to encourage greater co-ordination for elderly patient care by sharing patient treatment information (OECD, 2012).

The Japanese *Long-Term Care Insurance* scheme has become well-established within the past 14 years. Those qualifying for the care insurance scheme have access to a variety of services (mainly home-based) which are co-ordinated by “long-term care support specialists” (i.e. case managers). In March 2012, 4.34 million people took part in the scheme, accounting for a 2.4-fold increase in 11 years. An opinion survey on the insurance system conducted by the Ministry of Health, Labour and Welfare in 2010 found that the majority of respondents (over 60%) approved of the scheme (OECD, 2013a).

The frail elderly are also a government priority in Sweden since 2011. As part of government efforts to improve the co-ordination and quality of elderly care, block grant payments have been linked to performance targets, such as avoidable hospital admissions for chronic conditions. Although quality targets have not yet been reached by many local authorities, the initiative has shown to improve data collection and quality registers for elderly care (OECD, 2013a; OECD/European Commission, 2013).

In addition to these measures, the Swedish Government financed 19 local pilot projects to develop good-practice models of providing well-integrated care across primary and secondary health care and social services with a particular emphasis on preventing hospital admissions. One encouraging example was the use of mobile teams providing integrated services at elderly homes. Moreover, following the establishment of a common political board in charge of co-ordinating care for the elderly across counties and municipalities in Lindköping, hospitalisation rates decreased by approximately 90% (OECD/European Commission, 2013).

On the legislative side, Sweden has also enforced the right to an individual co-ordinated care plan and a case manager for continuous care for patients with cross-cutting health and social service needs (OECD, 2013a). (This programme is not restricted to the frail elderly.) Similarly, the Finnish *Elderly Care Act*, which went into effect in July 2013, also explicitly holds local authorities responsible for providing health and social services to the elderly in an integrated setting (Elderly Care Act, 2012/980).

Since 2006, following the introduction of the *National Network for Integrated Continuous care*, Portugal has committed to addressing the long-term gap in social support and health care by improving care integration for the elderly at the national level. This national network has taken a comprehensive approach to integrating care, and whilst it is not restricted to the frail elderly, since 2009, 85% of participants were over 65 years old (RNCCI, 2010).

Portugal has taken additional measures. In addition to introducing multidisciplinary care assessments for people with post-acute and long-term care needs, Portugal has also introduced local co-ordination teams to establish structures, staffing standards, and an online data management system. This National Network aims to create an integrated information system making information portable across settings. Moreover, health and social care professionals have undergone management, organisational and integrated care practices training as part of the network. Although the programme is only partway through a ten-year growth period (2006-16), the network has already produced promising outcomes regarding patients’ physical autonomy. There has been a 43% decrease in the number of disabled patients and large increases in autonomy (72%) and independence (154%) (RNCCI, 2010).

Finally, Scotland has also taken steps towards improving services delivery for the elderly. The “Reshaping Care for Older People” programme (to run between 2011 and

2021) takes a multidisciplinary partnership approach and aims to shift elderly services' delivery from institutional to home and community care settings. *The Public Bodies (Joint Working) Bill*, introduced to the Scottish Parliament in May 2013, will legislatively enforce integrated delivery of adult social and health care once enacted. The Bill has four key principles: nationally agreed outcomes; joint accountability of statutory partners for performance; integrated budgets for health and social care; and strengthening the role of care professionals and engagement with the third sector (Scottish Government, 2013). Intermediary evaluation of the programme shows a 6.8% reduction in the emergency admissions bed days rate for the elderly over 75 years between 2009/10 and 2011/12.

Providers are encouraged to invest more fully in new integrated methods of working when their efforts are supported by financial incentives or legislation, such as in Finland, Sweden, Portugal or Scotland. In countries where such attempts have been lacking, provision of care in an integrated setting has likely remained modest.

Full integration of financing and management of services

Long-standing examples of full functional or organisational integration of financing and delivery for the frail elderly come mostly from North America. *PACE*, *On Lok*, *SHMO* and *SIPA* are all models of integrated care that rely on very high degree of integration. However, these programmes' integrated health and social services are only accessible to a selected population and are not embedded in the mainstream services. Table 5.2 outlines the key details of these initiatives. Details on the methods of integration and evaluations are outlined more fully in the sections below.

Table 5.2. Examples of functional and organisational integration

Policy	Country	Coverage	Common characteristics and type of integrated care provided	Period
Co-ordinated Care Trials	Australia	Federal with two rounds of trials: first: 12; second: 5	Pooled funds, devolved purchasing and formal care co-ordination; enhancing the role of GPs; care planning	1997-1999 and 2002-2005
Institut National d'Assurance Maladie-Invalidité (INAMI)	Belgium	National	Nursing and ADL assistance within health coverage	n/a
System of Integrated Care for the Frail Elderly (SIPA)	Canada	Province of Quebec	Integrated institutional, social and community services; universal access, intensive home care availability; 24/7 on-call support; case management; multidisciplinary teams	1998-2001
Veterans Independence Program (VIP)	Canada	Federal	VIP complements existing federal, provincial or municipal programs to promote independence and self-sufficiency. Veterans may qualify for financial assistance to obtain services such as grounds maintenance; housekeeping; personal care; access to nutrition; health and support services provided by a health professional.	1981-present
Services Intégrés de Soins à Domicile	France	National	Nursing care and personal support in activities of daily living (ADL) for those covered under the health insurance	n/a
Program for All-Inclusive Care for the Elderly (PACE)	United States	30 States	Case management; interdisciplinary teams; adult day care; access to supportive health and social services; capitation payment	1997-present
Social Health Maintenance Organisations (SHMO)	United States	Regional	Case management; access to health and social services; capitation payment	1985-present
On Lok	United States	Federal	Integrated management or provision with pooled funding; comprehensive long-term care, health, social, housing and transportation services	1971-present

Source: Cited in the discussion below.

The Programme of All-inclusive Care for the Elderly

The United States' *Programme of All-Inclusive Care for the Elderly* (PACE) is an integrated provider-model that offers community-care services for frail older people (55+) with high needs covered by Medicare or Medicaid. With the aim of maintaining these frail individuals in the community, the core component of the programme is an adult health day centre, which co-ordinates and organises services delivery. These centres have their own, directly-employed staff, typically working in multidisciplinary teams, who are collectively responsible for each individual in their care (Curry and Ham, 2010; MacAdam, 2008). The foundation of PACE is the *On Lok*-programme, which was first established in 1971.

Outcomes of PACE for the programme participants have been mostly positive. A study found that patients receiving services through the programme as well as their care takers were 15% more likely to be satisfied with their care, compared to the control group that did not have access to PACE. PACE patients' use of nursing home care and emergency health services also decreased (Beland et al., 2006). Moreover, participants in the PACE programme reported positive outcomes in terms of health status and quality of life: 43% of participants compared to 37% in the control group reported being in good health, whilst 72% compared to 55% indicated to be more satisfied with their lives (Curry and Ham, 2010). PACE is also the only integrated model of care that has been shown to decrease mortality amongst programme participants (Kodner, 2009).

Although PACE has been successful in delivering quality elderly care, the model has also faced some criticism. First, it has been slow to expand due to the considerable upfront investment and the time PACE sites required to become self-sustaining. Moreover, the programme has failed to attract middle-income elderly, and primarily serves low-income individuals covered by Medicare and Medicaid. Medicare covers the majority of frail elderly, but they are often not poor enough to receive means-tested Medicaid benefits. Due to the high out-of-pocket costs for Medicare-only participants (a median of USD 2 841 per month), expanding the programme to middle-income markets has been difficult (Trice, 2006).

System of Integrated Services for Aged Persons

Inspired by PACE, the Quebec Government piloted an integrated model of care, the *System of Integrated Services for Aged Persons* (SIPA) that provided acute health, social, long-term care and some housing services. This programme, which ended in 2001, shared many characteristics with PACE, relying on service delivery methods such as case management, multidisciplinary teams and community-care provided in local community centres (Beland et al., 2006).

The SIPA programme in Quebec was found cost effective, especially when treating patients living alone with severe chronic illnesses. While not resulting in significant cost savings, an evaluation of SIPA showed a substitution from acute hospital and institutional care to community-care. The impact of the programme on patient satisfaction, however, was found insignificant (Beland et al., 2006).

Social Health Maintenance Organisations

The *Social Health Maintenance Organisations* (SHMO) in the United States relied on a different model of functional integration. Sharing similar goals with PACE and SIPA,

SHMO was an insurance model with a defined benefit of geriatric community-based and case management services financed on a capitated at-risk basis (MacAdam, 2008).

Evidence suggests that those who were enrolled in the SHMO programme in the United States had more positive experiences than those in just the general Medicare system (Newcomer et al., 1990). In the longer term, SHMO also reduced the risk of institutional placement of the frail elderly (Fischer et al., 2003).

Functional and organisational integration in Europe and Australia

In Europe, a few countries have developed models of service delivery for frail older people that share common features with North America's integrated health and social services programmes. The *Institut National d'Assurance Maladie-Invalidité* system in Belgium, for instance, delivers nursing care and personal support in activities of daily living (ADL) for those covered under the health insurance. A similar system is currently also in place in France, where nursing and ADL assistance across social and health sectors are provided in a home-setting for individuals within health coverage. These strategies have been shown to reduce incentives for hospitalisation but may lead to substitution of lower to higher intensity care (Colombo, 2013).

In Australia, the *Co-ordinated Care Trials* were a joint initiative of the state and territory governments aiming to reform and improve the Australian health care and community system. Targeting ageing populations with complex and chronic conditions, two rounds of trials were operated, between 1997-99 and 2002-05. Although the trials varied in scope and design, the models relied on two key innovations. First, they were financed through a joint "pool of funds", which combined funds from a range of Commonwealth and State health care programmes (e.g. Medicare Benefits Scheme; hospital funding). Second, the trials consisted of a care co-ordination process undertaken by either a case co-ordinator or a service (e.g. a GP or an Aged Care Advisory Team) (Parliament of Australia, 2013).

A national evaluation of the first round of *Co-ordinated Care Trials* recorded few improvements in cost savings or service use outcomes: the trials had no impact on patients' health or well-being. Although the use of community services increased, they had little effect on hospitalisation. Moreover, the trials recorded higher costs compared to existing resources. The limited success of the trials was explained by the short timeframe of the project, poorly defined outcome measures, and problems associated with implementing a new model of care within pre-existing care structures (Australian Government, 2007).

Drawing on lessons learnt from the first round of trials, the second round of care trials produced more promising outcomes. Programme participants recorded improvements in the quality of life, and frail elderly service users reported better access to services as well as "improved sense of [health] security". The second round trials also showed some indications of cost effectiveness (Australian Government, 2007).

Co-ordination of elderly care

Though few countries have fully integrated the financing or management of services, many OECD countries have invested in improving elderly care co-ordination. A variety of different approaches exist, ranging from case management and multidisciplinary geriatric teams to shared guidelines, selected cases are discussed in greater detail in the following sub-sections (Table 5.3).

Table 5.3. Integrated care policies at the delivery level

Policy	Country	Coverage	Common characteristics and type of integrated care provided	Period
Hospital Admission Risk Program (HARP)	Australia	35 state-wide HARP services in Victoria	Care co-ordination (e.g. case management); carer involvement; multidisciplinary teams; outreach care	Late 1990s - present
PRISMA	Canada	Province of Quebec	Case management, single-entry point, screening, joint governing board	1997-present
Geriatric Teams	Denmark	Some municipalities	Multidisciplinary teams to visit elderly patients following discharge; home-based treatment	n.a.
Wiesbaden Geriatric Rehabilitation Network	Germany	City of Wiesbaden	Standardised survey tool to ascertain the personal and domestic situation of the elderly; improved co-ordination across public and private health and social service providers	n.a.
The Multidimensional Assessment District Unit	Italy	Veneto region	Multidimensional assessment of elderly patients' needs; preliminary collection of information by the GP or social worker; standard assessment forms; case manager and an integrated care plan	n.a.
ASSRRERIT – CUP 200	Italy	Province of Bologna	Network between the voluntary sector, associations and public administration to support the frail elderly; service centres; 24/7 call support; link with GPs and clinicians; exchange with municipal social services; transport etc. services	2005-present
Rovereto	Italy	Rovereto commune	Integrated management or provision without pooled funding: one partner delegates their duties to another to jointly manage service provision; comprehensive community-based medical and social services	1995-1996
Vittorio Veneto	Italy	Vittorio Veneto region	Comprehensive community-based medical and social services; integrated management or provision without pooled funding: one partner delegates their duties to another to jointly manage service provision	1997-1998
The Working Unit for Continuous Care (WUCC)	Italy	Alto Vicentino region	Geriatric assessment unit organised within local hospitals; organisation and provision of continuous and integrated health and social care; multidisciplinary team; social worker acts as a case manager	n.a.
Walcheren Integrated Care Model	Netherlands	Walcheren province	A screening tool for the detection of frailty among the elderly; a single entry point; evidence-based comprehensive need assessment tool; a multidisciplinary individualized service plan; case management;	n.a.
Integrated Care Pilots	United Kingdom	England	Integration of practitioners working in different organisations; integration between community-based services such as general practices, community nursing services and social services	2009-2011
Community Assessment and Rehabilitation Teams (CART)	United Kingdom	National	Multidisciplinary team based in a single location; integrated assessment; funded from health and social care budgets, managed through the NHS or social services	n.a.

Note: n.a. refers to no information available.

Source: OECD (2013), “OECD Questionnaire on Integrated Social Services Delivery, Part 2, Frail Elderly”, unpublished Social Policy Questionnaire; MacAdam, M. (2008), “Frameworks of Integrated Care for the Elderly: A Systematic Review”, CPRN Research Report, April 2008; Integrated Action Group (2013), “A Compilation of Good Practices”, Action Group on Replicating and Tutoring Integrated Care for Chronic Diseases, including remote monitoring at regional level March-April 2013.

Programme of Research to Integrate the Services for the Maintenance of Autonomy

The *Programme of Research to Integrate the Services for the Maintenance of Autonomy* (PRISMA) in Canada was first established in the province of Quebec in 1997, targeting seniors aged 75 and older. While similar in many ways to the fully integrated North American programmes, PRISMA co-ordinates service provision through a joint governing board. Moreover, joint funding agreements (e.g. pooled funds) are not an essential part of the PRISMA programme, although they are commonplace. Generally, the board defines the strategy and allocates pooled funds to the provider network.

PRISMA has produced significant outcomes in a randomised controlled trial (RCT) evaluation. First, PRISMA has reduced the functional decline of programme participants compared to a control group. Second, programme participants have reported more

satisfied with their care. Finally, whilst there was little difference between the use of inpatient care and length of stays between the two groups, patients treated within the PRISMA programme were less likely to re-use emergency department services ten days after discharge (Hebert et al., 2005).

Rovereto and Vittorio Veneto

In the 1990s, two integrated care programmes, *Rovereto* and *Vittorio Veneto*, were piloted at the provincial level in Italy, targeting just 300 elderly individuals. These two programmes, relying on case management and multidisciplinary teams, integrated the provision but not the commissioning of services. Access to these services and geriatric assessment was enabled via a single point of entry, a local services centre which carried out a geriatric assessment (MacAdam, 2008).

Evaluations of both programmes showed positive results. Significant reductions in acute hospital admissions were recorded, and the two programmes also produced positive health outcomes amongst programme participants. Importantly, both *Rovereto* and *Vittorio Veneto* were found cost effective. Estimated cost savings of the former were ITL 1 125 per person. Cost-benefit analysis of the latter showed a decrease of 29% in costs per client (Johri et al., 2003).

The Australian Hospital Risk Admission Programme

Australia has also recognised the need for better co-ordinated care for ageing populations. To prevent increases in demand for hospital emergency services, a state-wide initiative, the *Hospital Risk Admission Programme* (HARP) was piloted by the Victorian Department of Human Services. HARP primarily targeted elderly people who frequently presented themselves to hospital emergency departments. Funding was provided for projects that integrated care to improve this group's health outcomes and service use. The key attributes of this programme included carer involvement, care co-ordination and facilitation, and self-management education.

The Australian Hospital Risk Admission Program was shown to reduce costs by USD 1 million compared to the existing system (MacAdam, 2008). Moreover, its effects on services use were significant. A reduction of 20.8% was recorded in emergency department admissions. Admissions for inpatient care fell by 27.9% and the length of stay (bed days) was reduced by 19.2% (Bird et al., 2007).

Integrated Care Pilots in England

The *Integrated Care Pilots* in England were first initiated in the NHS Next Stage Review 2008, which highlighted the need for better co-ordinated and integrated care. Some 16 organisations were selected to participate in the Integrated Care Pilots programme, the majority of them focussing on the care of older people with long-term conditions and at risk of hospital admission (RAND, 2012). The ICPs, reflecting needs and priorities at the local level, developed a number of integrating activities, mainly focussing on the processes of integration, such as case management or care planning.

The national evaluation of these two-year pilots showed mixed results. Process improvements were recorded (e.g. use of care plans, professional training). Although these process improvements were believed to improve care, they have not yet produced measurable outcomes. No increase in patient satisfaction was recorded. Moreover, the evaluation showed decreases in planned admissions and outpatient service use but no reduction in emergency department admissions (RAND, 2012).

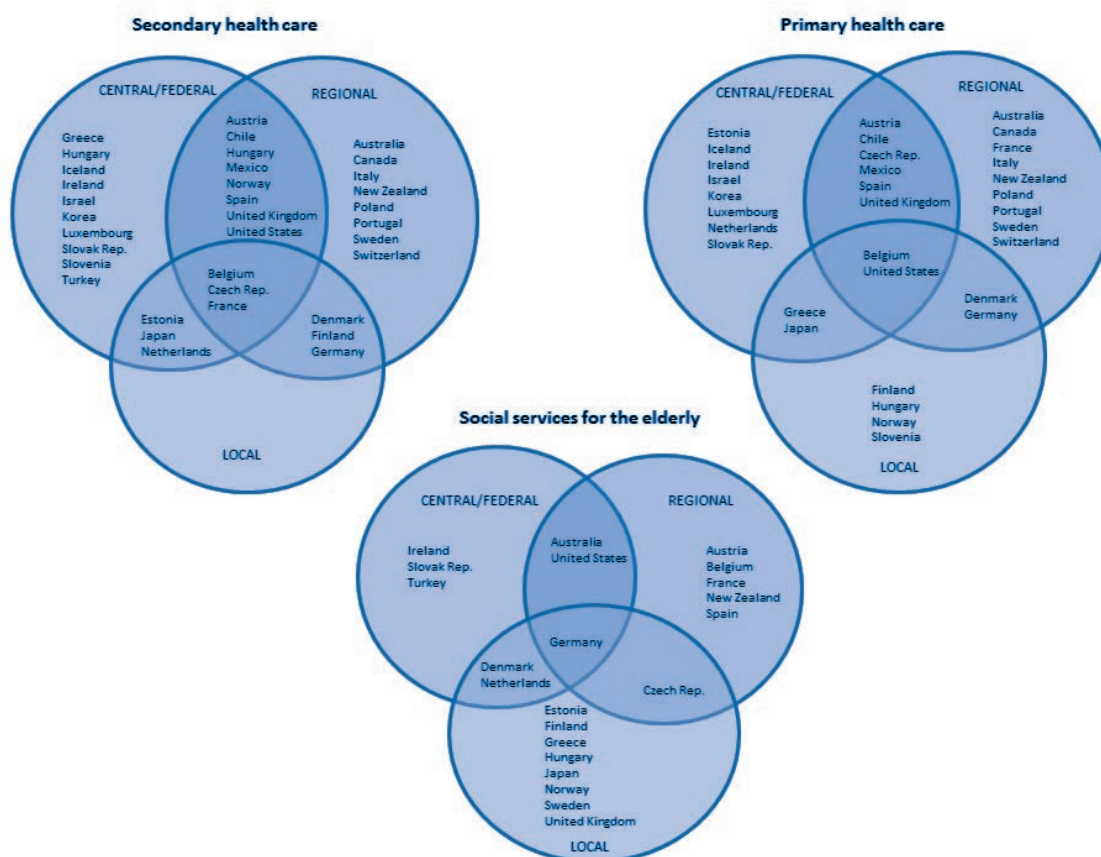
5.6. Integrating services for the frail elderly: Common issues for consideration

Existing care delivery structures and “bottlenecks” between the social and the health care sectors hinder efforts to provide care in an integrated setting (MacAdam, 2008). There is also need for better measurement on the quality of care co-ordination. This section examines the challenges to integration within existing care delivery and financing structures, and discusses the current state of care co-ordination in OECD countries.

Management and provision of services for the elderly tend to be fragmented

Across OECD countries, existing service delivery structures for the frail elderly tend to be fragmented. In particular, the division between the health and social sectors has often been highlighted as a major impediment to providing care in multidisciplinary settings (Mur-Veeman et al., 2008). As Figure 5.3 illustrates, many different actors and levels of governance are involved in service delivery. This contributes to the fragmentation of services between, and within, sectors.

Figure 5.3. Responsibility for managing primary and secondary health and social care services



Note: **Primary care** services include first contact services for diagnosis and treatment of acute and chronic illnesses, health promotion, disease prevention, health maintenance, counselling, and patient education, in a variety of health care settings. These services can be provided by primary care physicians and nurses or other types of professionals. **Secondary care** refers to medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialised knowledge, skill, or equipment than the primary care physician has.

Source: OECD (2013), “OECD Questionnaire on Integrated Social Services Delivery, Part 2, Frail elderly”, unpublished Social Policy Questionnaire.

In Sweden, for instance, despite the recent reform of elderly care (see Section 5.5), a number of system-level factors hinder care integration. Medical health services (i.e. primary and secondary health care) are a regional responsibility, whilst social services, including elderly social services for the elderly, are managed by local authorities (Anell et al., 2012). Moreover, at the management-level, information flows between primary and secondary care tend to be poor, and competition between GPs and social care providers has hampered efforts to improve collaboration and co-ordination between sectors and providers (Mur-Veeman et al., 2008).

The decentralisation of services in Sweden, which is similar to Finland, also leads to notable regional differences in successfully implementing integrated models of care. Limited steering power by the central government has also impeded the development of integrated care in these two Nordic countries (OECD, 2015; Mur-Veeman et al., 2008). Nonetheless, these countries have made progress in enforcing integrated social and health services delivery in recent years: Finland's new Health Care Act, for instance, requires that health and social services are provided in an integrated setting (Health Care Act, 2011). In Sweden, on the other hand, central governing bodies have been merged to streamline some administrative structures, including the Federation of County Councils and the Association of Municipalities (OECD, 2013a).

In many countries where health and social services are mainly privately provided (e.g. the Netherlands or Germany), service provision remains fragmented. Integrated care is difficult to manage, given the multiple, autonomous actors and levels involved in service delivery. In an insurance-based system such as the Netherlands, integrated care may also be affected by a lack of support by insurers and competition between service providers (OECD, 2013a; Mur-Veeman et al., 2008).

In the United Kingdom, the division between health and social sectors is long-standing and has been subject to many integration attempts in recent years. Delivering services in an integrated manner has been a core objective of the central government in the past decade, and a number of financial instruments and co-ordination mechanisms have been implemented (RAND, 2012). Nonetheless, many barriers to effective delivery of integrated care persist, due to, for instance, differences in accountability, funding mechanisms and budgetary cycles between different sectors.

Fragmentation of service has also been a long-standing concern in Canada. Two levels of government share power of legislation and governance. National principles are defined at the federal level, whilst the provinces and territories deliver, and administer services. Provinces receive federal funds toward health (and social) services, whilst the fiscal power is held by the federal government. The publicly funded health care system only covers medically necessary hospital and physician services, and as such does not include integrated community-care for the frail elderly. This has caused some tension between the levels of government, discouraging the provision of innovative, cost-effective services, such as integrated community-care for the frail elderly (Beland et al., 2006).

Service integration can be particularly challenging in countries where the acute care sector dominates, where there is little provision of community services and/or where there exists a weak primary care sector (Schwierz, 2013). Indeed, given that integrated models of care encourage ageing in place, they are likely to reduce the demand for, and shift resources away from, acute secondary care.¹ This goes a long way towards explaining the absence of integrated approaches in these countries (e.g. in Slovak Republic) (Mur-Veeman et al., 2008; OECD, 2013a).

Complex financing arrangements

Financing arrangements for health and social services are also highly complex, and the financing of care from multiple sources is regarded as a major barrier to effective, well-co-ordinated care. To avoid any “indirect spill-over effects” of a specific payment arrangement to another sector, the potential negative effects of different payment mechanisms on integrated delivery of care should be carefully addressed (Davis, 2007).

What are such “indirect spill-over effects”? For example, some forms of financing (e.g. fee-for-service) can encourage cost shifting between providers: in a setting with two or more bodies responsible for funding a service, there is an incentive to pass on the cost to the other (Hofmarcher et al., 2007). Moreover, when two services are both provided by a local authority, but the central government funds one service (e.g. secondary health care) and local sources fund the other (e.g. long-term care services), authorities may be incentivised to overuse services for which they do not pay, whilst controlling the costs of those they pay (Frank et al., 2012). In the Czech Republic, for example, diverse ways of financing the services – such as medical care from health insurance and social welfare subsidies from the state budget, from the regional governments and from the person’s income – is a major impeding factor to integrating care (OECD, 2013a).

Multiple financial arrangements between co-ordinated groups may also result in under investment in areas where the returns are not shared equally or proportionally between the co-ordinating bodies. This can occur, for instance, in funding and staff hours. In contrast to cost shifting, this return shifting may disincentivise increased investment, even in cases where efficiencies are shown.

Policies that control access to (and hence demand on) secondary care settings can also affect service provision for patients in need of comprehensive, well-co-ordinated care. For instance, when gate keepers in primary care for the elderly are not confronted with budgets or explicit prices, the proportion of elective admissions to secondary care can increase (Dusheiko et al., 2006). Furthermore, gate-keeping coupled with misdiagnosing can put pressure on secondary specialist services (Brekke et al., 2007).

Finding the most suitable payment regime – and aligning payment schemes across and within sectors – is a challenge across OECD countries. In addition to the potential negative effects of different financing mechanisms on delivering integrated care, policy makers should carefully reflect on how reforms in services delivery might negatively affect any other policy principles. Such principles may include equal access to, or patients’ right to choose services (Karlson, 2007).

Obstacles to integrated care at the provider level

Integrated care also challenges traditional working cultures and service providers’ roles: differences in training, culture and attitudes, for instance, can hinder joint working. Health care providers, particularly doctors, have traditionally been seen as holding a higher status than social service employees (Munday, 2007). Differences in interests, motivations, and behaviours at the provider-level enable potential inefficiencies, or failures, in service delivery. The workload of service providers is also likely to increase, at least temporarily, as a result of integrating care services. Learning new referral and information systems, and adapting to new integrated ways of working, can take time from handling their existing workload (Maslin-Prothero and Bennion, 2010).

There is a lack and little measurement of care co-ordination for the frail elderly

Despite the negative effects of poorly co-ordinated care on the frail elderly, there is little measurement of the quality and the extent of care co-ordination between the health and social sectors. Whilst only a few cross-national indicators exist to measure this co-ordination, the OECD Expert Group on Health Care Quality Indicators is now developing a list of comparable indicators on patient experiences on integrated care (for further information, see OECD, 2013b). Administrative data on hospital admissions, for instance, may offer more robust indicators for the quality integrated care for the frail elderly, as poorly co-ordinated and low-quality health, social and long-term care services are factors that lead to preventable hospital admissions (for further details see OECD/European Commission, 2013).

At present, the few measures on the quality of co-ordinated care rely mainly on patient experience surveys. These surveys, however, are primarily implemented at the national or sub-national levels, and data is currently collected in only a small number of OECD countries, including Canada, the Czech Republic, France, Ireland, Sweden, and the United Kingdom (England and Scotland) (OECD/European Commission, 2013).

The Commonwealth Fund (2011) also recently conducted a survey in eleven OECD countries, investigating health care co-ordination for sicker adults. Whilst the survey did not specifically focus on frail elderly individuals, it illustrates the current state of care co-ordination for patients with similar health and social care needs. The findings of this survey highlighted the need for well-co-ordinated care in all participating countries, but found some promising ways to improve the co-ordination of care (see Box 5.4).

Box 5.4. Health care co-ordination can be facilitated by medical homes, but effective, well-co-ordinated care remains a challenge

The 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults investigated care of over 18 000 adults who were in fair or poor health; had surgery or had been hospitalised in the past two years; or who received care for serious or chronic illness, injury, or disability in the past year. The average age of survey responders was 57 years, and 38% had two or more chronic conditions. Eleven OECD countries participated in the survey (conducted by telephone), including Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States. The survey focused on areas such as affordability and access, care co-ordination, patient-centred care, management of chronic conditions, and medical homes.

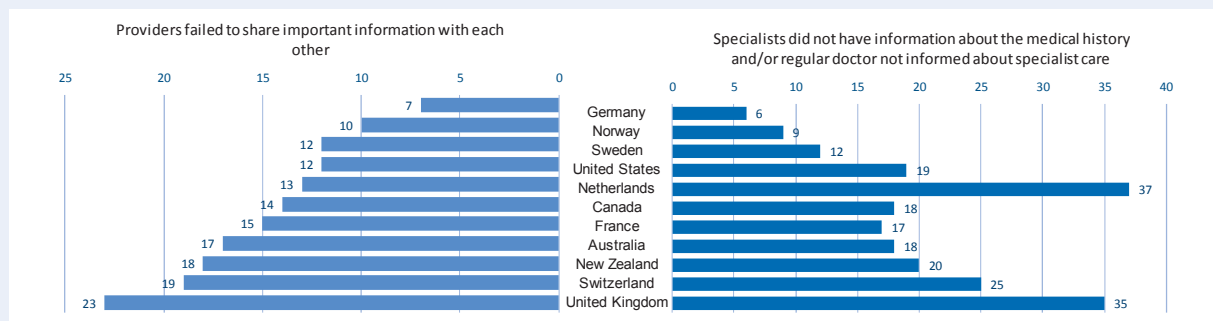
Whereas patients with complex care needs in the United Kingdom and Switzerland stood out in the survey as generally reporting more positive experiences compared to other countries, most problems were encountered by sicker adults in the United States, especially in terms of cost of and access to care. The share of patients having problems or being unable to pay medical bills in the past year, for instance, was as high as 27% in the United States, compared to only 1% in the United Kingdom and 14% in the Netherlands (the second highest percentage).

This survey highlights the need for improved care co-ordination in all participating countries from the perception of the patients. For example, providers failing to share important information with each other is a problem especially in the United Kingdom, followed by Australia, New Zealand and the Switzerland. The problem of specialists not having information about patients' medical history and/or regular doctor not informed about specialist care, on the other hand, was particularly pertinent in the Netherlands and the United Kingdom (see Figure A).

Moreover, the proportion of patients encountering difficulties in getting after-hours care without having to go to the emergency room was relatively high in all countries. The percentages range from 21% in the United Kingdom and 26% in Switzerland to over 50% in Sweden, France, the United States, Australia and Canada. There were also significant gaps in hospital or surgery discharge in some countries: the proportion of patients *not* receiving a written plan for care after discharge was as high as 46% in Sweden and 44% in Norway and the Netherlands, in comparison with 7% in the United States. In addition, almost half (47%) of the patients in Germany and France did not have arrangements made for follow-up visits, compared to only 12% in the United Kingdom.

Box 5.4. Health care co-ordination can be facilitated by medical homes, but effective, well-co-ordinated care remains a challenge (*cont.*)

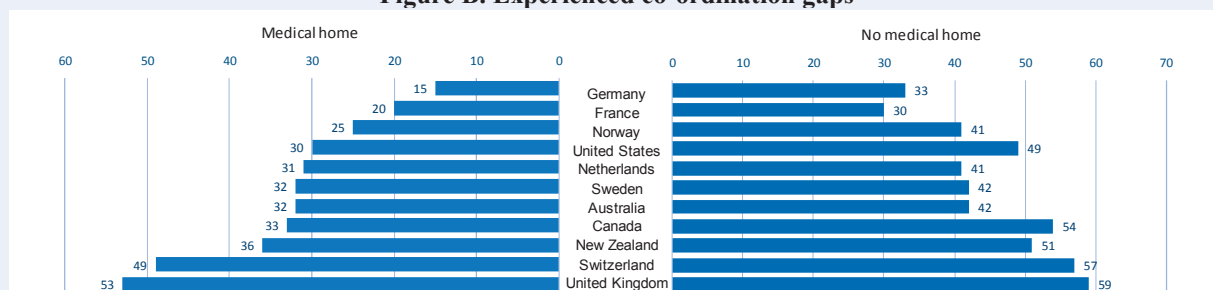
Figure A. Co-ordination problems in the past two years



Source: Commonwealth Fund (2011), “The Commonwealth Fund International Health Policy Survey 2011 of Sicker Adults in Eleven Countries”, Commonwealth Fund.

Medical homes¹ users were found to be more satisfied with their care and reported fewer care co-ordination problems than those without a medical home in all countries. This is illustrated in Figure B. Patients were most likely to have access to medical homes in the United Kingdom and Switzerland, where three quarters of patients reported having a regular doctor or a place that helps to co-ordinate care. In other countries, the share was slightly lower at around 60%, with the exception of Sweden (42%). In addition, patients with medical homes also reported more positive experiences in managing their care for chronic condition. This result holds across countries.

Figure B. Experienced co-ordination gaps



Source: Commonwealth Fund (2011), “The Commonwealth Fund International Health Policy Survey 2011 of Sicker Adults in Eleven Countries”, Commonwealth Fund.

As the survey illustrates, medical homes contribute to more positive patient experiences and fewer problems with care co-ordination. Nonetheless, all countries face problems in providing effective, well-co-ordinated care to patients. To provide more effective care to sicker adults, measures need to be taken to address issues such as co-ordination problems, gaps in hospital or surgery discharge, or patient engagement in chronic care management.

1. Medical home refers to an accessible primary care practice that knows their medical history and helps co-ordinate care (Schoen et al., 2011).

2. Test results/records not available at time of appointment, doctors ordered test that had already been done, providers failed to share important information with each other, specialists did not have information about medical history, and/or regular doctor not informed about specialist care.

5.7. Summarising the evidence

As this chapter illustrates, integrating care for the frail elderly has the potential to improve service use outcomes and cost effectiveness, although the evaluations show mixed results (see Section 5.5 and Annex 5.A1). While these programmes share similar aims, their success depends on a variety of factors, such as available resources; identified population; models; objectives and local circumstances. Moreover, it may be hard to determine which integrated models work best in different service delivery contexts. No single component of an initiative has shown to be effective by itself, but typical promising features of these programmes include integrated information systems; case management; and multidisciplinary teams.

Adequately measuring the impact of integrated care programmes on costs remains a challenge, especially in the short term. Indeed, it is difficult to assess which components of these programmes are necessary to realise financial gains given the variety of initiatives, differences in the services structures and care cultures, services offered, and target populations and their sizes (Curry and Ham, 2010).

Evidence on integrated care within the health sector, such as chronic care and disease management programmes, suggests that cost efficiency of a programme depends on the types of diseases treated. Any impact on cost savings or efficiency depends whether a disease's conditions are associated with high-cost unnecessary treatment or with under-treatment prior to the integrated care initiatives (RAND Europe and Ernst and Young 2012).

In sum, integrated care for the frail elderly shows potential in improving service users' outcomes and lowering public costs. Continued innovation and rigorous evaluation of these programmes should illuminate the discussion in coming years.

Note

1. Acute secondary care refers to short-term specialist medical care received by patient for a severe injury, an episode of illness or an urgent medical condition.

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Annex 5.A1

Summary of formal evaluations of integrated care

Rigorous evaluations of integrated models of care for the frail elderly show measurable evidence on cost effectiveness and service use outcomes. This evidence stands in contrast to studies of other vulnerable groups, such as the homeless, vulnerable families, and people with complex health needs. While there is a need for further research on the cost benefits and long-term effects of integrated care for the frail elderly, this group does not suffer from a weak evidence-base. Evidence from available randomised and quasi-experimental evaluations is presented in Table 5.A1.1.

Table 5.A1.1. Evaluated initiatives and outcomes measured

Source	Evaluation method	Policy	Hospitalisation ED	Mortality	Health outcomes/ Functional status	Patient satisfaction	Quality of life	Costs
Bird et al. (2007)	RCT	HARP	+					+
Australian Government (2007)	RCT	Co-ordinated Care Trials	+		+		+	(+)
Beland et al. (2006)	RCT	SIPA	+/-			(+)		(+) ³
Hebert et al. (2005)	Quasi experimental, non-randomised design	PRISMA	+		+	+		0
Kodner (2009)	Quasi-experimental, non-randomised evaluation	PACE	+	+	+		+	0
Fischer et al. (2003)	RCT	SHMO	1			+		
Ham et al. (2008)	RCT	Rovereto	+		+/-			+
Ham et al. (2008)	Quasi-experimental study with six-month follow-up	Vittorio Veneto	+		+			+

Note: “+” indicates significant positive result; “-” indicates significant negative result; (-) or (+) indicates non-significant positive or negative results. “-/+” indicates mixed results. An empty cell indicates that this outcome was not studied.

1. Over time, the availability of home and community services reduced the risk of institutional placement of at-risk elderly.
2. Increase in emergency admissions with reduction in elective admission and outpatient services; significant increases in costs for emergency admissions, balanced by significant reductions in costs for elective admissions and outpatient attendance; ;for case management sites, there was a significant 9% reduction in overall secondary care costs in the six months following intervention.
3. SIPA programme was found cost effective, but did not result in significant cost savings.

Source: See references in the table.

All models of integrated care aim to reduce institutional care and hospital admissions by emphasizing community-care. In general, integrated models of care have shown success in this respect: evidence across evaluations suggests a significant decrease in hospital and emergency department admissions for the majority of initiatives. Only On Lok in the United States and Integrated Care Pilots in England had a negative or little

impact on hospital stays and emergency admissions. SIPA, PACE, SHMO, Vittorio Veneto, and Rovereto, also recorded a decrease in nursing home care.

While integrated care seems like it should reduce the lengths of stays in hospitals, emergency department admissions, or nursing home care, the evidence on these outcomes programmes remains inconclusive. Only few initiatives have recorded significant cost savings compared to traditional services delivery.

Chapter 6

Towards better integration of social services

Governments across the OECD are experimenting with innovation in the integration of social services for vulnerable groups, despite a lack of detailed evidence in support of specific approaches or implementation practices in this area. To facilitate future policy development, this chapter sets a scene for successful delivery of integrated services based on the varied service integration policies, targeting different vulnerable groups, outlined in this report. The chapter includes a discussion of the main challenges to, and opportunities for, integration of social services, and concludes with a section outlining evidence on what works, promising practices for policy experimentation in the area, and cautions regarding expectations for returns from integrating social services for vulnerable groups.

6.1. Introduction

Public service delivery aims to ensure that people access services that are both good for them and good for society, both in terms of social outcomes and cost considerations. In recent years, a combination of social and economic conditions – increasing public service budgets, increasing social need, the Great Recession and fiscal consolidation – have put pressure on service systems to do more with less, leading to innovation and reform in the area of social service delivery.

Public social services not only seek to deliver public / merit goods directly to the general public, but also form an integral part of balanced support for the most vulnerable groups, and two aspects in particular make integrating social services for vulnerable groups an attractive target for policy makers:

- First, expensive vulnerable groups, who can be reintegrated into society or receive less costly “preventative” services, are the “perfect social intervention”. The most intensive social services not only cost the most, but also need to achieve the most for their clients. By successfully targeting those with complex and high service needs, governments expect to achieve the greatest social returns, as well as substantial (long-term) cost savings.
- Second, the simple concept of “working better together” has a common sense appeal that suggests that service collaboration around users with high-support needs will lead to a reduction in repeat services, as well as provide a better idea of who needs which services, in which order, and the priority levels attached to decision making. The appeal of working better together has already led to new collaborative forms of services delivery across OECD countries, ranging from small-scale pilots to national policy priorities.

But how realistic are these targets, and how successful are the existing interventions and early innovations? The overarching purpose of this report has been to better understand the value of innovative social services delivery by: developing a conceptual frame through which methods and innovations in the area of the integrated delivery social service can be described and developed; collating comparative data on vulnerable groups; mapping cross-nationally the governance of different social services for these groups; and reviewing available evaluative literature on integrated social service policy (including financial mechanisms). This final chapter aims to build on the cumulative evidence in this report to contribute to a burgeoning debate on by reviewing the range of integrated delivery methods and policies targeting vulnerable groups with complex, multiple and generally cost-intensive service needs to assess what works.

Overall, the integration of social services is a promising option to explore, but the evidence-base must be strengthened to determine its impact in the long-term on both social outcomes and cost savings. This report finds that unmet service needs, in particular in the most vulnerable groups, exist across OECD countries, meaning that even in the most advanced welfare states, despite universal access to mainstream services and targeted intervention for the most vulnerable, there is scope for reducing demand for costly and acute interventions, as well as emergency and correctional services. To meet these goals, methods for improving the effectiveness of social interventions in health and social services are needed, primarily those that focus on early intervention and prevention practices. These should come at a reasonable cost benefit ratio, which – given present

fiscal constraints – should be carefully aligned to both present budget constraints and future cost savings.

This final chapter is organised as follows: Section 6.2 looks at steps toward successful service integration by introducing some cautions for expectations of meeting the goals of integrating social services for vulnerable groups (of achieving more with less), and the key characteristics of a fully functioning integrated service. Section 6.3 introduces the main existing challenges to successful implementation of social service integration. Section 6.4 concludes with recommendations for policy makers from the points of view of evidence from the report on what works, pointers for promising practices in the field.

6.2. Towards successful service integration

Integration of services is a heterogeneous concept, and policies integrating services vary greatly in their scope, design and goals. Differences in the governance, financing and culture of delivering services largely explains the plethora of these types of initiatives, which in turn make it difficult to draw lessons and share information across OECD governments. This section starts by outlining what to expect, and importantly what not to expect, from integrated services delivery, before reviewing different ways of integrating services and presenting a model of an effective integrated service as a point of departure.

What to and not to expect

One of the clearest messages from this report is that expectation for integrated services to produce quick, clear, cost savings and improved services user outcomes has not been universally evident. With the exception of positive cost benefit findings in the area of frail elderly care, and evidence linking homelessness and mental health care to lower emergency health service use, the field still depends mainly on *predictions* of cost savings, based on expected falls in intensive or emergency services use, rather than on *actual observed* cost savings. To ensure that expectations for integrated services do not lead to overinvestment, or withdrawal of integrated practices that produce later (or yet unobserved) returns, it is important to outline some cautions for policy makers implementing such policies in the future. These are as follows:

First, the available evidence-base on the effectiveness and efficiency of integrated services, as well as the uncertainty around which components make integration successful, suggests that *governments should not expect direct and quick cost savings in all cases*, or simple integration to work. For instance:

- The costs of integration can be substantial and may increase in the short term as better identification of need and better services drive increased demand. Integration set-up costs may also be high and require considerable upfront investment. Budgets to meet the running costs of services need to be sustainable which highlights the need for mechanisms need to link upstream cost savings to these budgets.
- Outcomes and cost savings may not occur in the short term. New services take time to become stable and effective systems of care. Furthermore, due to limited evaluations, there is little robust evidence on whether improved outcomes and cost savings can be achieved in the long term. Therefore it is important to begin to build this evidence base. To facilitate long-term cost effectiveness evaluations, predefined outcomes should be matched to, or be capable of mapping to, measures available in longer term observational studies.

Second, when drawing evidence of what works from country to country, particularly cost effectiveness and cost benefit analysis, *it is important to apply the equivalent of “purchasing power parities” to services developed and importantly services that are replaced.* The cost of services such as hospitalisation, imprisonment, and other services – vary broadly country to country, and without contextualising costs and savings, cost benefit/effectiveness analysis is not directly transferable. Transferring savings expectations without adjustments will inevitably lead to under or over estimates of savings, information which can lead to inappropriate goal setting, or even underinvestment in cases where higher saving may be made.

Third, *governments can expect the general trend for increasing the role of third-party contribution to social services to impact on integrated service delivery* (private providers who are for profit, not for profit or volunteers). In particular, third party inclusion is likely to lead a number of challenges for integration, including increased reliance on mechanisms for data sharing, post-hoc accounting, and effective (long-reaching) evaluation studies. Without these it is hard to effectively facilitate, regulate, justify or reward, third party intervention (for more details on the practical considerations see Section 6.3 below).

Fourth, *austerity measures and fiscal consolidation taken as a response to the Great Recession can potentially affect demand for, and efficiency of, integrated social services.* While scaling back service infrastructure produces short-term savings, these may not translate into longer-term efficiency gains if significant human or institutional capital is lost in the process. There can therefore be trade-offs between quick cost cutting fixes (such as budget ceilings or envelopes), and measures to improve longer-term efficiency. These trade-offs are likely to be important in the case of services which will see increasing demand in the future (e.g., long-term care), and those which are complementary to productivity in the economy (e.g., childcare). When responding to cyclical fiscal pressures, one relevant consideration is that service cuts are typically not easily reversed, so that temporary reductions in service capacity can create greater future costs than temporary changes to cash transfers or taxes. Austerity measures instituted at different levels of government can also result in considerable additional co-ordination challenges, with devolved responsibilities for the delivery of these programmes. Likewise, cuts to education budgets could affect skills development, or school environments, and exacerbate problems such as youth unemployment.

Fifth, perhaps the largest contributor to the demand for integrated social services for the vulnerable is the design of the mainstream social protection system, *the mainstream system is most people’s first point of call for social supports, and therefore governments should expect that reform here will impact on the need for integrated services reform – both positively and negatively.* Moreover, the mainstream system is something that some former vulnerable service users will be reintegrated into, and may rely on as part of their recovery. For these reasons, governments should not expect to be able to solve issues of vulnerability with treatment services alone and ultimately should strive for social systems that prevent the need for such treatments; in an environment of increasing rates of acute social need and dependency, this is likely to require wholesale social protection reform.

What does success in integrated services look like?

Integration is an emerging trend, but as demonstrated in previous chapters, approaches to integration vary considerably. Yet, despite these large variations, a set of common choices or distinctions are repeated across the examples, including: universal versus targeted integrated services; top-down versus bottom-up approaches; vertical versus horizontal integration; formal integration (including financial and legislative initiatives) and more informal practices; and the ability to use, or restrictions to, the sharing of service user data across service providers and sectors (see Box 6.1).

But what gives an integrated service the best chance of success? While no one-size-fits-all solution exists, integrated services share broadly similar goals and the most successful integrated systems have a number of characteristics in common. A model of best practice in integrated service delivery includes the following aspects:

- Systems with stated goals to improve service quality, social outcomes and satisfaction with service delivery among both service users and providers.
- Systems with the explicit purpose, and necessary flexibility, to increase co-operation and collaboration between providers and agencies. To allow for the development of new, effective forms of services delivery beyond traditional professional boundaries and hierarchy, to the benefit of service providers and users.
- A system to reduce the cost burden of delivering support and care, by reducing multiple visits, duplication of services, and costly emergency interventions like hospitalisation.
- A system by which financial returns to investment can be balanced across difference sectors, including mechanisms to link upstream cost savings in sector B to extensions or innovations in series or programmes in sector A.
- Systems to facilitate information and knowledge sharing between professionals and agencies (e.g. through joint training programmes), to identify future clients and their future needs. To this end, an integrated service should collect data and enhance data-sharing within pre-determined, and monitored, ethical processes.
- Enhanced access to services, particularly for vulnerable people in need of priority services, such as housing, health care, employment supports or food for the homeless to address both the acute need and the underlying drivers of their vulnerability to repeated interventions.
- Budget streams for the integrated aspects of service delivery, which are sustainable, at the very least up until the point of (and including the costs of) first evaluation.
- A suitably long-term time frame to ensure the optimal development of the policy and appropriate evaluations, and benefit from cumulative investments in cases of success.

Box 6.1. Integrated services and data sharing – Central issues

A central issue when integrating services is data sharing, both horizontally and vertically. Exchanging information in the social services delivery context should reduce time and bureaucracy, prevent duplication of service delivery, allow more accurate and holistic understanding of the service users' needs, and strengthen overall service delivery.

Increasing interagency collaboration in social services while dealing data privacy and confidentiality protection concerns can, however, be conflicting. Despite new policy and legislative developments that enforce integrated services delivery, data and information sharing aspects of the developments often lag behind.

In any given integrated service delivery setting, service providers are governed by “certain statutory provisions and practice frameworks in relation to information sharing”, which concern safeguarding personal information and consider any data privacy laws (Richardson and Asthana, 2005). While formal integrated service agreements are often accompanied with information sharing guidance, they are generally complex and include several statutory provisions to be taken into account when sharing information in an integrated setting.

Other factors also complicate efficient sharing of data between services providers. Differences in professional cultures and values across sectors, for example, can affect the way information is shared: agencies and providers can interpret policy and legislation with regard to information sharing differently (health professionals focusing solely on medical aspects, social sector workers on broader issues that involve other aspects of clients' needs, e.g. family, community). Service governance arrangements are also likely to affect information exchange (Richardson and Asthana, 2005). Compatibility of IT systems can also be a major barrier to sharing information.

Examples exist of integrated services delivery programmes that successfully share, or plan to share, data across sectors.

- *Targeting Alcohol-related Street Crime* (TASC) in Cardiff, Wales. Links hospital and police data, no problems reported in relation to data-sharing (Richardson and Asthana, 2005).
- The proposed *Vulnerable Kids Information System* (VKIS) in New Zealand draws together information on the most vulnerable children from government agencies and frontline professionals. Government agencies and frontline professionals will be able to access the information specific to the children they are working with, when they need it. Community-based agencies contracted to deliver services to vulnerable children and their families will also have appropriate access. Security of the VKIS is an absolute priority, all data will be password protected with clear protocols for use, a code of conduct on safe information-sharing will be developed (all government agency staff will be required to sign the code of conduct, and agencies which are funded by government to deliver services will also be expected to make it part of their staff training), and there will be penalties for misuse. The system will have different levels of access for different professionals and groups – for example, a social worker, a school principal, and a paediatrician would be able to see different levels of information about a particular child or family.
- Two Acts in the United States which regulate the sharing of service user information include the *Health Insurance Portability and Accountability Act* (HIPAA) of 1996 and the *Family Educational Rights and Privacy Act* (FERPA) of 1974. These Acts outline an individual's privacy rights (and amendment rights) to data held by service providers about them or their children. Issues have included:
 - debate over the right balance between individuals' privacy and freedom versus the safety and security for all,
 - the need for health care professionals to stay abreast of privacy regulations regarding student records while providing needed care,
 - confusion over which privacy regulation is applicable when related to student health records.

6.3. Main challenges to achieving successful integration

OECD countries are experimenting with integrated service delivery, and will continue to do so as pressure to improve outcomes with limited budgets exists. While the potential benefits of service integration make it a worthwhile avenue to explore, several challenges hinder transitioning from “silo” approaches to more collaborative forms of service delivery. Due to these challenges, the precise added-value of social service integration remains uncertain, even in the case of the simplest integrated models of service delivery. In particular, it is yet unclear whether integration results in cost savings *and* improved outcomes, especially in the long-run. This section therefore starts by looking at what information is missing, the management of people and money in integrated systems and governance issues, the potential role of the private sector, and building an evidence base (including steps for policy evaluations).

Estimating the demand for integrated social services and optimising take-up

One major challenge to providing integrated services for vulnerable individuals with complex, cross-cutting needs is the lack of comprehensive information on the extent of vulnerable populations and their needs. To determine the demand for integrated services, and the priority of receipt, clients who will demand integrated services will need to be identified.

Identification has its challenges, especially in countries with barriers to comprehensive data sharing. These barriers can include, but are not limited to, split welfare databases, privacy legislation, or cases where vulnerable populations are more “hidden” for various reasons (e.g. stigma). The process of identification has an additional of overcoming the issues of stigma, and these will need to be effectively addressed if optimal take-up of services is to be achieved. One possible solution is the use of a cascaded approach, where universal services act as a referral point for more intensive interventions.

Managing people and money

A second challenge to affecting the integration of service interventions is the sub-optimal management of people once in the system, and money within the system. This challenge refers to the issues such as fiscal federalism and cost shifting and people shifting within the system (see Chapter 1).

The success of integrated services reform depends on how well different sectors – with different conditions and roles – work together in practice. Competition between service providers, leading to cost shifting, people shifting, and the “wrong pockets” (or returns-shifting) creates barriers to effective integration. The justification for competition of this kind may be due to a number of reasons such as professional competitiveness, budgeting linked to client numbers, or fiscal fragmentation leading to the ability to place costly service users into services funded by other parts of the system (see Figure 1.2).

- Mechanisms are needed to dis-incentivise people shifting and cost shifting, or to restrict the practice of clients being moved to between services in an integrated system without the agreement of all providers. Such a mechanism could be the standard appointment of case workers, who would be allocated to service users from an overview organisation, or by a review boards on which representative of all services are present.

- To manage the complex problem of returns accruing in one sector when work is put into another (the “wrong pockets problem”), particularly where there are mismatches in the conditions of professionals in these areas, new financing practices are needed. These practices may take the form of end-of-year auditing and realigning of budgets based on workloads and cost savings, or increased investment in preventive services (such as proposal for the United Kingdom’s Better Care Fund), pooling budgets, or the creation of surplus account funded by system-wide cost savings, to meet shortfalls in budgets created by overtime or hiring practices undertaken to meet higher demand in a given service. In the case of post-hoc budget realignment, cost-effectiveness evaluation might be needed, which will result in additional costs (see sub-sections below, and Box 6.2).

A macro-level issue for people and money management in social service reform, such as integrating service delivery, is that reform can achieve limited results if the mainstream social protection system in which they function is not preventing further vulnerability. Managing people and money through the social protection system better *over time* will reduce the demand for the types of intensive interventions outlined in this report.

Vulnerable groups are essentially a “stock” of persons who experience a set of social outcomes requiring multiple human service interventions. The duty of the social protection system is to try and ensure that further persons do not enter this state of vulnerability, and that those who are experience this state are helped to reintegrate into society if possible. Preventative approaches are key here, as are robust and timely evaluations of the effectiveness of mainstream policies. In cases where vulnerable groups are to be reintegrated into society, transition policies, and practices (including referrals and data-sharing where possible) should be developed. In cases where vulnerable groups are not to be re-integrated into the mainstream system (insofar as they are dependent to an extent that they will need continuous social support throughout their lives – frail older elderly, people with severe disabilities, or intellectual disabilities) client participation in service selection and evaluation, and methods to reduce emergency service use should be prioritised.

Governing administrative changes

As demonstrated across the report, a third challenge is complex governance structures that create immediate challenges to effective integration of social service delivery. Horizontal integration of front-line social services, will not only require new “top-down” organisational arrangements, but also:

- Multi-level governance agreements outlining managing and financing practices involved in integration (this varies based on the devolution of funds, or blocks grants from central to federal or local government which is common amongst OECD countries – OECD, 2013); and complicated by the political economy of the process;
- Significant financial input to account for administrative changes, which, when the returns on integration only have the potential to be long term, policy makers may be reluctant to make such commitments; and
- Differences in front-line professionals’ skills and employment conditions can inhibit effective integration and delivery both in terms of the ability and the incentive to collaborate effectively. Strong management (or case management) and training are ways to address this challenge.

Social enterprise or third party involvement in social service delivery

A fourth challenge to the integration of social service delivery is the expanding role of social enterprise or third party involvement in service delivery. Social enterprise often takes the form of autonomous or semi-autonomous service providers. They may be for profit, not for profit or volunteers. They may be supported by legislation (such as special company status – b-corps or limited liability), or restricted by legislation (tax obligations or profit expectations), and altogether driven by factors outside of the control of the public service delivery in general. In principle this means they will be subject to the challenges outlined above in the discussion of management and governance, but are likely to be outside the direct control of public service bodies, and may fail to benefit from practices available to public social services.

In particular, practices in public service delivery can create specific challenges to social enterprise involvement, such as:

- *System planning*: Public interventions, including integrated services, are designed to fit into systems, meaning complementary mainstream services are considered in the design. Social enterprises will need to be complementary to public services which are relied upon to regulate demand for integrated services, or facilitate outflow from a service (e.g. social protection will limit/regulate the inflow of vulnerable families' services). These complementary services will inevitably affect the demand for third party services, and may create sustainability risks.
- *“Cross-sectoral” returns and “wrong” pockets*: Cross-sector returns are a specific challenge to social enterprise (particularly for profit) as the incentives to allow for returns to accrue in the public sector from interventions undertaken in the private sector will be low. Social Impact Bonds do provide one solution to this issue, but because not all public returns are tracked or monetised at present, or achieved within a pre-determined timeframe, innovation in this area is critical for making third-party involvement work.
- *Fixed capital and human capital*: At present, in many countries, public service systems have large amounts of fixed capital and many employees. The management of both human and physical capital in public service systems represents additional policy options (with social outcomes) for governments. For instance, the geographical location of the service and the employment conditions of its staff can be part of national plans for employment creation, or community regeneration. Third party involvement may limit these options.
- *Borrowing, funding streams, and sustainability*: Public services traditionally have had access to borrowing or funding streams to allow for the treatment of social need even in the most difficult economic circumstances. They do not have a profit principle, meaning they can trade-off low cost cases with cases third party organisation might see as too costly to work with. Critiques of “for profit” social enterprise highlight the profit-principle which may “trump” social efforts at the individual or community level if the business model becomes unsustainable (Yunus cited in Esposito, 2013).
- *The need for third-party regulation*: Regulation can create disincentives for third-party involvement in public services delivery (through additional associated costs for instance), but regulation is required for two reasons. First, system planning, and expectations for minimum living standards and human rights achievement will

means that public services will inevitably serve as a safety net to failures in the third party system. Second, sustainability and impact assessments will be required on behalf of the public in order to justify: 1) the risk associated with private involvement public good and/or merit good delivery; and 2) payments made to third-parties. This is particularly important in the case where this third party involvement is predicated on profit making as the precondition of profit making results in incentives to reduce costs, and withdrawal from the market in times of difficulty. Ways of imposing regulation could be through impact-conditional payments (where payments are made following robust evaluations of positive impacts, either in terms of effectiveness or cost savings, without negative impacts) or through legislative instruments, such as framework acts which outline rights and responsibilities of third party service providers.

Meeting these challenges effectively is essential if social enterprises are to be fully integrated into public social service systems.

Building the evidence base

A final substantial challenge to significant, long-term commitment in integrated services delivery is the weak evidence-base as regards to its effects on service use outcomes and returns to investment. Indeed, several OECD countries have established new services delivery methods, which are essentially forms of integration, but have not recognised them as such. To build a stronger foundation for lesson drawing within and across OECD countries, it is imperative that efforts are made to evaluate and disseminate findings as regards to the effectiveness and efficiency of integrated services.

Evaluation innovations in social service integration practices

The need for better evaluations of the social impact of integrative services cannot be understated. Public services can have long lasting effects on people's lives, and the effectiveness of today's policies is part of the picture that determines the need for costly future social interventions. Yet, the combined evidence shows that there are too few good quality evaluations suitable for informing market participants and policy makers about "what works", and most importantly "how" the integration of social services might be implemented.

A number of concrete steps can be made to build this evidence base:

- Countries should review ongoing practices for integrative aspects, any completed evaluations should be made publically available, unevaluated practices should be evaluated.
- Social outcomes and cost savings of each new integration practice should be defined, involve client and providers input, and include expected spill-over effects.
- These social outcomes should be measurable independently of the policies' target measures (to avoid new "short-cutting" practices being developed), and include at least one distributional measure to retain a check on the "inclusivity" of the intervention effect.
- Compulsory evaluations should be incorporated into new integration practices to provide a check on the effectiveness of the approach, and revisit and reform failing approaches form a more secure evidence base.

- Evaluations need to be methodologically rigorous, and undertaken by independent researchers, or a formal regulatory body.
- Timing of all social intervention evaluations should be predetermined and based on when social returns to interventions, or cost savings, can be expected. More than one evaluation might be needed, as the same integration practice may contribute to more than one outcome over time.
- Data techniques, such as data matching to administrative sources and national surveys, could be facilitated by governments and independent groups to provide access to contextual data in order to and improve the quality and efficiency of evaluation processes.

A serious consideration for policy makers searching for robust evidence for designing new social services, including interested services, is that there is a trade-off between the need for timely policy interventions and the weight of – and wait for – the most rigorous evidence. Because it is important to act on social need in a timely way, there should be an expectation for “learning on the job”. Risks associated with such an expectation can be limited first and foremost by piloting social interventions, by undertaking independent evaluations on untested aspects of the intervention, and preparing a recipient-focussed (pilot) “exit plan” with appropriate funding in place.

What to evaluate? Cost-benefit analysis and cost effectiveness analysis: Some key points

Two types of evaluation methods are needed to assess whether integrated services delivery can do more with less: cost-benefit analysis (CBA) and cost-effectiveness analysis (CEA) (see Box 6.2 for a more detailed discussion of these methods). Cost-benefit analysis (CBA) enables evaluators to compare the costs of a policy or intervention with its benefits measured in monetary terms. Cost effectiveness analysis (CEA) compares the costs of meeting a given policy objective measured in the form of a social outcome (e.g. “number of lives saved” or “DALYs”; EuropeAid, 2005). In the case of CBA, accurate information on the costs of meeting the objective must be available. Secondly, and most importantly, the programme benefits must be *valued* even if these do not have a price. CEA is used to determine the costs of meeting a given objective, and to compare between the costs of meeting that given objective.

In the context of policy discussions related integrated delivery of social services the role of CBA and CEA is limited if the service provider or service user derive a value from the investment which may or nor may not be identical to that which is being used for the evaluation of public policy. This is a strong argument for participation of service users and providers in the design of both services and evaluations, and requires that evaluators confer with providers and users prior to determining desired outcomes in order to avoid reform sacrificing unobserved benefits.

The evaluation should be as comprehensive as possible in the determination of costs and benefits, accounting for indirect and long-term effects of the programme and reflecting the interests of all stakeholders involved (Better Evaluation, 2014). In some policy settings, an intervention may also be expected to have spillover effects in other sectors, both positive and negative. Additional evaluations may be needed to monitor these spillover effects into other sectors for the purposes of addressing the “wrong pockets” problem (when returns to investment are found in other sectors), or identifying cost or people-shifting problems.

Evaluators should also be prepared to adjust the outcome measures used to evaluate an intervention based on the time since the intervention occurred – these might be termed “accumulated outcomes” and valued accordingly. The Perry Preschool intervention is a working example of this, where early years’ interventions were still having positive social impacts decades later, but in the labour market and educational outcomes, as oppose to early years’ outcomes of child health and parenting skills development. Equally, spillover outcomes may also be subject to this principal.

Box 6.2. How to evaluate the cost benefits or effectiveness of integrated services?

Cost-benefit analysis (CBA) is useful for policy makers to compare the costs of an intervention with its monetary benefits. Whenever possible, this type of analysis should be undertaken for any project involving policy development, capital expenditure, use of assets or setting of standards (Better Evaluation, 2014).

CBA is frequently used before the start of a programme, in order to assess which course of action should be taken, as well as after its implementation, to determine the monetary returns of a specific intervention. Decisions are taken by policy makers by comparing the net present value (NPV) of the intervention’s benefits with its costs. Future benefits are attached a smaller value, and are generally discounted at a 3-6% discount rate (Better Evaluation, 2014).

Two conditions are necessary when conducting CBA. First, accurate information on the intervention costs must be available. Second, and most importantly, the programme benefits must be assessed in monetary terms. In the case of integrated service delivery for vulnerable groups, the monetary benefits associated with the intervention would accrue both to the individual and to society in the form of cost savings, which can be estimated by using both individual-level data on service users and national data sets (HighScope, 2005).

Programme evaluation with CBA generally focuses on economic efficiency, ignoring the wealth redistribution effects on the targeted population. The latter might be of particular concern, for instance, whenever a policy has positive effects on high income groups at the expense of poorer groups. In this case, the analysis can be modified to assign more weight to the outcome for disadvantaged groups. CBA is the right tool to evaluate whether planned interventions targeting vulnerable groups are economically worthwhile. The benefits of these programmes accrue to the individual and to the general public in terms of savings in the use of other services. The generalisation of CBA results to diverse settings, however, can be misleading. Savings deriving from programmes to disadvantaged groups are due to reductions in negative outcomes (e.g. crime, remedial education, unemployment, use of public health care services), where the costs of these negative outcomes can vary widely across countries. Ad-hoc CBA’s should be conducted when planning implementation of projects in new settings, so as to produce valid and grounded evidence to decision makers.

When the monetary value of the programme benefits cannot be estimated, cost-effectiveness analysis (CEA) can be a good tool to compare alternative courses of action. CEA is particularly effective when the desired outcome of a certain programme is easily identifiable. This type of analysis is frequent, for instance, with health care policies, for which it is difficult to assess the monetary benefits but it is relatively straightforward to determine the desired outcome 5e.g. “number of lives saved” or “DALYs”. EuropeAid, 2005).

As with CBA, CEA can be used by policy makers both before and after the start of a programme. CEA measures costs in monetary terms and compares them with the outcomes, expressed in terms of physical units. The ratio of costs to effectiveness is computed in order to determine the cost per unit of effectiveness; most effective projects will have lower cost-effectiveness ratio.

CEA is generally best used when evaluating projects with a direct and well identifiable outcome. When the benefits of the intervention accrue to different stakeholders, or when the programme has indirect effects, CEA might not be the right evaluation tool, and policy makers might prefer to use CBA instead.

Both CBA and CEA should be as comprehensive as possible in the determination of costs and benefits, accounting for indirect and long-term effects of the programme and reflecting the interests of all stakeholders involved (Better Evaluation, 2014).

6.4. Making integration work: Good practices and promising practices

How to make the integration of social service delivery work? Despite limited evidence and information on integrated services delivery across the OECD, some broad policy recommendations can be drawn from the analysis in previous chapters of this report on what steps are required to give integration policies their best chance of success, and what is promising in terms of practice, in the area of integrated social service delivery.

Steps for success in integrated social service delivery

A crucial step to improving services delivery for vulnerable populations with multiple needs is to *better identify these groups and monitor their services use* (see Section 3.6 and 4.3 in Chapters 3 and 4). Currently, few countries systematically collect data on multiple vulnerabilities or multiple services use, which hinders obtaining a comprehensive picture on their services use, and needs. However, available evidence shows that multiple vulnerabilities across different groups are common, and in some cases on the increase (e.g. vulnerable families, the frail elderly). Improving data collection on vulnerable populations is an essential element in the design of innovative services delivery methods that target these individuals.

Information-sharing across providers and sectors should be facilitated as another important step. Efficient information-sharing agreements facilitate identifying gaps in services provision and reducing duplication of services (see Sections 1.5 and 1.6 in Chapter 1, and Box 6.1). Despite legislation in some countries that withholds recorded personal and treatment information of service users, where data can be ethically shared for the purposes of improving services delivery, this should be undertaken. This may mean matching identification numbers of service recipients, for the purposes of managing (not withdrawing) the delivery of multiple but unique services, or the use of pooled anonymous data at the individual or community level in order to predict the demand for services, to facilitate up-streaming and early intervention, as well as budget management.

Outcomes-oriented strategies, as well as evidence-based guidelines and protocols, are needed to facilitate effective delivery of integrated services for vulnerable populations. As raised in Section 6.3, the lack of evidence-base on (cost) effectiveness of integrated services is a major challenge to draw lessons across countries and invest in innovative methods of delivering services. Integrated service initiatives that are accompanied with clearly-defined targets and measurable indicators produce more robust and reliable evidence on the impact of integration.

Service user-centred approaches to integration of services are most efficient. Services should be integrated from a service user, not a provider, perspective, as it allows service users to make informed choices about their own care. Carefully defining the target population and their particular needs enables a holistic, patient-centred approach to integrating care. For the frail elderly, for example, community care provided in a home setting is the optimal delivery method in this context, both in terms of cost effectiveness and patient satisfaction. Patient-centeredness also helps taking a *non-stigmatising approach* to providing services for the homeless, or people with mental health concerns (see Sections 3.4 and 5.4 in Chapters 3 and 5).

Best-practise initiatives should be scaled up where possible. While evidence on the effectiveness on integrated services remains somewhat inconclusive at the national and international levels and in the long term, a number of evidence-based practices have been

found effective both in terms of user outcomes and costs in the short term and should be scaled up. Examples are available in each of the preceding chapters.

Integration of services delivery needs to be accompanied with financial integration. Financial integration is necessary to prevent cost shifting when multiple sectors are involved in services delivery (see Section 1.5 in Chapter 1). Good-practice examples of bringing together financial resources in the area of service integration for the vulnerable include, for example, pooling together budgets or resources under a single funding envelope or integrating budgets for defined care services (Section 5.4 in Chapter 5).

Greater investment and focus on early intervention and prevention is warranted when integrating and delivering social services for vulnerable populations. This finding is not novel and supports vast research on the benefits of intervening early for at-risk groups.

- *Early intervention and prevention can also reduce future demand for services* for individuals with highly complex needs, and savings will accrue from reduced demand for (costly) service in the centrally managed budget. For instance, integration of (mental) health services with education systems can yield positive return by enhancing children's and adolescents mental well-being, having positive returns in terms of compulsory school completion and educational attainment (see Section 3.6 in Chapter 3). By moving demand for services “up-stream” meaning intervention happens in advance, and perhaps prevents the need for complex or intrusive intervention in the hospital. This also would improve the quality of living for those involved.
- Integrating early years support offers most potential when tackling family vulnerability (see Section 2.6 in Chapter 2). Whether preventing vulnerability as part of universal services, or further social exclusion and intergenerational disadvantage in the context of targeted means-tested initiatives, *placing an emphasis on multiple interventions in the early years is often shown to have the most positive outcomes on child and family well-being.* Younger children's behaviours are more malleable, and interventions for younger children have longer to accrue than those late, and the more malleable children. Early intervention reduces the likelihood of costly intervention later in life.

Making use of “locked” social resources is important, and could, for example, mean a greater role for schools in social service provision. For vulnerable families, and children and youth with mental health concerns, schools can provide a cost-effective opportunity for child welfare policies, there are complementarities between social outcomes (health and education), and the cost of new interventions will be marginal compared to those placed in new settings or environments, with new professionals (see Section 3.6 in Chapter 3).

Promising practices in integrated social service delivery

While drawing broad conclusions on what works, or does not work, is difficult in the light of available evidence on integrated services, a number of promising practices have emerged. While these practises may not be necessarily transferable, fully evaluated, or cost efficient, they show potential in improving the process and/or outcomes of integration.

In regards to delivery in particular:

- *Case management and single-entry points to access services* (one-stop shops), are promising delivery methods. Nonetheless, case-management of home-based services remain necessary for the most vulnerable groups who are not able to go to service providers for various reasons.
- *Models of integrated care that have shown to be cost effective are commonly those that find ways to substitute costly acute emergency, or hospital/nursing home care.* Indications of cost savings or effectiveness have primarily been found in the area of integrated care for the elderly. The integrated-provider models SIPA and PACE in Northern America, for example, have produced returns for investment, either in the form of shifting resources to less expensive and preferred forms of care settings or cost savings.
- *Integrated delivery of social services is most effectively embedded when taking a whole-system approach.* Integration of services at the delivery level works better when it is accompanied by integrated governance and accountability arrangements. Lack of support or commitment at the higher governance-level will also impede the up-scaling of effective initiatives. Moreover, whilst top-down approaches to integration facilitate breaking the “silo-mentality” when planning and implementing services, they risk failing to enforce new methods of services delivery if not accompanied by strategic tools at the local-level.

In regards to administration:

- One promising practise to improve the co-ordination of elderly care is *the use of block grant payments which have been linked to performance targets* in Sweden, such as avoidable hospital admissions for chronic conditions. Although quality targets have not yet been reached by many local authorities, the initiative has shown to improve data collection and quality registers for elderly care.
- *Legislation to facilitate the process of implementation integrative practices can be helpful.* Integration of services is formalised by a legal obligation for example in Finland and Sweden. Sweden has enforced the right to an individual co-ordinated care plan and a case manager for continuous care for patients with cross-cutting health and social service needs. Similarly, the Finnish Elderly Care Act, which went into effect in July 2013, also explicitly holds local authorities responsible for providing health and social services to the elderly in an integrated setting.
- *A promising practice in financial integration, in terms of preventing cost shifting or other perverse incentives to integrating care, is the use of pooled funds, managed by an joint oversight body* that ensures agreement on how funds are spent. When funds from a central service (e.g. health) are pooled with local service (social care) – managed by oversight group – and spent only on social care services at the local level, the inflow of patients to the health services can be reduced (or reduce the level of need of these presenting). Consequently, this approach can be both effective (improve service use outcomes or quality of life) or efficient cost (save money).

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Integrating Social Services for Vulnerable Groups

BRIDGING SECTORS FOR BETTER SERVICE DELIVERY

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