

Unclassified

English - Or. English

5 March 2024

**DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE**

An integrated approach to service delivery for people with multiple and complex needs

OECD SOCIAL, EMPLOYMENT AND MIGRATION WORKING PAPERS No. 305

JEL classification , Z18

Authorised for publication by Stefano Scarpetta, Director, Directorate for Employment, Labour and Social Affairs.

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JT03538734

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Abstract

Increasingly, integrating or joining up public services to improve service users' access to, and experience of those services is being viewed as fundamental to ensuring personalised services are effective in addressing the multiple and often complex needs of those in vulnerable situations. These are service users who often require a range of tailored and, in some cases, specialised supports and services from more than one agency or service provider. This working paper provides an overview of promising approaches OECD countries are taking to integrating service delivery for care experienced young people, people with disabilities, and people leaving prison. The aim of making this paper available is to support policymakers who are seeking new or improved approaches to improving the outcomes of those who rely on personalised services.

Acknowledgements

This working paper was produced as part of the project titled 'Developing a New Approach to Personalised Services for Vulnerable Groups in Lithuania'. To inform the project, the OECD undertook several activities including a review of relevant international good practices. This review included looking at how OECD countries are implementing integrated service approaches, specifically for care experienced young people, people with disabilities, and people leaving prison.

The activity was funded by the European Union via the Technical Support Instrument, and implemented by the OECD, in cooperation with the Directorate-General for Structural Reform Support (DG Reform) of the European Commission. The views expressed herein can in no way be taken to reflect the official opinion of the European Union.

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1 Introduction

In 2021, the government of Lithuania requested the support of the OECD and the Directorate General for Structural Reform Support (DG REFORM) of the European Commission to develop a new approach to personalised services for people in vulnerable situations in Lithuania, with a specific focus on services for care experienced young people, people with disabilities, and people leaving prison. This request was in line with commitments in the Programme of the 18th Government of the Republic of Lithuania to strengthen personalised social services and make them more accessible, effective, and timely.

As part of the project, the OECD produced a series of notes and organised workshops on relevant good practices, including on integrated service approaches across OECD countries. Integrated service provision was identified as a key focus area because well integrated services, across domains and sectors, are fundamental to ensuring personalised services are effective in addressing the multiple and often complex needs of those in vulnerable situations.

The note on integrated service approaches for care experienced young people, people with disabilities and people leaving prison (which was drafted in mid-2022) is released as an OECD Working Paper as it contains useful information for policy makers in other countries. While the note is not an exhaustive review on the topic, it provides a useful summary of how countries are integrating services for those who require a range of tailored and, in some cases, specialised supports and services from more than one agency or service provider.

The aim of making this paper available is to support policymakers who are seeking new or improved approaches to improving the outcomes of those who rely on personalised services.

The working paper starts with a general overview of the literature on service integration, before turning to good practice examples specific to the three priority groups and concludes with some relevant general principles.

The full set of reports published for the project *Developing a new approach to personalised services for vulnerable groups in Lithuania* can be found at <https://www.oecd.org/els/soc/dg-reform-lithuania-personalised-services-for-vulnerable-groups>.

2 Integrated approaches to service delivery

There is growing evidence that integrating public services, and in particular health and social services is a major public policy priority in many European countries. Different models and initiatives are emerging, with varying degrees of integration from partially to fully integrated approaches. This working paper looks at a range of models being implemented to improve the lives and outcomes of care experienced young people, people with disabilities, and people leaving prison.

The literature suggests that integrating or joining up public services to improve service users' access to, and experience of those services could result in sizable efficiency and effectiveness gains, and significantly improve outcomes for service users. Integrated services are particularly relevant for service users with multiple and complex needs who require a range of social services typically provided by more than one agency. Specialisation in social services makes it difficult for these service users to get the right mix and sequencing of services that best meet their needs (New Zealand Productivity Commission, 2015^[1]).

Integration as a solution to service fragmentation originated in health care and much of the literature on models and examples of integrated care and services come from the health sector. Increasingly, however, examples are appearing within the social system and between the health and social systems, and integration definitions, terms, models, and approaches are for the most part equally applicable in both settings.

There are numerous models and initiatives that promote greater integration of services, many multi-dimensional. A 2018 review of integrated care (Baxter et al., 2018^[2]) found that existing models typically encompass multiple elements aimed at improving integration within and between systems. For example, within one model you might find case manager/case co-ordinator initiatives, integrated care pathways/plans, changes to working practices, changes to organisations and systems, and/or initiatives to address the financial and governance aspects of integration.

Integration can be thought of as horizontal and/or vertical. Horizontal integration, which is a more common approach and the focus of many European initiatives, typically brings together policy groups, services, professions, and organisations from across different sectors and/or organisations to address the needs of service users. Vertical integration on the other hand is more likely to be systemic and involve the integration of governance and finance arrangements within multiple service settings. At the macro level this looks like closer co-operation between different levels of government and at the micro level, using a health example, greater alignment of residential, community and home-based services (OECD, 2015^[3]).

Achieving vertical integration can be challenging. In response to this challenge and to support the work of its Service Network Collaboration initiative, Canada developed a publicly available user-guide for service partnerships – the Service Partnerships Playbook. The Service Network Collaboration aims to deliver seamless services across governments and leverage jurisdictions' service delivery networks; the playbook provides a roadmap for anyone looking for advice on how to develop a successful intergovernmental service partnership. It shows how jurisdictions can replicate and/or scale up innovation occurring throughout the country and provides a rich variety of innovative service partnerships underway including those with Indigenous governments. The user-guide was developed prior to the COVID-19 pandemic and

possible update work to incorporate lessons learned in more recent years is currently being planned.

Common across both horizontal and vertical integration approaches is the idea of intensity from limited, possibly ad hoc arrangements to full integration. The OECD report on *Mental Health and Work: Achieving Well-integrated Policies and Service Delivery* (OECD, 2014^[4]) proposed a framework for classifying the degree of integration from least-change (linkage) to co-ordination (structured, inter-organisational action with a focus on co-ordinating services) to full integration (responsibilities, resources and financing combined in a single organisation or system).

In another report, titled *Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery*, the OECD (2015^[3]) defined (horizontal) integration to cover collocation, collaboration, and co-operation, each with a different degree of intensity of integration. Collocation refers to having all agencies in one location which can reduce complexity and costs for service users and help promote collaboration among groups of service providers and professionals. Collaboration entails a higher level of integration and refers to agencies working together through information sharing and training and creating a network to improve service user experience. The highest degree of integration is achieved through co-operation defined as professionals communicating and working together for example “within small clinical teams or from multiple agencies” on a service user’s case.

A well-cited paper by Munday (2007^[5]) expresses the continuum of intensity as a ‘ladder of integration’ in the planning, coordination and provision of social services with appropriate methods to be chosen to suit personal needs, circumstances and possibilities (Box 2.1). The ladder is not meant to imply a hierarchy of methods but rather offers a visual aid to order thinking and action. Its usefulness is in identifying the various forms of closer working arrangements; it is offered as a working model and as such is open to variations and improvement.

Box 2.1. Munday’s ladder of integration of social services

1. Integration of central government ministries and policies: implementation throughout all levels of society.
2. Whole systems working – not necessarily throughout the country.
3. Effective partnerships.
4. Multi-service agencies with single location for assessment and services.
5. Planned and sustained service cooperation and co-ordination.
6. Multidisciplinary teams of professionals.
7. Ad hoc, limited, reactive co-operation in response to crises or other pressure.
8. Almost complete separation / fragmentation of services.

Source: Munday (2007^[5]), *Integrated Social Services in Europe*, Council of Europe Publishing.

There is no one-size-fits-all solution. It is important to choose an optimal set of complementary models, structures and processes that fit the contextual situation and the needs of the target group(s) across their continuum of need. The key is to assist decision makers to select the most appropriate mix (Keast, Brown and Mandell, 2007^[6]), while keeping in mind that not everything has to be integrated into one package. There are many possible permutations to integrating services (World Health Organisation, 2008^[7]).

While there are high expectations of integration as a means of improving service effectiveness and efficiency in a global context of increased demand for services at a time when resources are limited, there is yet little empirical evidence that integrated services are effective because there have been relatively few evaluations of existing integrated service delivery models. The literature does, however, highlight

characteristics observed in existing models that, if fully implemented, may facilitate successful integration, those being: person-centred approaches, the availability of general and specialist services, strong leadership, and information sharing across the system.

The New Zealand Productivity Commission (2015^[1]) identified a set of conditions necessary to deliver an effective, integrated package of services for the most disadvantaged people suffering a complex of intertwined problems. These conditions centre on round-skilled, client-centred navigators who have the necessary decision-making rights and resources to access the services required to improve outcomes for their clients.

The Productivity Commission went on to say that not all services should be integrated. Integration has costs and benefits and these need to be weighed up when deciding how much integration to pursue and by what means, or whether to pursue integration at all. Integration initiatives should focus particularly on areas where the net benefits of integration are strong. Services for the mainstream are mostly provided satisfactorily through the familiar service “silos” – government agencies such as health, education, police and justice (New Zealand Productivity Commission, 2015^[1]).

Following an assessment of integration initiatives in 17 European countries, Munday (2007^[5]) created a set of policy guidelines to assist policymakers in the design and implementation of integrated models of social services. Simply stated those guidelines are:

1. Be clear about purpose – justify the need for integration.
2. Consider critical success factors, for example, undertake a fully transparent and inclusive consultation process.
3. Evaluate critically the challenges involved and how to address them.
4. Examine the various integration models and methods to determine which one suits the particular needs.
5. Consider integration initiatives at the national level - many initiatives to integrate social and other services have typically been relatively small scale, local and often experimental.
6. The regular and routine collection of information on integrated working is necessary for both systematic monitoring and evaluation.

This brief overview of the integration literature is intended to guide the assessment of good practice examples for the three groups set out in subsequent chapters to better understand what integrated service models, approaches or activities have worked best, in what circumstances, and to identify any general principles, irrespective of the specific characteristics of the three groups. Questions to ask when considering whether to integrate services, to what extent and by what means include: what are the individual elements and how do they contribute collectively to the execution of the full model, what is the level(s) of intensity, what types of services have been integrated and for which service users, and what is the context in which the initiative(s) were chosen and implemented? Finally, for each of the groups and across the groups is there a predominant model or models?

The remainder of the working paper provides examples of good practices in the integration of services for the three focus groups of this paper: care experienced young people, people with disabilities, and people leaving prison. For each group, a distinction is made between horizontal integration and vertical integration, with initiatives ranked by degree of integration.

3 Care experienced young people

In 2019, the European Social Network (ESN) identified several new trends in care leaver policy and practice. One is the provision of integrated services that consider the holistic needs of young people leaving state care. Another, related one, is the development of transition plans in cooperation with the care experienced young person at least one year before they reach the age of adulthood (European Social Network, 2019^[8]).

In 2021-22 the OECD undertook a review of OECD countries' policy settings and aftercare supports for care experienced young people to identify both the challenges young people face as well as good and promising approaches countries are taking based on evidence of what works to improve their outcomes in areas such as leaving care legislation, extended care arrangements, aftercare supports and involving care leavers in decision-making (OECD, 2022^[9]). The review found that some countries have embedded an intention to better integrate services for care experienced young person into legislation, including France, Italy, and the United Kingdom.

In 2019, France introduced new legislation to improve services and supports for young people leaving state care, including enhanced cooperation between local public authorities to reinforce access to healthcare, training, and higher education. In 2018, the Italian Government introduced a requirement that social services must establish together with young people in state care, once they turn 17 a personalised activation and social plan based on their individual needs. These plans include coordination of services and the people involved: care experienced young people and their families, social services, NGOs, and public authorities.

In 2017, the United Kingdom introduced in the Children and Social Work Act 2017 seven corporate parenting principles that local authorities must have regard to whenever exercising a function in relation to looked-after children or care experienced young people. One principle is to help children and young people gain access to, and make the best use of, services provided by the local authority and its relevant partners.

Horizontal integration

Many initiatives aimed at better integrating services for care experienced young people discussed in the literature are horizontal integration approaches. Several countries have introduced programmes that provide care experienced young people with intensive wraparound support that includes an element of case management, where a care experienced young person is provided with a professional support person. This person is someone who builds a relationship of trust with the young person and is responsible for ensuring they receive necessary supports identified through a holistic assessment. Critically important is the nature and strength of the relationship between the care experienced young person and their support person.

The importance of relationships is a reoccurring theme in the literature about what works for care experienced people to transition successfully from care. This includes relationships with both professional supports such as case managers or social workers and informal supports e.g., friends, sports coaches and teachers. A number of recently published studies that explored care experienced peoples' experiences during Covid-19 highlight the importance of strong relationships and support networks. A research study

undertaken by the University of Bedfordshire exploring care experienced peoples' transitions in the context of the pandemic to improve policy and practice found that physical distancing measures disrupted traditional models of direct social work practice at a time when support needs and anxieties were heightened. In some local authorities the creative, flexible, and tailored solutions that emerged were seen as a continuation of existing relationship-based practice models within the local authority (Munro et al., 2021^[10]).

Mentoring has become a popular intervention to support young people who are missing social support networks or role models, providing them with a “go to” person when they need help, advice or just someone to talk to. Mentoring could be strengthened in several ways to support the emergence of consistent, stable and trusting relationships. One way is to recruit “natural” mentors who are already part of the young person’s social network, for example coaches if the young person is part of a sports team. Another way is to offer ongoing training and support for mentors so that they are better able to build a stable relationship and know who to turn to if they run into a particularly challenging situation. Finally, structured activities for mentors and young people can also contribute to successful mentoring relationships (OECD, 2022^[9]).

Several countries have formally introduced the concept of a trusted support person. In 2022, France enacted a new law on the protection of children which included a provision that care experienced young people can designate a trusted person if they wish (OECD, 2022^[9]). That person could be a parent or close friend and their role is to help the care experienced young person prepare for autonomy, including accompanying them to an interview with departmental authorities six months after leaving the care system to take stock of their career and access to autonomy.

In 2017, England introduced a new duty for local authorities, requiring them to offer a Personal Adviser to all care leavers towards whom they had a duty under the Children Act 1989. (Box 3.1) In April 2022, the Department for Education announced GBP 36.4 million of funding for Personal Advisers over the next three years (Niamh Foley, 2023^[11]). The planning process, culminating in a pathway plan for each care experienced young person, is a critical input to the support provided by a Personal Adviser and the quality of the planning process is ensured by an *Independent Reviewing Officer* (Box 3.2).

Box 3.1. Personal Advisers and Pathway Plans (England)

Personal Advisers are designated professionals responsible for providing and/or co-ordinating the support the young person needs up to age 25. As such they act as a focal point for the young person, ensuring that they are provided with the practical and emotional support they need to make a successful transition to adulthood. This includes responsibility for monitoring, reviewing and implementing the young person’s pathway plan. A pathway plan details the kind of support the young person might expect their Personal Adviser to provide and address – for instance, information on housing options, benefit entitlements, or support in finding employment. The plan should support the young person’s access to positive activities, education, training, and employment. It must also include the young person’s health and development, building on the information included in the young person’s health plan created when they first entered care. The plan is a “live document”, setting out the actions that must be taken by the responsible authority, the young person, their parents, their carers, and the full range of agencies required to address the needs identified.

Source: Department for Education (2018^[12]), Extending Personal Adviser support to all care leavers to age 25: Statutory guidance for local authorities, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/683701/Extending_Personal_Adviser_support_to_all_care_leavers_to_age_25.pdf

Box 3.2. Independent Reviewing Officers (United Kingdom)

The appointment of an Independent Reviewing Officer (IRO) for each child that comes into state care in the United Kingdom is a legal requirement under the Adoption and Children Act 2002. An IRO's primary responsibility is to quality assure the care planning process for each child, and to ensure that their wishes and feelings are given full consideration throughout all stages of care. According to the statutory guidance issued by the government in 2010 (Department for Children, Schools and Families, 2010^[13]), a key duty of the IRO is to ensure that any ascertained wishes and feelings of the child concerning care are given due consideration by the appropriate authority. The IRO also has the responsibility of promoting the voice of the child throughout the process.

When a young person in care turns 16, an individual pathway plan needs to be put in place in preparation for the young person's transition from care. The IRO handbook states that the voice of the young person should be at the centre of the planning process. The IRO should make sure that the proposed pathway plan has been informed by a good quality assessment in which the young person and their family or professional agency has been appropriately involved.

Source: Based on Stein (2019^[14]), Supporting young people from care to adulthood: International practice, Child & Family Social Work, Volume 24, Issue 3, and Department for Children, Schools and Families (2010^[13]), IRO Handbook, Statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review for looked after children, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/337568/iro_statutory_guidance_iros_and_las_march_2010_tagged.pdf.

Several initiatives aimed at improving service integration for care experienced young people in the United Kingdom were funded by the *Children's Social Care Innovation Programme (CSCIP)*, a Fund launched in 2014 to test and share effective ways of supporting children and young people in vulnerable situations. For instance, Derby City Council received funding from the CSCIP to include young adults who had recently left care (aged 16-25 in *Local Area Coordination (LAM)*). LAM is an all-age community-based approach that aims to empower individuals to develop their personal strengths and find solutions within their community before considering formal services.

The results of an evaluation indicated that the support of a LAM Coordinator can benefit young people who have spent time in care. Young people reflected positively about their relationship with their Coordinator, who was often perceived as more accessible and reliable than other statutory roles. They could contact their Coordinator as often as they wanted or needed to, and there was no 'end date' for their support in contrast to other supports provided by the Council, including that of the Personal Adviser. Evidence from the studies showed that the quality of relationships contributed to positive outcomes for young people (Mollidor et al., 2020^[15]), reinforcing the point above about the importance of trusted relationships.

Shared Lives 16+, a pilot that ran from October 2017 to March 2020 in seven sites across England, was also funded through the CSCIP. Sixty-five care experienced young people were able to share a home with carer(s) who offered personalised support. An evaluation highlighted the need for increased integration across children and adult services and greater awareness of the variety of options for young people leaving care. As a result of the evaluation findings a decision was made to continue offering Shared Lives to young people leaving care. The learnings were shared with other Shared Lives schemes nationally and 18 additional local authorities indicated an interest in developing the offering in their localities (FitzSimons and McCracken, 2020^[16]) (Mitchell-Smith, Caton and Potter, 2020^[17]).

Norway is developing a basic model to improve support measures in child welfare services to ensure that children, young people, and families receive the joined up help they need at the time they need it (Box 3.3).

Box 3.3. Aftercare as part of a “basic model” for assistance measures in municipal child welfare (Norway)

The Norwegian Directorate for Children, Youth and Family Affairs is in the process of developing and testing a “basic model” for support measures in municipal child welfare services. The model will structure and ensure a comprehensive system for selecting, evaluating, and ensuring ownership and collaboration around all assistance and support measures (usually in-home care) from Child Welfare Services across the country.

Aftercare support has been chosen as one of the first areas to be developed and tested during the iterative process. Practice recommendations are developed in collaboration between researchers from three national and regional knowledge centres, practitioners from ten child welfare services across the country, as well as representatives from organisations of child welfare users (young people with care experience, parents of children with care experience and other relevant life experience). The aftercare model builds on key components of knowledge-based communications methodologies, to promote active engagement of young people in planning and evaluating their aftercare support. Practical tools for assisting young people to identify goals and milestones to structure the aftercare support plan are being tested, and young people provide weekly feedback on how they experience contact with their child welfare services case worker. Among the tools in the model currently being piloted are a draft routine with set objectives for the first conversation about aftercare (at age 16 at the earliest, depending on the young person’s situation and maturity), the consent confirmation and aftercare planning discussion (at 17 and a half years) as well as a follow-up interview (at around age 19) with young people who have refused aftercare support.

Source: OECD (2022^[9]), *Assisting Care Leavers: A Time for Action*, OECD Publishing, Paris, <https://doi.org/10.1787/1939a9ec-en>.

Australia has trialled and taken to scale several programmes that offer wrap-around support for care experienced young people, particularly those at greater risk of poor outcomes. Programme components typically include intensive case management support, information and advice services, and flexible funding. Home Stretch for example provides case work support and flexible funding to facilitate a young person’s access to education, employment and health and well-being supports, as well as an accommodation allowance. As of 2022 Home Stretch is offered in all eight states and territories of Australia.

The *Better Futures* programme in Victoria, Australia, is a new way of supporting young people leaving out-of-home care. *Better Futures* is based on a person-centred approach which supports young people to thrive by aligning resources, opportunities and the community with their skills and aspirations. The programme engages with young people and their support networks, including their case managers and care teams, early in their transition from care.

To be eligible for *Better Futures* support, young people must be in kinship care, foster care, residential care, or permanent care on or after their 16th birthday. If eligible, the case manager refers the young person to *Better Futures* when they reach 15 years and nine months, and a *Better Futures* worker is made available to them to age 21. The support covers a wide range of areas including housing, independent living skills, education and employment, health and wellbeing, and connections with the local community.

Stand by Me was established in 2013 by Berry Street, the largest child and family welfare organisation in Victoria, Australia. The programme consists of an intensive, early intervention model aimed to promote a successful transition to independence by engaging and developing relationships with care experienced young people while they are still in care and continuing to work with them more intensively post care. Two social workers are appointed who each work with six young people on a child protection guardianship or custody order i.e., they are likely to be more vulnerable when leaving care. The programme is considered an adaptation of the United Kingdom’s Personal Adviser model (Mendes and Purtell, 2021^[18]).

Vertical integration

Examples of vertical integration tend to be larger-scale and include a range of initiatives. In 2003, *Every Child Matters* (ECM) was launched in England, partly in response to the much publicised and tragic death of a young child as well as the findings of eight public service inspections that noted ‘while public services generally appeared aware of, and acknowledged, their shared responsibility for ensuring children were safe; this was not always reflected in their policy and practice arrangements’ (Department of Health, 2002^[19]).

ECM was designed to improve outcomes for children by making the organisations that provided services to children work better together. Five outcomes that shape child and youth wellbeing were given legal force in the Children Act 2004 and provided the purpose for multi-agency partnerships. Local public services were expected to agree their priorities, plan changes to their services, and measure their collective progress against the five outcomes.

The approach was based on a vision that improved outcomes for children and young people would only be achieved by delivering integrated services and introducing work processes that were common across partner agencies within a framework of integrated strategy and governance. Organisations involved in providing services to children - hospitals, schools, police, and voluntary groups – were expected to team up in new ways, share information and work together. Integrated working arrangements included locating managers and practitioners from different disciplines and services in multi-agency teams (e.g., Youth Offending Teams) and/or, in common sites (e.g., a community or health centre) to break down the obstacles and barriers that existed between professional disciplines, services and teams.

Evidence about the success of large-scale endeavours like ECM is limited. This lack is likely due, in part at least, to the time it takes to realise the goals of significant reform programmes and the challenges of evaluating system-wide transformation. A change in direction is more likely to be the result of new political priorities (ECM was reformed in 2010 when the government changed) or in response to perceived or real system failures rather than any empirical evidence, of success or failure.

One country that has sought to evaluate system-wide change is the Netherlands. In 2015, as part of broader social services reform, the Netherlands decentralised its youth care to the municipalities to simplify the youth care system and to make it more effective and efficient. Decentralisation was achieved through the enactment of the new Child and Youth Act (2015), the idea being that municipalities were better positioned to provide young people and their families with more tailored and integrated supports.

A first evaluation of the Act and the changes it introduced was undertaken by an eight-member multi-disciplinary consortium in 2016/2017. It showed that the intended transformation had not yet been achieved, as decentralisation takes time and extra efforts were needed to realise the ambitions and goals of the Act (Friele and Hageraats, 2018^[20]). In their report summarising the evaluation findings, one of the consortium members highlighted that families in vulnerable situations were less positive about the care provided, and expectations that decentralisation would better meet the needs of young people and their families in particular had not yet been met (Netherlands Youth Institute, 2019^[21]).

The 2015 social services reforms revealed just how poorly care experienced people were supported in their transition from care to adulthood. In the years following, municipalities and central government have worked together on evidence-informed solutions for a 16–27-year-old target group with professionals from different domains now working together to better support the independence of young people in vulnerable situations. Support is based on five pillars of independence, the Big 5: support, live, school and work, income, and well-being, which includes working with young people to identify the networks and sources of support they already have, what material and other informal supports they need such as mentoring and planning for their provision. Further reforms are underway such as the ‘Working with a Plan for the Future’ pilot in six regions that aims to map out what future-oriented working requires of professionals and their clients.

4 People with disabilities

People with disabilities often lack the opportunities other, able-bodied people enjoy. Negative stereotypes and preconceived notions, such as thinking that people with disabilities are dependent on the charity of others, has influenced policy making and service provision over the years. Examples include people with disabilities living in institutions and/or working in sheltered employment, where people with disabilities work together in closed settings (Visier, 1998^[22]). Such policies can contribute to negative attitudes about people with disabilities, categorising them as being different from the rest of society.

To address the many underlying issues that affect people with disabilities and enable them to participate more actively in society, a more co-ordinated and integrated approach to service provision has been highlighted as important (OECD, 2015^[3]). With integration, various types of services are joined up for the benefit of service users with the aim of improving effectiveness and efficiency.

Horizontal integration

Deinstitutionalisation is increasingly seen as key to improving outcomes for people with mental health disorders, defined as the process of moving care and supports for people with disabilities from institutions to more community-based solutions. The process consists of, on the one hand reducing the number of individuals living in care institutions, and on the other hand reforming care services to “reduce dependence, isolation and other behaviours that make it difficult for people to adjust to life outside of care” (Fulone et al., 2021^[23]).

People with disabilities have emphasized the philosophy of Independent Living as a way of providing them with the same opportunities as their peers and eliminating the stigma attached to their lack of inclusion in society. Independent Living is an internationally recognised movement that originated in the United States, that was created by people with disabilities and focuses on empowerment rather than the medical aspects of disability. It recognises that disability policies should be designed by people with disabilities themselves and emphasizes their freedom to be able to choose their own services and providers (Ratzka, 2007^[24]).

A key element of this approach are the Centres for Independent Living, which are integrated hubs where a wide range of services are provided for people with disabilities, such as peer counselling, information and referrals, skills training, and other services to ease challenging transitions – such as integrating into the labour market and workplaces. A strength of the Independent Living movement through the years has been its community aspect and the united spirit of the people involved – the majority of whom are people with disabilities. The common goal is to better integrate people with disabilities into society (Evans, 2003^[25]). All states and territories in the United States are required to develop and support a network of Centres for Independent Living under their State Plans for Independent Living (see Box 4.1).

Community mental health teams are a promising measure that aim to deinstitutionalise people with mental health disabilities. Teams are composed of mental health specialists tasked with providing mental health services, through expert assessments, treatments, and care. A defining feature of community mental health teams is their involvement with the community and most importantly the families of those they work with. Despite inconclusive evidence, community mental health teams appear to be associated with increased inter-agency collaboration, improved customer satisfaction, and decreased levels of stigma in

the community, which could explain the reduction in the number of suicides after follow-up from such teams (Simmonds et al., 2001^[26]; Fulone et al., 2021^[23]).

Box 4.1. State Plans for Independent Living (United States)

In the United States, all states and territories have implemented State Plans for Independent Living and/or Centers for Independent Living. State Plans for Independent Living are detailed three-year plans that set objectives and parameters for the provision of Independent Living services in the state and are eligible for federal funding under the conditions set in the 1973 Rehabilitation Act (Section 725). Under the Act, states are required to develop and support a state-wide network of Centers for Independent Living which have been widely recognized for their inclusive and integrated nature and are private non-profit, community-based institutions operated by people with disabilities.

Source: Based on the Administration for Community Living (2019^[27]), Instructions for the State Plan for Independent Living (SPIL), <https://acl.gov/sites/default/files/programs/2020-09/State%20Plan%20for%20Independent%20Living%20%28SPIL%29%20Instrument%20and%20Instructions%20-%20Template.docx> (accessed on 19 May 2022).

People with disabilities often have needs that require services from more than one provider. In these cases, case management support can be effective. Case management comprises of an individual or an agency whose role it is, is to represent the service user in the service delivery process. A caseworker assesses a service user's needs and identifies various services for the service user accordingly. Case management for people with disabilities has been found to increase problem-solving skill development and increased self-efficacy (Areán et al., 2015^[28]), making it easier for them to navigate complex public service systems.

A related but more individual-focused approach to case management is person-centred planning. Entailing a higher level of intensity of integration, it differs from other types of individual planning in three ways: it considers the aspirations and capacities of the service user as expressed themselves or by those speaking on their behalf, rather than their needs and deficiencies; it engages actively with the service user's friends and family, reflecting the special interests they may have; and it aims to provide service users with the support they require to reach their goals, as opposed to limiting their goals in accordance with what services are available (Mansell and Beadle-Brown, 2004^[29]).

Case management encompassing a person-centred planning approach can increase the effectiveness of funding packages aimed at people with disabilities. A common problem with flexible individualized funding – where an individual is given control over how they spend a certain amount of funding on services to achieve their goals – is that an individual and their family often know exactly what they need but do not have the knowledge or the experience to traverse the complex system of services and programmes available (Yates et al., 2020^[30]). Case managers, guided by individuals and their families in terms of what they need, can in help identify relevant providers and services.

The evidence about the effectiveness of person-centred planning approaches is not conclusive. However, effectiveness appears to depend on committed caregivers, whose emotional support can be instrumental in supporting people with disabilities to achieve their goals. Service users who have experienced the person-centred planning approach particularly highlight the interpersonal and relational qualities of case managers as important to its success (Robinson, Fisher and Gendera, 2016^[31]). Effectiveness also depends on the adoption of person-centred care in all levels of service delivery, from direct carers to planners (Ratti et al., 2016^[32]). For instance, Kaehne and Beyer (2013^[33]) note that a lack of adult social services and employment agencies at post-school transition meetings, a particularly important life transition point for people with disabilities, can create a significant barrier to implementing a system based on the choices and preferences of individuals – as opposed to one based on the availability of services.

An example of an initiative that applies a person-centred approach to service delivery for people with disabilities is the New Directions Day Services model in Ireland, described in Box 4.2.

Box 4.2. The New Directions Day Services model (Ireland)

The New Directions Day Services model provides up to 12 personal supports to all service users through one-stop-shops. These supports include making plans; accessing education and formal learning; health and wellbeing; accessing vocational training and work opportunities; with an emphasis on choice, personal expression, and creativity. An evaluation of the model was undertaken during the first year of its implementation in 2016-2017 with service users and their families expressing overall positive views. Service users' expressed happiness with the range of services available and parents valued the individualised and person-centred approach taken. Concerns were expressed however about access to service hubs, with many having to undertake long bus journeys. Annualised budgets devoted to the program were also not proportional to the increases in numbers of service users. To continue providing high-quality services, sustainability of funding was found to be key.

Source: Lydon, D'Eath and Heary (2017^[34]), *New Directions: Evaluation of the first year of implementation in a regional intellectual disability service*, NDA, <https://nda.ie/nda-files/rps%202017%20files/new-directions-evaluation-of-the-first-year-of-implementation-in-a-regional-intellectual-disability-service1.pdf> (accessed on 6 April 2022).

User-controlled personal assistance (UPA) is a child of the Independent Living ideology and gives people with substantial needs for assistance more freedom to manage for themselves their choice of services and everyday lives (Box 4.3). Norway successfully tested UPA through a small-scale pilot in Oslo in the early 1990s and has been gradually expanding the service since then. In 2015, the right to UPA became enshrined in law and municipalities have the obligation to offer the service to people with long-standing and high needs. An evaluation in 2019 confirmed that UPA contributes to independence and participation in society (Askheim, 2019^[35]).

Box 4.3. User-controlled personal assistance (Norway)

User-controlled personal assistance (UPA) is intended to help service users in their daily life, both inside and outside the home, through either compensatory services or developing services. The primary aim of *compensatory services* is to compensate for activities service users are unable to do on their own, such as house cleaning, cooking, or running errands. *Developing services* aim to provide service users with the same conditions to live an independent life as non-disabled people enjoy, for instance taking part in leisure time activities outside the home. Studies undertaken indicated that nine out of ten service users accessed help to perform compensatory tasks (housework, cooking, and errands) while seven out of ten services users accessed developmental services (transportation and leisure time activities).

Source: Askheim (2019^[35]), *The Norwegian system of supporting people with disabilities in independent living, including assistant services*, Skriftserien 32, https://brage.inn.no/inn-xmloi/bitstream/handle/11250/2631102/Skriftserien32_19_online.pdf?sequence=1&isAllowed=y.

Over the last ten or so years, integrating services across sectors (for example, the health, social and employment sectors) to improve the inclusion of people with disabilities for example in the labour market, has become more common. Take for instance mental health and employment services. Traditionally, in most countries the health and employment sectors have operated quite independently of each other, yet mental health issues are often the main barrier to finding and keeping a job, while being in a job can help improve mental health and wellbeing (OECD, 2014^[4]). Promoting (re-)integration of people with disabilities

into employment, if they can and wish to work, can reduce exclusion and benefit dependency. Many countries have also introduced a stronger focus on employment when assessing applications for disability benefits, for example bringing work assessments forward in time and/or strengthening non-medical elements and/or broadening the labour market reference (OECD, 2010^[36]).

The Netherland's Work and Income (Employment Capacity) Act 2006 has the primary aim of promoting a return to work, including for people with disabilities (unless they are determined to be wholly and permanently incapacitated). Clients have access to a reintegration coach, and reintegration activities are tailored to meet their specific needs and wishes, with a trend towards them having more freedom of choice about how reintegration happens. The increased influence of clients on the reintegration process has been found to work with a clear positive indication about the influence of clients and motivation on the one hand and the results of reintegration on the other (OECD, 2007^[37]).

Similarly in Denmark, disability assessment is focused on what a person can do rather than their loss of capacity; more precisely, the extent to which a person is able to carry out a subsidised job (a so-called "flex-job"). An early retirement pension for people with disabilities can be granted where capacity is held to be permanently reduced to the extent that a flex-job cannot be performed, and participation in rehabilitation would not help to restore this capacity. In determining capacity, a comprehensive individual resource profile is put together and includes measures of health, social and labour market proximity criteria (OECD, 2010^[36]).

An OECD Economic Survey of Denmark in 2016 found that integration of people with disabilities into the labour market had not improved significantly since early 2000, acknowledging, however, that new rehabilitation programmes integrating health and employment services and involving multidisciplinary rehabilitation teams had recently been implemented (OECD, 2016^[38]). A more recent report, commissioned by the Danish Agency for Labour Market and Recruitment, *Disability and Employment 2021* found that 61% of people with disabilities are in employment, compared to 86% of people without disabilities (Larson, Jakobsen and Mikkelsen, 2022^[39]). This gap is the smallest one since 2008 and represents a reduction of five percentage points since the OECD's report in 2016. Denmark's Minister of Labour sets an annual objective to integrate more people with disabilities into the labour market and, from 2019 to 2022, 120 million DKK has been distributed across eleven initiatives to improve awareness about, and inclusion of people with disabilities in employment.

In Flanders, job seekers are systematically assessed at intake for problems which may hinder their re-employment. Caseworkers not only pay attention to employment-specific competences and qualifications, but also to any disabilities and mental health issues. If a caseworker suspects that there is a more severe mental health problem, the client is referred to a psychologist, or an external employment research centre specialised in in-depth multidisciplinary screening. Job seekers with a work disability including those with mental health problems, receive tailored and specialised support in their job search. As well as its internal active labour market measures, the Flemish Public Employment Service (VDAB) works with specialised centres for the training, guidance, and intermediation of job seekers with a work disability (OECD, 2013^[40]).

The United Kingdom has progressed integrating its health and employment sectors for people with disabilities through a Work and Health Unit, jointly run by the Department for Work and Pensions (DWP) and the Department of Health and Social Care. A key part of the unit's work programme is the Employment Advisers in Improving Access to Psychological Therapies (EA in IAPT) programme described in Box 4.4. On World Mental Health Day (10 October 2022), it was announced the programme would deliver a GBP 122 million package (to 2024/2025), expanding the service to provide 100% coverage across NHS England. An explicit objective of the programme is to see one million more people with disabilities in work by the year 2027 (Department for Work & Pensions and Department of Health & Social Care, 2022^[41]).

For people with more severe disabilities, the United Kingdom together with many other countries around the world including parts of Europe, Australia, New Zealand, the United States, Canada, Hong Kong and Japan have adopted the Individual Placement and Support (IPS) model. IPS is an employment support

service provided alongside mental health treatment for people who experience severe mental health conditions. In England and Wales, DWP trialled a model of IPS integrated into primary healthcare services for people with common physical and mental health conditions: Individual Placement and Support in Primary Care (IPSPC) and from April 2023 plan to build the evidence-base for the effectiveness of IPSPC.

Box 4.4. Employment measures for people with disabilities (United Kingdom)

Employment Advisers in Improving Access to Psychological Therapies (EA in IAPT)

As part of their effort to improve access to mental health services for people with common mental disorders, the United Kingdom has introduced the Improving Access to Psychological Therapies where employment advisers work alongside therapists. Advisers provide practical advice to the therapists and assist clients struggling with staying in, returning to, or finding work. Results include:

- More than two thirds (68%) of those surveyed who accessed the service reported that they had either remained in work or found work 12 months after using the service.
- Out-of-work individuals who accessed the service were more likely to be in work by the end of their treatment compared with those who did not.
- Accessing employment advice has a proven impact on improving mental health outcomes for those accessing psychological therapies.

Individual Placement and Support in Primary Care (IPSPC)

IPSPC works by co-locating Employment Specialists with various primary care health teams who then work collaboratively with clinicians and carers to support clients into meaningful and sustainable employment. The support available includes:

- Engaging with employers on the client's behalf to broker opportunities.
- Providing information about different types of jobs.
- Support with writing a CV and job search.
- Running awareness sessions for employers.
- In-work advocacy.
- Time unlimited and highly personalised support for both employers and employees.
- Liaising with Jobcentres to support clients around welfare benefits.

Disability Confident

Developed by people with disabilities, employers and disability organisations representing people with disabilities, Disability Confident is a voluntary, business-to-business led scheme, designed as a learning journey with all employers starting at 'Level 1' and progressing through the scheme at their own pace.

The key aims of the Scheme are to:

- Engage and encourage employers to become more confident so they employ and retain people with disabilities.
- Increase the understanding of disability and the benefits of employing or retaining people with disabilities.
- Highlight 'Disability Confident' accredited employers through a specific algorithm on the Department's 'find a job' website.
- Support the government's commitment to reduce the disability employment gap.

Additional Work Coach Time

Additional work coach support for health journey claimants is a new work-coach led support offer, which aims to help more people with disabilities and claimants with a health condition into and towards work. The trial of additional Work Coach support is initially available across a third of Jobcentres in England, Scotland, and Wales. It will roll out to more Jobcentres from 2023 and be available in all Jobcentres in 2024. This initiative will help more people with disabilities and those with health conditions to start, stay and succeed in work - unleashing wider talent and ensuring the opportunities from employment are available to everyone, and ensuring employers can recruit the employees they need to support economic growth.

Additional work coach support is tailored to the individual's needs using the most appropriate channel for support including face to face, telephone or digital appointments for Universal Credit customers.

Sources: <https://www.gov.uk/government/publications/employment-advisers-in-improving-access-to-psychological-therapies>; <https://www.gov.uk/government/publications/individual-placement-and-support-in-primary-care-initiative>; <https://www.gov.uk/government/collections/disability-confident-campaign>

Vertical integration

A key barrier to greater integration of services is multi-governance finance issues arising from competing incentives between central, regional, and local governments. Services for people with disabilities for example often account for a sizable portion of a local government's budget. When free-to-access services are available, such as hospital-based services, that are funded by central governments, incentives exist for local governments to make use of them – regardless of their efficacy for the target group. Such cost-shifting can lead to under-investment in services for people with disabilities when the returns from investment are not shared equally or proportionally between the co-ordinating bodies (OECD, 2015^[3]). This is where vertical integration particularly when combined with horizontally integrated initiatives can enable common goals to be achieved and provide service users with better, more integrated service delivery.

Vertical integration measures can help to facilitate access to services, for example through improved data-sharing policies. Data-sharing as a legislative instrument has many advantages, including saving time and reducing bureaucracy; preventing service delivery duplication; allowing a better understanding of service users' needs. However, data sharing in integrated service delivery settings is often challenging due to complex data privacy legislation and information sharing guidance and differences in professional cultures and values across sectors (OECD, 2015^[3]).

Vertical integration can also help to limit competition and promote collaboration between the multiple actors involved in service provision. Policies that promote competition between service providers are more likely to lead to fragmentation of services and hinder further integration. Co-ordination can be particularly difficult when non-profit and private providers are also involved in service provision alongside public services, although successful examples of co-operation exist. In such cases, horizontal and vertical integration as shown in Denmark (Box 4.5).

Box 4.5. Co-ordination at the regional and municipal level (Denmark)

In Denmark, co-ordination between sectors and levels of government has been encouraged by multidisciplinary rehabilitation teams in municipal job centres. These teams, consisting of the health sector, relevant labour market institutions, social services, and the education sector, seek to prevent young adults with mental health issues and little work experience moving onto disability benefits. The primary objective of the co-located teams is to vertically integrate the various services available rather than focusing just on assessing illness or a client's work capacity. By clarifying and integrating the different types of services provided by the regional and municipal levels of government, costs are reduced, and service provision becomes easier to navigate for both the worker and the service user.

Source: OECD (2014^[41]), "Mental Health and Work: Achieving Well-integrated Policies and Service Delivery", OECD Social, Employment and Migration Working Papers, No. 161, OECD Publishing, Paris, <https://dx.doi.org/10.1787/5jxsvvn6pg6g-en>.

Vertical integration however may not always be feasible and may even be detrimental to service delivery. Considerable time and resources are needed for structural reforms to succeed. In Québec, four major service integration policy reforms have been carried out since the 1960s. Such frequent restructurings have been self-defeating, with two main negative effects having been observed: distant relationships between service providers and the community; and managerial forces preventing effective service delivery due to the need to complete mergers (Couturier et al., 2021^[42]). A merger which created so-called health and social care centres in the early 2000s altered funding allocations and thus upset established relationships between providers, undermining a key feature of coordination of the PRISMA model described in Box 4.6. The system-wide changes brought about by the PRISMA initiative have had a lasting effect on the integration of service delivery, both horizontally and vertically.

Box 4.6. PRISMA programme (Québec, Canada)

In Québec, the Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) was initiated in 1997 and has since become a mainstream approach to services for elderly people and people with disabilities in the province. The project blends various approaches to service integration, namely case management, single entry points, individualized service plans, a functional assessment tool and an information sharing system. Due to high demand, case managers are not always immediately available – in which case the single point of entry teams work to ensure that the needs of individuals are met, for instance with follow-ups for individuals on the waiting list. The PRISMA model does not require mergers of service providers, and thus avoids the resulting costs associated with vertical system-wide governance restructurings.

Source: MacAdam (2015^[43]), "PRISMA: Program of Research to Integrate the Services for the Maintenance of Autonomy. A system-level integration model in Quebec", *International Journal of Integrated Care*, Vol. 15/6, <https://doi.org/10.5334/ijic.2246>.

5 People leaving prison

The literature identifies social reintegration programmes as the primary means of delivering integrated services to people leaving prison. Such programmes provide supervision, supports and services, starting in the criminal justice process and continuing outside it with the aim of successfully reintegrating people leaving prison back into community, and avoiding recidivism (UNODC, 2018^[44]). Social reintegration programmes can involve multiple levels of government (vertical integration), or coordination among agencies and other community resources (horizontal integration). Examples of the latter include coordination across employment, housing, education, prison administration and law enforcement sectors.

Social reintegration programmes often begin in prison. Without effective supports in place, people leaving prison can feel isolated from society and at times even within the prison itself. Mitigating the de-socializing effects of imprisonment through prison-based rehabilitation measures can thus play an important role in reintegration into society (UNODC, 2006^[45]). The findings of a recent report in the United States, *State Strategies for Improving Child Support Outcomes for Incarcerated Parents* illustrate the benefits of providing services inside prisons, describing the success many states have had connecting child support workers with parents while they are still incarcerated to initiate adjustments (Aharpour et al., 2020^[46]). The United States is exploring similar efforts in healthcare to connect eligible youth and adults to Medicaid prior to release.

The transition out of prison is a particularly difficult time with people often struggling to find employment and housing; finding employment is the single largest concern reported by both men and women before their release from prison (Visher, 2007^[47]). People leaving prison report receiving limited support to find accommodation and as a result, many end up in unstable housing arrangements or homeless, which can exacerbate mental health problems and/or substance abuse. Substance abuse is already a reality for many people before they enter prison. Leaving prison involves a transition from a fully structured environment where substances are not allowed to “a lifestyle of instant gratification” (Cnaan et al., 2008^[48]).

Horizontal integration

Effective post-release services and supports are crucial to people leaving prison successfully reintegrating into society and reducing the likelihood of recidivism. Personalised case management leading up to and upon their release is a key means of ensuring people leaving prison receive the different services they need. The United Nations Office on Drugs and Crime (UNODC) has emphasised case management practices as a requirement for providing through-care support from prison to the community (UNODC, 2018^[44]). Case management reduces recidivism or relapse, encourages social reintegration, and enhances public safety (Healey, 1999^[49]; London and Dupuis, 2020^[50]). Case management models typically provide service users with an assigned case manager, often a social or health worker, whose role is to coordinate personalised services for their client depending on their needs.

While case managers play a supervisory role and good supervision skills are necessary, those skills are insufficient on their own for improving the situation of people leaving prison; the availability and quality of services inside and outside prison must complement them (Maguire and Raynor, 2016^[51]). Desistance theory highlights the importance of a case manager listening to the service user as a primary source of

knowledge which involves building a close relationship where the service user is comfortable to talk to their case manager about their personal goals.

Services such as employment and housing will be particularly important to the re-integration of people leaving prison into society. People will also have other unique needs to be addressed, which may include reconnecting with their families, help acquiring administrative documents, legal help, medical needs, and/or transport. Given the extensive help each person leaving prison may require, case managers should ideally limit their workload to a small number of individuals at any point in time (Cnaan et al., 2008^[48]).

What helps to make case management for people leaving prison successful is to place the individual at the centre of the process with an emphasis on building a trusted relationship between them and those working with them, as opposed to emphasising managerial processes and system-centred thinking. The literature identifies relational continuity and trust on the one hand, and supervision skills on the other as important aspects of effective case management. “Pass-the-parcel” case management, where service users are passed from one case manager to another is not conducive to developing the trusting relationship required. To help start building that trust, case managers would ideally visit people in prison prior to release to start developing an individual after prison support plan. Such visits have been found to increase service users’ commitment to working with their case manager post-release.

The importance of trusting relationships underpins the social capital/peer supports model in the United States, which helps individuals to address employment, health, and substance abuse issues. People who have been in prison themselves serve as mentors and case managers for others, building a trusting relationship based on shared experiences. For example, RecycleForce is a recycling factory in Indianapolis that has received government funding and provides employment and mentoring opportunities for people who have been in prison.

Risk-need-responsivity (RNR) treatment and assessment models were developed in the 1980s and have been used with increasing success around the world to assess and rehabilitate people who have left prison. Applying skills associated with RNR models including effective use of authority; appropriate modelling and reinforcement; problem solving; use of community resources; and quality of interpersonal relationships has been highlighted as important for reducing re-offending. As its name suggests, RNR builds on three guiding principles (Government of Canada, 2007^[52]; Her Majesty’s Inspectorate of Probation, 2020^[53]):

1. *Risk*: Criminal behaviour can be reliably predicted, and treatment should focus on the higher risk individuals.
2. *Need*: Criminogenic needs are important in the design and delivery of treatment.
3. *Responsivity*: The way in which services are delivered is important, with an emphasis on cognitive social learning methods and a tailored approach to the strengths of the individual.

Evaluations of the RNR model found that adherence to the three principles results in reduced recidivism rates, with a 17% positive difference in average recidivism between treated and non-treated individuals when delivered in a residential/custodial setting, and a 35% difference when delivered in a community setting (Her Majesty’s Inspectorate of Probation, 2020^[53]).

Preparing people leaving prison for the labour market is critical to their reintegration into society. In Belgium, the Flemish Employment Service has worked closely with prisons providing people with vocational training and related skills. Detention counsellors operate in prisons where they oversee training workshops, and in some cases, people are allowed to attend courses in training centres outside the prison. Despite relative success since its implementation in 2001, costs remain significant, and stigma continues to be a barrier to employment. To mitigate those problems, the “Velcro” project was initiated (Box 5.). Through the project, service users are assigned a “coach” who simultaneously act as their case manager and engage with prospective employers to increase their employability prospects (OECD, 2013^[54]). In Norway, as part of an agreement between the Norwegian Correctional Service and the Norwegian Labour and Welfare Administration (NAV) employment advisers are increasingly located in prisons (Box 5.).

Co-located services are another way of integrating services for people leaving prison. For many, timing is important as the need to find a source of income becomes greater each day as the term of imprisonment ends or once outside prison. By co-locating relevant services in one place, time and resource allocation issues are addressed not only for the service users themselves but also for the service providers (OECD, 2015^[3]). These kinds of co-located services exist both inside prisons and outside of them.

Co-located services in the form of “family centres” are common in the Nordic countries, where multidisciplinary teams of specialists are located under one roof. The specialists available include nurses, psychologists and social workers. One example is the Red Cross re-entry house in Oslo, Norway, where different state and municipal services are in the same building, so that people leaving prison can access services more easily (Box 5.). Similar one-stop-shops have been introduced in other European countries, such as in the United Kingdom. For people leaving prison, these kinds of community hubs provide a more welcoming and less stigmatising environment than traditional probation services, as service users do not feel they have a criminal ‘sticker’ placed on them. The hubs are viewed positively by providers and offer a range of services that address accommodation, substance use, domestic abuse, employment, and training needs. (Her Majesty’s Inspectorate of Probation, 2020^[55]).

Box 5.1. The “Velcro” project (Belgium)

A person-centred approach has been implemented in prisons in Flanders to bridge the gap between people in prison and potential employers to enable successful entry or re-entry into the labour market upon release from prison. The “Velcro” project involves a contract between a service user and a mentor, the latter’s role being to assist the service to find employment. Initially they work together to strengthen employability and communication skills, while the mentor also works with a detention counsellor from the public employment service. After finding work, whether it be in limited detention or full employment after release, the mentor counsels both the employee and the employer for up to a few months.

Source: OECD (2013^[54]), *Tackling Long-Term Unemployment Amongst Vulnerable Groups*, https://www.oecd.org/cfe/leed/Tackling%20Long_Term%20unemployment_%20WP_covers.pdf

Box 5.2. Employment advisers in prisons (Norway)

In 2014, the Norwegian Correctional Service signed a collaboration agreement with the Norwegian Labour and Welfare Administration (NAV) with the aim of improving access to NAV services for people in prison. As part of the agreement NAV advisers were increasingly placed within prisons, tasked with undertaking employability assessments, actively helping to identify needs for assistance and establish access to various NAV services prior to release, in collaboration with the local NAV office. Both agencies prepared guidelines to divide responsibilities and ensure effective service provision. An evaluation of the intervention published three years after its launch found that the guidelines and their emphasis on employment prospects are helpful and have the potential to increase the rehabilitation rates of service users in their transition to employment and activity. However, the provision of health and education/training services in prisons requires improvement, namely due to their divergent models of funding.

Source: Fafo (2017^[56]), *Services provided by the NAV in prisons*, <https://www.fafo.no/en/publications/english-summaries/services-provided-by-the-nlwa-in-prisons> (accessed on 28 March 2022).

In Sweden, the Prison and Probation Service grants people in prison with special reintegration assistance measures under certain conditions to smooth their transition from prison. These measures include day release; treatment periods; halfway houses; and enhanced day release. Day release provides service users with opportunities to leave during the day to study, work or participate in a treatment programme. Day release is also a way of enabling people in prison to access services not readily available in the prisons. Treatment programmes are the most common reintegration measure, where a service user participates in either a 12-step orientation or cognitive behaviour therapy programme that takes place in a residential care home. Over half of treated individuals have found that treatment periods decrease their risk of reoffending (The Swedish National Council for Crime Prevention, 2015^[57]).

Box 5.3. The Red Cross Re-entry House (Norway)

The Red Cross in Oslo houses Norway's first Re-entry centre, bringing together services and facilities to support people leaving prison successfully reintegrate into society. Included are a NAV office for employment and social services; an office of the Prison and Probation Service with a drug court programme for people with a drug history; debt counselling and financial education programmes; child welfare; a municipal secondary school; case management for young people; and a radio station with broadcasts from inside and outside of prisons.

The Re-entry House also runs a company (bike shop) for work and social training to prepare people leaving prison for the labour market. The work of the Red Cross with people leaving prison has a strong focus on normalisation and social contacts – doing ordinary activities with ordinary people – to prevent loneliness after imprisonment.

The Re-entry house is financed from different sources, including the Ministry of Social Affairs and to a lesser extent the Ministry of Justice, a municipal budget, volunteering, and some companies. The goals are to develop together best practice on how to collaborate; take care of as many needs as possible; save time and money and reduce recidivism.

Source: Norwegian Red Cross (2022), *Network after imprisonment*, unpublished presentation, Oslo, 2022

Swedish prisons also offer some individuals further opportunities to adjust to life outside of prison, namely through enhanced day release or halfway houses (Box 5.4). Under enhanced day release, service users live in their own homes where they are limited to going out under certain conditions such as for work, treatment, or training. Enhanced day release is the most common reintegration assistance measure in Sweden and repeated studies reveal that lower recidivism rates are associated with such a measure. Despite their success however, the reintegration assistance measures offered in Swedish prisons suffer from a lack of resources; a long period of imprisonment is generally required to allow for a space in one of the programmes to become available (The Swedish National Council for Crime Prevention, 2017^[58]).

Box 5.4. Halfway houses (Sweden and Norway)

Halfway houses are an increasingly popular rehabilitation measure in Sweden and Norway. Halfway houses are transitional residences that are monitored by prison staff but are less restrictive than other prisons. Service users are required to undertake educational activities, work, or other community activities outside the transitional residences. Although high demands are placed on participants, many clients in Swedish halfway houses report very positive experiences.

Halfway housing staff are expected to not only guard individuals in the residence, but also help, care for, and motivate them. This service approach within prisons is seen as promoting close collaboration with outside health and welfare services. In fact, the importance of cross-agency and management co-operation is recognised in the Norwegian Penal Code.

Source: Dugdale and Hean (2021^[59]), "The Application of Norwegian Humane Ideals by Front-Line Workers When Collaboratively Reintegrating Inmates Back into Society", in *Improving Interagency Collaboration, Innovation and Learning in Criminal Justice Systems*, Springer International Publishing, Cham, https://doi.org/10.1007/978-3-030-70661-6_5.

Vertical integration

The World Health Organization has emphasized a “whole-of-government” approach to administering prisons. Such vertical integration can result in, among other things: improved integration of people leaving prison into society on release; lower rates of reoffending and re-incarceration and a reduction in the size of the prison population; and enhanced governmental credibility based on increased efforts to protect human rights and reduce health inequalities (WHO, 2013^[60]).

Correctional services are often implemented in local communities which can contribute to a “silo mentality” between local, regional and national governments and a lack of continuity of service provision for people leaving prison. Closer integration of governance and finance structures accompanied by strategic solutions at the service delivery level can lead to more effective service provision (OECD, 2015^[31]). Furthermore, making sure people leaving prison feel welcome in their community once out of prison can be critical in ensuring their successful reintegration into society.

The United Kingdom’s Integrated Offender Management (IOM) strategy (Box 5.5) is a shared governance approach established to limit persistent and problematic offending. It links national and local governance and contains aspects of both horizontal and vertical integration. It operates at the community level and thus differs across communities, with co-located teams set up where possible. Key services involved are the criminal justice system, including police and probation services; as well as rehabilitative services, which include housing, drug and alcohol, employment, and benefits support.

Local schemes are however co-ordinated at the national level. These consist of firstly a strategic oversight group comprising key agencies; and secondly a Central IOM Unit dedicated to monitoring the strategy’s success. The IOM Strategic Oversight Group consists of relevant agency representatives from the Ministry of Justice and the Home Office who are responsible for making sure IOM is reflected in their agencies and in government policy.

Sitting under the Strategic Oversight Group, the Central IOM Unit facilitates effective information sharing between schemes, helping to ensure consistency of approach across schemes. Agencies and other partners include the Police, the National Probation Service, Youth Offending Teams, Local Authorities, Clinical Commissioning Groups, drug and alcohol services and the voluntary sector. The wider the stakeholder community, the more comprehensive resources are available to offenders and their communities. In this regard, accommodation and employment services, in addition to drug and alcohol treatment, are explicitly mentioned as areas of emphasis.

Box 5.5. Integrated Offender Management strategy (United Kingdom)

Established in 2009 with a horizontal, cross-agency emphasis, the Integrated Offender Management (IOM) strategy was updated in 2020 to address some of the shortcomings of the previous strategy such as the challenges involved in managing a diverse range of IOM delivery models across the country because of local determination. Its broad scope and the task of managing all kinds of people leaving prison became increasingly difficult; the updated strategy focuses on neighbourhood crimes and not all crime as was previously the case.

Integration is the central tenet of IOM and is embodied in three principles – police and probation working together; ensuring local priorities are met through local leadership and partnerships; and a holistic offender supervision approach. The embedded flexibility of the model allows local leaders to adapt the focus of IOM to ensure it is sensitive to local concerns. The Strategy refers to several planned or existing national pilots and initiatives which can be drawn on to support IOM teams: Community Sentence

Treatment Requirements, Problem Solving Courts, Acquisitive Criminals location monitoring programme and Probation Short Sentence function.

Source: HM Government (2020^[61]), *Neighbourhood Crime Integrated Offender Management Strategy: A unified approach to offender supervision in the community*,

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942145/neighbourhood-crime-iom-strategy.pdf (accessed on 16 June 2022).

6 Conclusion

While there are many references in the literature to the value of integrated services as a means of improving access to services for people in vulnerable situations, there are relatively few examples to be found for the three groups that are the focus of this paper. Horizontal integration initiatives are more common than vertical ones and most examples of vertical integration also include elements of horizontal integration.

Many, if not most of the good practice examples identified for care experienced young people, people with disabilities and people leaving prison involve at least an element of case management, i.e., integration of services at the level of the individual service user. Case management is a well-developed model for integrating services for individuals with complex needs and is frequently used in countries such as the United Kingdom and Australia. Munday (2007^[5]) argues case management is not a culture-specific form of service and as such may well be adapted for use in countries where it is yet to be introduced.

The nature and strength of the relationship between the service user and their case manager or professional support person is critically important. The COVID-19 pandemic served to emphasise the importance of relationships, with professionals and with informal social supports. In a study of the lived experience of care experienced young people in Ireland during the pandemic, aftercare workers and other professionals were identified by participants as a source of support during the pandemic, particularly in relation to practical issues such as housing (Gilligan, Brady and Cullen, 2022^[62]). The literature on people leaving prison also highlights the importance of trusting relationships with both practitioners and service users citing relational continuity and trust as an important aspect of effective case management support.

Also important to the success of case management is a comprehensive and individualised assessment of a service user's needs and aspirations. This assessment in turn informs a plan that identifies the formal and informal supports required to address the needs identified and to ensure the necessary follow-up actions are undertaken in a co-ordinated and holistic way. In the case of care experienced people and people leaving prison in particular, planning should start early and in the case of all three groups, service users should be fully involved in the planning process and related decision-making.

There are instances of case management occurring within the context of co-located services or one-stop shops. As described in Box 5., the Norwegian Labour and Welfare Administration locates employment advisers in prisons, who work actively with inmates, undertaking employability assessments and establishing access to employment services prior to release. Similarly, for people with disabilities, Centres for Independent Living (discussed in Box 4.1) are integrated hubs where various services are offered, including peer counselling, information and referral, and skills training. These centres are community-based and are designed and operated by people with disabilities, a crucial aspect of the initiative's success.

The paper also presents examples of funds and programmes that provide an opportunity to innovate in a lower-risk way. For instance, the *Children's Social Care Innovation Programme* in the United Kingdom encouraged pilots of innovative approaches for people in vulnerable situations, including integrated supports for care experienced young people. In November 2018, the Italian Government approved a three-year EUR 15 million Fund for pilot projects supporting care experienced young people that regions could apply to for funding to support local authorities develop pilot projects. The Fund was introduced as the

result of a national study undertaken by SOS Children's Villages Italy in 2017 that mapped the issues, gaps and actors that could drive change for young people facing challenges when leaving care.

Despite the promise integrated services hold, particularly for service users with multiple and complex needs and an increasing number of initiatives, there is yet little empirical evidence that integrated services are effective. A consistent finding in the literature is that while many approaches have been tried, there have been relatively few rigorous evaluations. There is little clear evidence about whether models of integrated care are cost-neutral or increase or reduce costs (Baxter et al., 2018^[2]).

The main reason for this lack of evidence is likely to be that measuring the effectiveness of integration initiatives is challenging. Many of the existing models are complex and multi-dimensional, and the individuals and families that integrated services are often targeted at have deeply entrenched and potentially inter-generational issues. As illustrated by examples in this paper, existing models of integration can encompass multiple elements aimed at improving integration within and between systems.

Furthermore, vertical integration approaches tend to be large-scale, involve system-wide changes and include a range of initiatives; accordingly, it can take decades to bed in changes and realise the goals of these reform programmes. Any change in direction is more likely to be the result of changed political priorities than empirical evidence. The Québec example, where frequent restructurings since the 1960s have proved self-defeating, illustrates that vertical integration may not always be feasible and may even be detrimental to service delivery. Time and resources are required to ensure structural reforms are successful. As Leutz (1999^[63]) points out, integration costs before it pays. There must be adequate investment in planning, training, and system changes for integration to succeed.

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