



# Integrated social services in Europe



Council of Europe Publishing  
Editions du Conseil de l'Europe

# **Integrated social services in Europe**

**Report prepared by Professor Brian Munday**

**University of Kent (United Kingdom)**

**Consultant to the Group of Specialists on User Involvement  
in Social Services and Integrated Social Service Delivery  
(CS-US)**

French edition:  
*Services sociaux intégrés en Europe*  
ISBN 978-92-871-6208-3

*The opinions expressed in this work are the responsibility of the author and do not necessarily reflect the official policy of the Council of Europe.*

All rights reserved. No part of this publication may be translated, reproduced or transmitted, in any form or by any means, electronic (CD-Rom, Internet, etc.) or mechanical, including photocopying, recording or any information storage or retrieval system, without the prior permission in writing from the Public Information and Publications Division, Directorate of Communication (F-67075 Strasbourg Cedex or [publishing@coe.int](mailto:publishing@coe.int)).

For further information relating to the field of access to social rights, please contact:

Karl-Friedrich BOPP  
Head of Access to Social Rights Division, Social Policy Department  
Council of Europe  
F-67075 Strasbourg Cedex  
e-mail: [karl-friedrich.bopp@coe.int](mailto:karl-friedrich.bopp@coe.int)  
<http://www.coe.int>  
<http://www.coe.int/t/dg3/socialpolicies/socialrights/>

Cover design: Desktop Publishing Unit, Council of Europe  
Layout: Jouve

Council of Europe Publishing  
<http://book.coe.int>  
F-67075 Strasbourg Cedex  
ISBN 978-92-871-6209-0

© Council of Europe, September 2007  
Printed at the Council of Europe

“We have twin girls aged 5; both have a moderate learning disability. Jenny also has autism. We’re totally confused with all of the different professionals and agencies we have to deal with. The following are some of the people we deal with on a regular basis: GP, counselling nurse, speech and language therapist, occupational therapist, psychiatrist, psychologist, teacher, classroom assistant, ophthalmologist, audiologist and administrators – to name but a few.

We’re so confused sometimes. We don’t understand the different roles and have so many appointments that clash.

Can nobody or no system sort it out?”<sup>1</sup>

---

1. Midland Health Board Executive Summary (2003). Parents “Olive and Peter” in *Developing a model for integrated primary, community and continuing care*.



## TABLE OF CONTENTS

<b>Summary</b> .....	7
<b>1. Introduction</b> .....	9
1.1. Terms of reference for the project .....	9
1.2. Working methods .....	9
<b>2. Integrated social services in the European context</b> ...	10
2.1. Definitions .....	10
2.2. Arguments for integrating social services .....	13
2.3. The “disintegration” of social services? .....	15
<b>3. Review of other work on integrated social services</b> .....	16
3.1. Evaluation and evidence .....	16
3.2. Useful theories and concepts .....	19
<b>4. Models for integrating social and health services</b> ...	31
4.1. Models and approaches to integration .....	31
4.2. Barriers to integration .....	38
<b>5. Integrating social services in Europe</b> .....	38
<b>References</b> .....	77
<b>Appendix I: Policy guidelines for the design and implementation of integrated models of social services</b> .....	81
<b>Appendix II: Members of the working group</b> .....	89



## **SUMMARY**

### **Project rationale and task**

The integration of selected public services is increasingly a prominent policy issue for European governments, based on the recognition that separate services are frequently not in the best interests of service users and their families/carers. Separate services may also be more costly.

The main task of the project was to review existing work on services integration across Europe, concentrating on its benefits for the most vulnerable groups and the strengthening of social cohesion, as well as to develop policy guidelines.

### **Intended recipients**

The report and the policy guidelines are designed to assist policy makers at national and local levels, service organisations and service users in designing and implementing effective integration policies and practices.

### **Definition of “integration”**

The term “integration” refers to not just one but a range of approaches or methods for achieving greater co-ordination and effectiveness between different services, principally to achieve improved outcomes for service users. Cost advantages are also possible. There is no “one size fits all” in integration work as so much depends upon particular circumstances and possibilities.

### **Main topics of the report**

These include:

- the main benefits of integrating social services with services such as health, together with arguments for a separate status for social services;
- an extensive review of cross-national research and single country contributions to the more theoretical and evidence-based approach to integration of services;
- details of a wide spectrum of approaches to integrating services, ranging from major structural integration from central government downwards, to informal, ad hoc co-operation between practitioners

at the very local level. Some of the main barriers to integration are identified;

- a substantial section of the document in which individual countries report on the main aspects of integration of social services, in many cases with examples of initiatives ranging from national programmes to small-scale local projects.

### **Policy guidelines for the design and implementation of integrated models of social services**

These guidelines – which are also available as a separate document – focus on the following key topics:

- the advantages of integrating social services;
- critical success factors of integration programmes;
- challenging elements in integrating social services;
- integration models and methods;
- national integration programmes;
- evaluation and monitoring.

There is also a list of references and useful websites.

# **1. Introduction**

## **1.1. Terms of reference for the project**

In summary, the CDCS adopted the following terms of reference:

1. review existing work in this field;
2. identify “best practice” in Europe and, in particular, how this facilitates access to social rights for the most vulnerable groups and so strengthens social cohesion;
3. develop policy guidelines;
4. develop methodological material for the promotion of the guidelines and best practice with stakeholders.

The work of the project group and its subsequent report follows these terms of reference.

The background to this project is the substantial long-term work by the Council of Europe on citizens’ rights. This includes the European Social Charter and revised Charter; and more specifically, the report on “Access to social rights in Europe” (2002). This latter report examined social rights as they apply in the fields of employment, social protection, housing, health and education. The recently completed Council of Europe work on “Users’ involvement in social services” (2004) is very directly related to the complex subject of integrating social services with other major services – as this report reveals. A frequently reported concern of users of social services is the problems they face because of the lack of co-ordination of services they receive from a variety of sources.

## **1.2. Working methods**

A group of social services specialists (see Appendix II) was formed in 2004 to work with a consultant to prepare this report for the Council of Europe. The timescale for the project was eighteen months, involving five meetings of the project group.

The project methodology included: reference to published writings and research; a questionnaire; specially commissioned papers; contributions from outside practitioners; and considerable input from the project group, particularly related to developments within their individual countries. The group was aware that a considerable volume of published work already existed in and around this wide-ranging subject, with new material appearing regularly. This project has drawn selectively upon other work

on integration, relating it to the main focus on a wide range of European examples and comparisons, including examples from central and eastern European countries.

## **2. Integrated social services in the European context**

### **2.1. Definitions**

It is important to clarify the meaning of the two key terms “social services” and “integrated social services”.

#### *Social services*

It is difficult to produce a definition of “social services” that is universally acceptable across Europe and which accurately represents the variety of services and organisational patterns across such a large region. In other work (see “Users’ involvement in personal social services”), the Council of Europe – along with others working internationally in this field – uses the term “personal social services” (PSS) to distinguish these services from others within the broader field of social welfare. In this report, for convenience the term “social services” will be used to refer to what are more precisely understood as “personal social services”.

#### *Personal social services*

Personal social services (PSS) are normally provided for individuals related to their specific needs and circumstances, in contrast to standardised services provided to people as members of categories. People who are typically users of PSS include elderly people and their carers, children and families, and people with disabilities. However, people with a variety of other needs and problems will use PSS, with differences between countries in who can and should use such services. Newer services for special groups have emerged such as people with HIV/Aids. Services are provided in different locations such as individuals’ homes, in day centres and residential establishments. They are staffed by personnel including social workers, social assistants (or variations on this term), care managers, home helpers, therapists and kindergarten teachers. Organisations providing PSS may be: state (particularly local authorities or municipalities); not-for-profit non-governmental agencies; or commercial businesses. Services

provided by third sector civil society organisations have become increasingly prominent in recent years.

A recurring question concerns the extent to which PSS are distinct from or similar to services provided within health, education, employment and social protection services. This is reflected in changing organisational structures, ranging for example from separate local authority departments for PSS – the “PSS are distinctive” model – to arrangements where PSS are seen as essentially services provided as part of a portfolio of services provided by health, social, protection, employment, and so on. Evers’ (2003) view is that

Social services include all services that are (a) considered to be of special importance for society on the whole and where (b) personal interaction between providers and users has a key role. Using such a broad definition, health, education, occupational integration and cultural services become as well part of the picture beyond the usual three fields of child day care, care services for the elderly and various small areas of services for problem groups.

There are differing views as to whether the distinctive or broad definition of PSS is the more appropriate.

### *Integrated social services*

The term integration should be understood as applying to a range of approaches or methods for achieving greater co-ordination and effectiveness between different services to achieve improved outcomes for service users. These approaches include: service co-ordination, co-operation, partnerships, collaboration, inter-professional or joint working – to name but a few. Therefore, “integration” is conceptualised as a continuum or ladder of integration, with methods chosen to suit specific needs, circumstances and possibilities. Experience shows clearly that there is “no one size fits all” in integration work.

There are different definitions of the term “integration” (Integrated Care Network, 2004, p. 12):

In its most complete form, integration refers to a single system of service planning and/or provision, put in place and managed together by partners (parent bodies) who remain legally independent. A single system for a particular service would, for example, unite mission, culture, management, budgets, accommodation, administration and records, and would apply at any and every level of integration (team, service or organisation).

Other approaches to solving the problems of service separation (for example, co-ordination) are all less total than this complete form.

The Procure project of the European Union (2004) refers to integrated care as (Leichsenring and Alaszewski, 2004, p. 15):

A concept of providing care services in which the single units act in a coordinated way and which aims at ensuring cost-effectiveness, improving the quality and increasing the level of satisfaction of both users and providers of care. Means to this end include the reduction of inefficiency within the systems, the enhancement of continuity, tailoring services within the process of care provision and the empowerment of service users.

In the same project the French national report suggests (p. 18):

Integrated services are a set of services made available for a specific population group over a given geographical area, or for the population of a given geographical area, by a single company or organisation, grouped together under a single decision-making authority.

Both definitions express the aims and elements of well-integrated care services. The extent to which they exist already is entirely another matter. Integration as understood in these definitions is stronger than other related terms such as “joint working”, “partnership”, “collaboration” and “networking”. These terms and the practices involved may perhaps be understood as important means to the end of service integration but, on their own, are rather less than what is required.

### *Horizontal and vertical integration*

It can be helpful to consider integration as both horizontal and vertical – an important distinction. In social care, vertical integration at the macro level refers to measures to achieve closer co-ordination of policy and service arrangements at different levels of government – national, regional and local; and, at the micro level, to residential, community and home-based services for different user groups in localities – all within social services alone. For example, in the UK in 1971 a new law brought together into one new local authority social services department the previous separate services for children and different adult user groups. But social services were separated from health and educational services in local authorities.

In health services, vertical integration brings closer together the hospital, clinical and community-based health services. Multidisciplinary health care of a “high tech” character is increasingly required as the patient moves in and out of different settings, implying that patient care will have

to become more vertically integrated (see Delnoij et al, 2002). The same article highlights how integration of services at the micro level is affected by characteristics of health systems at the macro level (for example, funding mechanisms); and how “fragmentation and a lack of coherence, and inability or unwillingness to engage in multidisciplinary co-operation are serious problems in many European health care systems”.

Horizontal integration is quite different. This refers to moves to bring together previously separate major public services in the interests – primarily – of service users, for example health and social services. This form of integration is the main focus of interest in many European initiatives and is the main but not exclusive focus of work in this project. The main services with which social services may be integrated to varying degrees are health, education, employment and cash benefits, with some interest also in criminal justice services. Successful horizontal integration may be needed at all levels, starting at integrating separate ministries at national level.

### *Integration of different types of service providers*

The clear tendency in Europe towards “mixed economies of social care” has major implications for social services integration. Integration can be difficult enough to achieve when either social or health care services are provided only by the public sector. When services for a particular group of users are provided by public, private not-for-profit and commercial providers, then service integration – according to the explanations above – may be much more difficult to achieve. The introduction of quasi-markets with competition between different providers is a further complication, raising the question of whether competition acts against service integration. Terms such as “partnership” reflect attempts to introduce co-ordination and co-operation between state and non-state service providers in social care.

## **2.2. Arguments for integrating social services**

This short case study is typical of many service users’ experiences of separate, unco-ordinated services (Midland Health Board Executive Summary, 2003):

We have twin girls aged 5; both have a moderate learning disability. Jenny also has autism. We’re totally confused with all of the different professionals and agencies we have to deal with. The following are some of the people we deal with on a regular basis: GP, counselling nurse, speech and language

therapist, occupational therapist, psychiatrist, psychologist, teacher, classroom assistant, ophthalmologist, audiologist and administrators – to name but a few.

We're so confused sometimes. We don't understand the different roles and have so many appointments that clash.

Can nobody or no system sort it out?

There is growing evidence that the integration of various public services is becoming a major policy priority in many European countries, for example new legislation, research projects, websites, conferences and publications. The focus is substantially upon social and health services and to a lesser extent includes other public services, such as education and employment. As the examples later in this report illustrate, the degree of integration may be total or partial; for example certain children's services in social and education services may be integrated while leaving other aspects separated.

The following are some of the main arguments in favour of integrating social services with one or more other major public services:

1. *Benefits to service users*: there is growing evidence from research and users groups that separate services – such as health and social services – are not in the best interests of service users. Selective integration of services can and does result in better outcomes for users, particularly users with complex, long-term needs, for example elderly people. An additional factor underlining the necessity for integration at the service-user level is the increasing range and complexity of services in many countries. As users become more confident and empowered, their experiences and demands for integration become more influential.

2. *Specific benefits from different forms of integration*: as stated above, "integration" is an umbrella term covering a range of approaches to improving service co-ordination in the interests of users. Typical benefits quoted in publications include:

- improving the speed of response to identified needs;
- simplifying the decision-making processes by involving fewer people;
- ensuring better use of resources;
- reducing communication failures;
- increasing satisfaction with services.

3. *Social exclusion and integration*: both the European Union and the Council of Europe give high priority to the promotion of social inclusion and citizens' rights – particularly in respect of the most disadvantaged and marginalised groups in European society. Tackling social exclusion at both national and local levels normally requires policy and service integration to make an effective impact on multifaceted social problems. To quote the rhetoric “Joined-up solutions are required for problems with multiple causes”. Traditional service separation is seen to have largely failed in this respect.

4. *Integration is cost-effective*: globalisation and strong international economic competition raise serious questions for countries about the cost-efficiency of the separation of major public services at both national and local levels. In this context, countries expect significant cost-efficiency benefits to result from integrating major public services. Hard evidence for this expectation has yet to be obtained. Linked to the cost-efficiency argument is the view that by creating larger integrated social and health services they will be able to make more impact in the increasingly tough struggle to secure a higher political priority for scarce resources.

### **2.3. The “disintegration” of social services?**

There are several important questions raised in this report and elsewhere about the strength of the case for integration. There is no “common sense” assumption that social services integration is necessarily a good thing. For example, there are arguments for maintaining the separation of certain services; and for separating services that are currently integrated. An example of the latter point is where some countries integrate both social care (for example, social work) and the cash benefit elements of social assistance, such as in most or all countries in central and eastern Europe (CEE). There are strong arguments advanced for both the integration and the separation of cash and care services. On the one hand, the less tangible social work service may be more acceptable if it is combined with much-needed financial help for particularly vulnerable people. The alternative view is that the power and responsibility to assess and administer cash payments can complicate and even overwhelm the provision of professional social work.

A second argument for maintaining separation between services is that their integration may amount to a “take over” of one by the other; and that the special knowledge and skills of one service may be diluted in

horizontal integration. This is a particular concern in the history of the relationship between health and social care professions, where the former – especially doctors – are seen as more powerful and of higher status than social workers and related staff. A working hypothesis may be that the integration of services is more likely to be possible where there is approximate status equality and professional security of the key staff groups involved. Where this is not the case then integration may be unwise.

### **3. Review of other work on integrated social services**

It is difficult to do justice here to the considerable volume of published work in this subject. Published work ranges from the results of large research projects such as Procure, to government reports and legislation, conference proceedings, books and articles, websites and more practical how-to-do-it guides on integration.

#### **3.1. Evaluation and evidence**

A common feature of this diverse collection of material is the paucity of completed evaluations and hard evidence as to whether and to what extent integration actually works in terms of producing better outcomes for services users and for the services themselves (for example, lower costs). The UK Integrated Care Network ([www.integratedcarenetwork.gov.uk](http://www.integratedcarenetwork.gov.uk)) was recently invited by the Ministry of Health, if it is able, to produce such evidence. We await responses. Evidence remains the big hole in the integration movement.

Just one example of the unevidenced literature is found in an article about integrated working from the Integrated Care Network.

The article refers to key principles in integrated working:

- all involved recognise their interdependence;
- vision, action, resources and risks are shared;
- users experience services as seamless (NB: “seamless services” is a key concept in this field).

Key ingredients in successful integrated working by services are:

- clear, shared objectives;
- a realistic plan and timetable;

- a commitment from partners to mainstream;
- a clear framework of responsibilities and accountability;
- realistic ways of measuring achievements.

Factors helping integrated working include:

- a distinctive leadership style in which leaders look beyond the needs of their own organisations to find solutions;
- a flexible, “can-do” organisational culture;
- tools such as pooled budgets or care trusts can help to change cultures.

Finally, everyone benefits from this approach:

- people have their whole range of needs considered at the same time;
- partner agencies concentrate on what they do best and have a better understanding of who else can help;
- the whole system becomes better managed.

This sounds positive and encouraging to support the case for integrating services but enthusiasm is not enough. This concern about evidence for the claimed benefits and superiority of integrated services will be referred to later in this report.

Ilse Julkunen (2005) was commissioned to prepare an initial review of some of the academic literature on integrated social services. Some of the key points from that review are highlighted here:

- Several commentators point to the absence of evidence that integrated social services produce better outcomes for service users, for example Kalpa Kharicha et al. argue that “while collaborative (or joint) working between social services and primary health care (in the UK) continues to rise up the policy agenda, current policy is not based on sound evidence of benefit to either patients or the wider community”.
- There are promising developments in citizen online access to government services through “one-stop” facilities, for example the eGOV project of the European Commission providing electronic public services of distinct public authorities to citizens and businesses in a customer-oriented manner from a single point of access.
- Ilse Julkunen cites several examples of how “public and private sectors are turning to service integration efforts to reduce barriers to

needed service created by separate programs". Typical barriers are bureaucracy, professional power and inefficient use of resources.

In her study several models for interdisciplinary working are outlined and compared, including again the question of evidence for outcomes of different models. In particular, cost and clinical effectiveness of inter-disciplinary teams have not been studied nor documented adequately. Important questions are identified for future research to assess the contribution of interdisciplinary teams.

- Julkunen ends her preliminary review of the literature with some precise conclusions:
  - studies reviewed tend to be rather descriptive and viewed from an organisational perspective;
  - problems are stressed rather than how the different integration models actual operate, leaving the all-important "black box" phenomenon unexplored;
  - outcomes and evidence are rarely found in accounts of integration initiatives;
  - studies reported are mainly from the USA and the UK.

Therefore, the following questions should guide future work in this field:

1. How can we achieve research-based exchange and mutual learning from good practice in different countries?
2. How can we develop a systematic exchange of comparable research findings and policy experiences to enable us to identify the factors accounting for success or failure in integrating services?

It is unusual to find examples of the kind of evaluation conducted by Bernabei et al. (1998). This is summarised below:

***Randomised trial of the impact of a model of integrated care and case management for older people living in the community***

*Objective:* to evaluate the impact of a programme of integrated social and medical care for frail elderly people in the community in Rovereto, northern Italy.

*Design:* randomised study with one-year follow-up.

*Subjects:* 200 older people already receiving conventional community services.

*Intervention:* random allocation to an intervention group receiving integrated social and medical care and case management – or to a control group receiving conventional care.

*Main outcome measures:* admission to an institution; use and costs of health services; and variations in functional status.

*Results:*

- administration to hospital or nursing home in the intervention group occurred later and was less common than in control group;
- health services were used to the same extent, but control subjects received more frequent home visits by doctors;
- in the intervention group the estimated financial savings were about US\$1 800 per person per year of follow-up;
- the intervention group had improved physical function; and a reduction in the decline of mental functioning.

*Conclusion:* integrated social and medical care with case management programmes may provide a cost-effective approach to reduce admission to institutions and functional decline in older people living in the community.

### **3.2. Useful theories and concepts**

So far there is a relative absence of firm evidence on the superiority of integrated services compared with separate services. But are there nevertheless useful theories and concepts to provide a sound knowledge base in this field? Some possibilities are found in the integration literature, with examples referred to in summary form below. They range from adaptations of formal social science theories, to propositions of an interesting but rather more pragmatic nature (for example, Leutz's "laws").

In their chapter on 'Understanding collaboration', Skelcher and Sullivan (2002, p. 35) suggest that academic studies of collaboration between organisations and services is the exception rather than the rule:

The predominant perspective in the literature is one that views collaboration as the exception. The narratives of policy development, decision making and programme delivery are ones in which individual organisations work largely independently in their functional 'silos' and where inter-organisational

working ... are presented as activities that cause difficulties and generate disproportionate transaction costs.

In the same chapter the authors take a broader perspective in which they explore theoretical approaches that help us to understand:

- why collaboration happens – the key drivers and imperatives in organisational and policy initiatives;
- the form collaboration takes – a variety of models and forms of governance;
- factors that affect the capacity and practice of collaboration – for example, professional, organisational and individual resources to develop, sustain and manage collaboration.

Here – as an example – it is only possible to discuss briefly one main theory relating to why collaboration happens – the drivers for collaboration. Skelcher and Sullivan refer to the optimist's view that collaboration takes place in order that a shared vision may be achieved with an underpinning theory characterised by two main features:

1. that collaboration will result in positive outcomes or improvements for the system as a whole;
2. that the stakeholders share a level of altruism in relation to collaboration, namely that future positive outcomes for the system override the desire for sectional gain by the participating organisations.

Exchange theory (Levine and White, 1962) has made an important contribution to understanding collaboration. Exchange theory is particularly relevant to integrated social services because it highlighted the way service users with multiple problems needed to engage with a highly fragmented and specialised array of health and social services providers.

Levine and White found that the different service providers shared similar objectives, but few individual organisations had access to sufficient necessary resources to fulfil their objectives alone. Other organisations in the system controlled resources necessary for any one organisation to undertake its tasks; for example hospitals need social services to provide care homes to enable elderly patients to be discharged from hospital.

This finding leads to the – unremarkable – conclusion that (Levine and White, p. 37):

Scarcity of resources motivates a pattern of voluntary exchange relations between individual agencies (e.g. social and health services) in an inter-organisational network.

In elaborating exchange theory, Levine and White make much of a concept central to much work on collaboration – that of the organisational domain. Organisations reach a formal or informal agreement as to their particular areas of operation within the total service system. When resources are scarce the larger and more powerful organisations use their strength to challenge others' domains to gain greater security for themselves. In contrast with this familiar picture, exchange theory applies to organisational systems that have a high normative regard for altruistic behaviour – and a strong respect for others' autonomy.

Comment: Levine and White's work offers just one conceptual framework for understanding the relationships between social services and other – more powerful – services such as health and education. The notions of exchange and domains are useful in macro and micro initiatives to achieve great collaboration or integration of services.

### *"Culture" in partnerships*

The word "culture" features prominently in writings and discussions about attempts to achieve greater collaboration of services across the fragmentation-integration spectrum. For example, different or even clashing professional cultures in social and health services are cited as major barriers to achieving integration of the two services. Similar issues arise in the commercial sector where the characteristics of companies can seriously affect the outcomes of mergers and acquisitions. The term "cultural fit" refers to this central issue.

It is important to have a clearer understanding of the basic concept; and the possibilities of changing or creating new cultures in the integration field. Unfortunately, "culture" is quite difficult to define – it is a rather elusive concept. At its simplest it refers to "The way we do things here" – that is, accepted behaviour, language, dress codes, shared values, rituals and so on. Well-established professions such as law and medicine have distinctive professional cultures, social work less so. Anthropologists have argued that in studying whole societies or individual organisations, culture – as expressed in dominant ideas and beliefs – can be explained by reference to the social structure in which they occur.

One of the most common ideas in the academic literature (for example, Meyerson and Martin, 1987) is that, in the study of service organisations, culture may be understood in three ways:

1. an integration model where culture is seen as something organisations possess and is broadly recognisable and consistent across the organisa-

tions concerned. So culture is an influence promoting integration and which may be manipulated to enhance integration;

2. a difference model in which there may be several different interest group cultures (for example, social workers and managers) within the same organisation. Therefore, culture is an influence which may be a barrier to integration – including partnerships. An optimistic view is that the various cultures may be open to manipulation, particularly in relation to the ways in which they interact;

3. an ambiguity model where culture is seen as more local and personal, constantly being negotiated and re-negotiated between individuals and groups within an organisation. It is suggested that this type of organisational culture offers the least prospects for manipulation in the interests of integration.

Studies of culture as applied to social and health services in particular produce various practice implications and examples. The following are a selection:

- Shared health and social assessment work with older people illustrates cultural differences between nurses and social workers. Nurses could not understand why social workers needed an hour to complete an assessment form: social workers could not understand how nurses thought it could be done in fifteen minutes. Nurses found it as difficult to enquire about people's finances as social workers did about their bowel movements.
- There are noticeable cultural differences between health services and local government social services in the importance they attach to and use made of research.
- Identity as difference – defining who I am as distinct from who you are – is a key component of culture and one that it may not be wise to challenge. Boundaries between professionals should not necessarily be seen as barriers to co-ordination and integration of services.
- Lessons from mergers in the commercial sector indicate that staff from merging organisations should be given as many opportunities as possible to meet in "transitional groups" to explore preconceptions and perspectives.
- "Regardless of the organisational form chosen and the user outcome desired, any strategy to manipulate organisational culture in health and local government (social services) will have to work with and through the professionals and their cultures. Managers should not

assume that all tension arising from cultural differences within organisations is either unhealthy and/or avoidable." (Peck et al., 2001)

### *Whole systems working*

A theoretical contribution from the sociology of organisations (Benson, 1975) offers a conceptual framework for "whole systems working". Hudson (2004) identifies four chronological phases in thinking and practice about the relationship between social services and health and education. They are:

1. separatism: each agency and profession plans and delivers its own contribution in isolation from the contribution of others;
2. competition: purchasing is separated from providing, with providers placed in a competitive relationship to one another;
3. partnership: agencies and professionals participate in specific and ad hoc collaborative relationships;
4. whole systems working: a new and more ambitious phase.

The whole system is not simply a collection of organisations that need to work together, but a mix of different people, professions, services and buildings which have patients and users as their unifying concern, and deliver a range of services in a variety of settings to provide the right care, in the right place at the right time. (Department of Health, 2003)

Hudson and others have examined the social science literature for theoretical work that helps our understanding of what constitutes a "whole system". The sociologist Benson (1975, 1983) wrote about "inter-organisational networks" with a dual approach that:

- identifies eight components that together constitute a holistic perspective on any specific problem or domain;
- proposes that these components are inter-related: changes in one will have effects upon the others.

It is not appropriate to discuss Benson's work in detail here but the eight components are central to his theory. His hypothesis or argument – using the eight components – is that effective whole systems working will occur when the following is in place:

- a high degree of domain consensus;
- a high degree of ideological consensus;
- a high degree of positive evaluation;

- a high degree of work co-ordination;
- a high degree of compatibility between partnership requirements and agency programme requirements;
- a high degree of maintenance of the profile of the programme;
- a low degree of application of defence of organisational paradigms;
- a high degree of maintenance of resource flows.

Other writers (Attwood et al., 2003) follow these more theoretical proposals with ten core values underpinning whole systems development. These suggest qualities and values that are needed by people responsible for implementation of whole systems integration:

- optimism;
- empathy and humility;
- tenacity and courage;
- learning;
- relationships;
- whole-system perspective;
- local knowledge for local solutions;
- building social capital;
- celebrating small steps;
- the long view.

#### **A whole-system case study**

Hudson reports on how the Benson framework is currently being used for evaluation of an ambitious project in the UK – The Durham Adult Community Care Enhancement Strategy and Services initiative. The key features of this interesting project are:

- a single visible identity for health, housing and social care services within local communities, so that users and potential users are clear about where to go to access the support they need;
- a one-stop single assessment service that integrates access to housing, health and social care support;
- commissioning and providing an integrated and flexible range of services that will allow users more choice, and be quickly responsive to their changing needs;

- joint working between all disciplines and staff involved, with full sharing of resources, including the pooling of budgets.

Compared with many partnership initiatives, the Durham project is distinctive in three ways:

1. the range of partners: housing, health and social care;
2. the levels of activity to be integrated are comprehensive rather than partial, encompassing strategic, operational and support systems: integration is the core business, not an optional add-on;
3. integration is to be co-joined with localisation: a radical shift in power and responsibility from the centre to the localities and neighbourhoods is taking place.

The project is being carefully evaluated with positive interim findings.

### *Leutz's five laws for integrating medical and social services*

The work of the American academic Leutz (1999) is often referred to in the integration literature. He studied integrated care in the USA and UK, comparing underpinning concepts and developments. His proposed five "laws" of integration are not strictly scientific laws but research-based, suggestive – and quite entertaining – propositions with practice implications. They are summarised briefly here.

#### *First law*

"You can integrate some of the services all of the time, all of the services some of the time, but you cannot integrate all of the services all of the time."

It is important to target expensive integrated approaches on people with complex needs. Not to do so is likely to be hopelessly inefficient.

#### *Second law*

"Integration costs before it pays."

Success in integration depends upon adequate investment of planning time and resources for training and systems development.

### *Third law*

“Your integration is my fragmentation.”

As much attention needs to be given to what may be lost through integration as to what is likely to be gained.

### *Fourth law*

“You cannot integrate a square peg and a round hole.”

Remember that some things may remain permanent challenges, for example different funding and governance systems for social and health services.

### *Fifth law*

“S/he who integrates calls the tune.”

This is not principally a comment on relative professional and organisational power. It is more an argument for finding ways for service users and carers to play the leading role in shaping services and their integration, for example through increasing use of direct payments/client budgets.

### *Frameworks*

In addition to the selective use of theories and concepts relevant to integration work, several practical frameworks have been devised to assist and focus analysis and planning in developing integrated services. Some frameworks are elaborated in this section.

There are two basic questions to ask of activities designed to integrate social services with other services:

- First, how can this activity be understood in relation to the fragmentation – integration continuum: that is, what may be claimed as integration may actually be co-ordination or co-operation between organisations?
- How is the activity assessed in relation to questions designed to identify good practice?

The work of the WHO in the integration field has been referred to earlier. Their framework identifies the features likely to be associated with integration, distinguishing them from autonomous working or a co-ordinated approach:

	<b>Autonomy</b>	<b>Co-ordination</b>	<b>Integration</b>
<b>Vision of system</b>	Individual perception	Shared commitment to improve system	Common values, all accountable
<b>Nature of partnership</b>	Own rules, occasional partnership	Time-limited or similar co-operative projects	Formal mission statements, laws
<b>Use of resources</b>	To meet self-determined objectives	To meet complementary objectives	Used according to common framework
<b>Decision making</b>	Independent	Consultative	Authority delegated, single process
<b>Information</b>	Used independently	Circulate among partners	Orientates partners' work towards agreed needs

This WHO framework can help those involved in integration – or other forms of closer working – to look for themes and patterns, rationales and directions, as well as being precise in the use of words. Where does a particular project or service fit within this matrix?

Skelcher and Sullivan provide a different framework, comparing different forms of collaboration from an organisational perspective. At one end of the spectrum are informal, loose network arrangements. At the other end are highly structured, formalised relationships which can result in the integration of collaborating agencies into one single organisation.

*Forms of collaboration and rules of governance*

<b>Forms of collaboration</b>	<b>Rules of governance</b>	Terminology
Loose network of informal relationship	Self-government through shared norms, values	Network
Limited agreement to share information	Varies from left to right	Partnership
Agree to joint activities	Varies from left to right	Partnership
Agree to formal governing body	Varies from left to right	Partnership
Create federal structure	External governance with constitution	Federation
Merger of separate organisations into single organisations	Hierarchy	Integration

The continuum of integration can also be expressed as a “ladder of integration of social services”. This should not be taken as implying an ascending hierarchy of methods for co-ordinating services, ranging from the worst (bottom) to the best (top) but is simply offered as a visual aid to order thinking and action in what can be a confusing array of methods.

### *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 country
3. Effective partnerships
4. Multi-service agencies with single location for assessment and services
5. Planned and sustained service co-operation 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

Steps in the ladder may be conceived and phrased differently but its usefulness is in identifying the various forms of closer working between services, ranging from complete separation/fragmentation, through to a fully integrated services system. As with all such constructs, it is a working model and is only one approach to representing reality. It is open to variations and improvement.

It suggests a progression upwards from almost no attempt at integration, through approaches of co-ordination, co-operation, collaboration, to the most comprehensive systems of integration. Additional rungs could undoubtedly be added to the ladder and perhaps one or more should be higher or lower.

Note that each step of the ladder is not exclusive. As the steps go higher they will almost certainly include one or more of the types of integration found in lower steps.

### *The steps of the ladder*

8. A rigid, rather old-fashioned system of separation of services at all levels. This was a standardised approach with fragmented service delivery. Such systems have more to do with maintaining bureaucratic interests than addressing the real interests of service users. They still exist to varying degrees.
7. The pressure of circumstances may force organisations to introduce a degree of integration of services but this is often introduced reluctantly and without a real commitment to developing integration as needed.
6. For example, staff from different professions working as multidisciplinary teams in a local community mental health centre. This may be a local rather than a widespread initiative in integration. An example of a process-centred approach which is less concerned with structural integration of organisations responsible for different services.
5. Arrangements where there is evidence of integration initiatives that are part of a systematic, planned approach – rather than ad hoc attempts at service integration.
4. Examples are the so-called “one-stop shops”, where service users access one building for integrated services, including single assessments and service plans. An approach to integration that is essentially user-orientated.
3. There are two kinds of agency or service partnerships. The first is setting up a formal partnership entity or process, with implications for structural changes, joint funding and so on. The second is a style of working where service organisations behave as partners with one another – regardless of the formal links between them. State-NGO partnerships of both kinds are increasingly evident and often required by EU funding programmes.
2. Integration of services within a single organisation/decision-making authority, providing a range of services for a specific population. Users are clear where to go to access the support they need. Incorporates the service model in rung (4) but involves more fundamental structural change than simply setting up “one-stop shops”.
1. As yet, such a comprehensive approach to service integration is rarely found. There are beginnings in some countries that concentrate initially on a top-to-bottom integration of specific parts of two major services. For example, integration of social, health and education services for children with special needs. Of course, this selective approach to top-to-bottom integration of services is more realistic than integration, for example, of all social and health services.

## 4. Models for integrating social and health services

As stated earlier, much of the published work on the integration of services refers specifically to health and social services. The main sources of information on developments at the national and European levels are found in research reports – especially those relating to Procare (2004); articles in the *International Journal of Integrated Care*; and various websites. This section of the paper now draws substantially upon the main Procare publication which reflects upon the experiences of countries involved in the project.

### 4.1. Models and approaches to integration

#### *Structural integration*

This is arguably the most radical, difficult and costly approach to integration. It involves bringing together staff and resources in one single organisation under a single unified structure. Legal sanction is required for public bodies.

A key characteristic of an integrated organisation is a single point of entry for potential users at which all their requirements can be assessed and an appropriate provision of services agreed.

In the UK, Care Trusts provide one model of structural integration, single organisations providing community-based health and social care to a given population (see later for more details).

#### *Joint working: process-centred collaboration*

This is crucial to integrated working, focusing on caring activities rather than on the organisational context for these activities. Organisational and professional boundaries create major obstacles. The process-centred approach to integration focuses on ways of overcoming obstacles through the use of incentives for closer working between professionals, for example specialist funding such as client budgets and long-term care allowances.

#### *Interdisciplinary working and teams*

Process-centred approaches focus on the ways in which care activities are integrated. They are less concerned with the agencies or organisations that form the basis of the structural approach.

### *Person-centred, seamless care*

Approaches that are concerned more with either structure or process are limited as they describe means rather than ends. The ends of health and social care systems are their outputs, the care and support they provide to users and their families. A central theme is that integrated care should be defined by the ways in which users experience it. They should experience it as seamless or continuous care that does not have gaps, waiting or overlap between different components.

### *Strategies, methods and instruments*

There are different levels of service integration:

- direct practice: for example, through case or care management (see Banks, 2004): matching supply and demand in complex situations – client and demand orientated – maximises benefits from a given amount of money through co-ordination of care delivery;
- professional: between the different professions as staff groups;
- organisational: whatever is the welfare mix arrangement in a country;
- functional: continuum of cure, care and prevention.

### *Assessing integration*

There are three approaches with possible measures:

1. service outputs: continuity of care, no delays or backlogs;
2. objective and subjective experience of users;
3. broader societal perspective such as social inclusion which requires joined-up solutions. Neighbourhood renewal is based on the integration of all services provided within a neighbourhood to improve services and increase involvement.

### *Other findings from European experience*

*Joint working – shattering the cultural divide:* experience shows that effective joint working in health and social care can take a long time to establish. However, traditional divisions between the two services can be overcome with “incentives”, for example in the situation where the local authority has no residential care home for an elderly person ready to leave hospital. In Denmark – and possibly other countries – the municipality has to pay a ‘fine’ for each extra day the person has to remain in hospital.

On the other hand, contracts specify that community services must be informed several days before a patient is discharged needing community services.

*Integrating housing, welfare and care:* housing is often important to integrated care but not always available as part of a service package.

*Supporting informal family care:* this also needs to be included within integrated care. Care management service models normally ensure this is fully included.

*Quality management as an instrument to create mutually agreed outcomes:* total quality management (TQM) has helped to change the culture of care, with integration seen as an important means towards the end of better outcomes, proper orientation to users' needs and wishes.

In addition:

- integration reforms must be based on integration of financing systems and overcoming institutional barriers;
- demand-driven, integrated care has to work to increase users' control over the care process, for example individual budgets;
- top-down initiatives should only exist to support bottom-up change processes;
- a central service point for advice, information and help is useful to support users in clarifying their care needs and improving co-operation between different organisations;
- change processes are very time consuming;
- evaluation is gradually becoming a more common and necessary practice, for example in France;
- it is not possible to imagine a good practice integration model for all countries – a very important finding.

### *Integration as part of a continuum for linking services*

It is critically important to understand that integration of separate services is only one means of overcoming the disadvantages of separate services – other possibilities exist (see above) and may often be more suitable. This is elaborated by various commentators who place integration at one end of a fragmentation-integration continuum. Some of these formulations are referred to later in the report.

### *Autonomy, co-ordination and integration*

Autonomy refers to service situations where there is no holistic view of users' needs; actions and decisions are arrived at independently and without co-ordination.

Co-ordination exists where there is a shared view of users' needs; and actions and decision making are co-ordinated. Co-ordination takes place within a user-centred network of services.

Integration is found where fragmentation between providers and autonomous action are minimised. Working practices become transparent. Integration is of greatest benefit to those with complex needs, and where the system is clear and readily understood by service users. The degree of complexity of individual needs should determine the requirement and context for integration.

Better co-ordination of services can also:

- deliver many or even most of the benefits to users of an integrated system;
- be a positive, facilitating step towards an integrated system;
- also, an integrated approach where service delivery staff form an informal co-operative network to meet user needs has important advantages as a way of overcoming service fragmentation.

An important question is whether co-ordination – compared with integration – can be sustained and optimised over a longer period. A strategic decision to be made in localities is whether a single integrated service system will be more suitable than the less costly and disruptive co-ordination of separate, fragmented services.

### *Partnerships*

Partnership is a “buzz” word in European social policy as it is central to the widespread development of “mixed economies of social care” with increasing emphasis on the involvement of non-state sectors in provision of social services. It is heavily promoted, for example, by the European Commission.

There is a distinction between setting up a formal partnership entity or process and informal partnerships where organisations act as partners but without necessarily changing organisational arrangements.

### *Reasons for developing partnerships of either kind*

- to deliver co-ordinated services to users;
- to tackle issues that cross traditional service and professional boundaries, for example social exclusion, economic regeneration and community safety;
- to reduce the impact of organisational fragmentation and minimise any resultant perverse incentives, for example new additional agencies to deal with matters other agencies/services have been dealing with separately, dividing into purchasers (commissioners) and providers.

### *Partnership models*

There are various approaches to forming partnership arrangements between different service organisations. The most suitable model will depend upon factors such as local circumstances, what is acceptable to partners, what can be afforded (costs). Different models include:

- a separate organisation – most suitable for larger, well-resourced partnerships (for example, Health and Social Care Trusts);
- a virtual organisation which is not a legal entity;
- co-locating staff from partner organisations: a relatively informal arrangement but not suitable for managing major new projects;
- steering group without dedicated staff resources: the simplest and least formal model. This is ideal for a partnership that aims to improve co-ordination of services across organisational boundaries; and less suitable for longer-term projects and those where a separate entity is needed.

Other alternative options to the above models include:

- consultative arrangements with a single agency retaining responsibility for decisions and action;
- networks not involving organisational commitment;
- contractual relationships with different benefits for partners, for example new social services involving the local statutory authority, an NGO and a bank providing funding (in the UK known as a “private finance initiative”).

### *Benefits and costs of partnerships*

There are several predicted/assumed benefits of partnerships between services organisations. They:

- result in a better fit between services and users' needs;
- make better use of resources;
- share information in an open way;
- stimulate more creative approaches to problems, such as social exclusion. This is one of the greatest strengths of this way of working;
- encourage experimentation and generate innovative service improvements;
- influence others. Partnerships frequently wield greater influence than their individual partners: for example commercial organisations can be unwilling to contribute to a local authority programme but may be more willing to engage with an independent agency.

*But what about the costs of partnership working?*

- difficult to assess if benefits resulting from a partnership are greater than the costs involved;
- direct and opportunity costs (for example, staff time) need to be considered in any "value for money" assessment of partnerships.

A decision not to work in partnership may be taken if it is too difficult and expensive in relation to benefits.

Comment: the subject of partnerships is central to work on integration. It may well be that partnerships are understood and practised in different ways in other countries. As other writings and practice indicate, partnerships need to be located somewhere on a continuum (or ladder) between service fragmentation and service integration. To quote one commentator, "A partnership is needed to create an integrated system, but a partnership is not the same as integration" (Integrated Care Network, 2004).

*Case management*

Case management – also referred to as "care management" – is a method for integrating care at the individual user level. It originates from practice in the USA as a way of organising services from a wide range of governmental and NGO welfare services in their particularly diverse welfare and health system. It has been adopted in different forms in European countries to provide a more efficient, organised and individual-tailored approach to integrating the various services required by users with complex and usually long-term needs.

Holistic assessment, user and carers' involvement, and construction of care packages are central features of this service integration model. Typically a care manager will work collaboratively with a service user – and carer(s) where appropriate – to make a full assessment of needs and capability; construct a suitable and costed package of necessary services; arrange for their integrated delivery; and monitor the ongoing implementation of the service package. The arrangement is formally reviewed periodically.

Banks (2004, pp. 102-103) states that:

Organisations will be considering the potential of case management to offer a cost-effective and efficient way of co-ordinating services so that older people receive: what they need (across service boundaries); and when they need it (continuum of care). The challenge for case management is that it takes place at the level of service provision at which needs and resources, scarcity and choice have to be balanced.

As Banks indicates, there are several different models and approaches operating under the umbrella of case management. These include, amongst others:

- intensive case management: case managers co-ordinate services for users with severe and complex needs in order to tailor services to individuals across time and place of service use;
- joint agency: case management is supported by a multidisciplinary team of workers from different agencies. One team member acts as case manager or key worker;
- brokerage: case managers are employed by an independent agency, with the potential to act as powerful advocates – but their position may be weaker because of being outside the service system;
- users co-ordinating their own care: this approach offers more user control than other methods. The increasing introduction of "client budgets" has increased the scope for selective use for users to co-ordinate and buy in their own care packages.

An evaluation of a care management project in the UK showed that (Lewis, 2005, p. 5, quoting Challis et al., 1995):

Providing services in this coordinated way enabled vulnerable older people to stay at home; that the services were felt to be more reliable, effective and sufficient than other arrangements; that the older people had high morale; that the distress of carers was reduced; and that the costs were no more expensive than the alternative arrangement.

## **4.2. Barriers to integration**

This section has reviewed a variety of approaches to the integration of services, ranging from modest informal methods to major structural reorganisation of separate services. There can be significant barriers to achieving integration as Nies (2004) indicates in relation to attempts to integrate social and health care services. His examples include:

- insufficient public funding for services: shortages can result in waiting lists with an effect on referrals and service provision that make it hard to implement integrated, smoothly operating systems;
- complexity of the system: multiple stakeholders may have different roles, interests and power positions. Factors making integration difficult include: different legislation and funding streams; the social, political and economic context; and different procedures and structural arrangements at different system levels;
- lack of responsibility: in most systems, no one has overall responsibility for the integration of care and services, nor for outcomes. This is a barrier to decision making;
- supply-driven systems: despite the ideology of needs and client-driven service systems, practice is still often determined by supply and providers' interests;
- human resources: integrated services require new types of professionals (for example, case managers) and inter-professional teams. Staff shortages and slow development of necessary training may hamper the implementation of integrated care;
- integration becoming an end in itself: integration will be supported as long as it delivers better outcomes for users, but will be resisted if instead it becomes a way of solving other system problems.

## **5. Integrating social services in Europe**

Most of the remainder of this report concentrates on what the Council of Europe project has discovered about the integration of social services, primarily in countries involved in this project. The report then concludes with suggested guidelines. This review claims neither to be complete nor perfectly up to date because of the changing nature of this subject in Europe. The countries are referred to in alphabetical order.

## Albania

The quantity and quality of pre-1989 social services in Albania was so poor as to make it a particularly challenging task to develop them in recent years. Albania is now involved in a major World Bank project to develop new social services, including passing responsibilities and funding to local governments. In this situation one approach may be to organise new local social services separately to allow them time to develop properly before any possible integration with services such as health. Alternatively, this may be a good opportunity to establish new integrated service models at the outset. The example below illustrates just one approach to this latter strategy.

### **The Balash social services centre in Elbasan**

The social day centre for older disabled people is financed by the Italian Department of Labour and Social Politics as part of a programme of Italian co-ordination for human aid in partnership with the Ministry of Labour and Social Affairs (MOLSA) of the Albanian Republic, the Elbasan municipality, and various social services NGOs.

The Balash social centre is also a public service for older teenagers with social needs. It also has the function of reintegrating people whose problems have left them outside the mainstream of their local community. One of the aims of the project is to achieve a pilot model of integrated community-based services in partnership with local government and NGOs.

The project started in August 2000 and finished in March 2002, having achieved its main objectives. A second project started in October 2002, which builds on the achievements of the previous project; control has been handed over to the local community. The centre is administered by the Elbasan Municipality and funded by the MOLSA.

#### *Typology of services*

The centre offers a variety of social and health services for elderly people and others in need. Examples of services include:

- employment therapy and professional formation;
- home assistance and prevention of institutionalisation;
- physiotherapy;
- social activities;
- food and hygiene service;
- activities in community awareness;
- inclusion of those attending the centre in culture and community services.

The centre is focused on: securing real opportunities for autonomy and a social life; and improving the chances of social inclusion.

## **Armenia**

In Armenia social services delivery affects most citizens. The services are administered by a network of over 180 separate offices. The administration of social protection services – including programmes aimed at both serving the needy as well as those involved in distributing social insurance benefits – are fragmented and do not work efficiently. The need for a degree of integration among the many different services is clear.

As the example below illustrates, the introduction of “one-stop” centres will help to increase the quality of delivery of social services and improve citizens’ access to information about services. Applicants will be able to go to one location for all their assistance, social benefit and pensions needs. A key element of co-location of services is the sharing of information among the organisations. In Armenia, the ASTP programme has adopted an innovative collaborative and consultative approach towards developing a model for the integrated social services centre.

### **Vanadzor integrated social services centre**

In their social welfare programmes in CEE, international donors concentrate on “bringing services closer to the citizen and integrating the services available so that the citizen has to visit just one location to obtain social services”. This is particularly necessary in Armenia where services are administered by a network of over 180 separate offices. The Government of Armenia is committed to a policy of improving services to citizens, which involves bringing all services together under one roof.

Vanadzor is a pilot project to test all aspects of creating integrated social services centres (ISSCs) in Armenia. The main goals of an ISSC will be to:

- improve access for the citizen to social services by co-locating all social services in one building, and improving access to information;
- enhance and extend the range of social services provided to the citizen by working more closely with NGOs on health and social care;
- improve information sharing among organisations by creating systems for sharing databases to simplify applications;

- improve the administration of social benefits programmes through streamlining procedures, more efficient work practices and improved staff training;
- make more efficient use of staff and technical resources among the co-located offices.

Citizens in Vanadzor will have one location to apply for pensions and benefits, register as unemployed and enquire about other social services. Reception staff will provide information, advice and help with completing forms. Data sharing between services will reduce the number of separate, overlapping applications for benefits and services. Where necessary, customers can be directed to the NGO referral service in the building.

If successful, the new ISSC will provide important benefits to citizens that are not present in the highly fragmented system that it will replace. The particular approach to integration of services with its "one-stop" location will be central to this new concept.

## **Czech Republic**

Since 1989 the situation in social services in the Czech Republic has been marked by a significant shift towards integration both horizontal and vertical, that is towards services that are based on users' real needs. There has been a significant and accelerated trend of focusing on the individual and the quality of his or her life. This even applies to some extent to the remaining residential services with a protective and paternal character where there are now obvious efforts to integrate them with local communities. Before the revolution, residential homes for the elderly and people with a mental disability were placed in unsuitable large buildings like old monasteries, isolated from built-up areas.

These efforts are greatly supported by the government, both in the form of promoting community planning within the country, that is a method of service planning that maps out users' needs in a given area under the equal co-operation of the triad – user, provider, operator – and through promoting quality standards, which are based on the needs and protection of the rights of the social service users and that were issued by the Ministry of Labour and Social Affairs in 2002.

In the Czech Republic, the integration of service provision is common, but does not guarantee the quality of the different kinds of care provided.

There is no interdisciplinary strategy, even though when different kinds of care are provided to the same person, service provision should be integrated in order to facilitate the person's social integration and rehabilitation. Specific types of institution are still generally designed for specific user groups. Integration in social service provision is seen as essential in bringing a more human dimension, safeguarding users' human rights and, above all, improving the quality of social service provision. If certain groups of users (the elderly, persons with mental disabilities, etc.) are dealt with separately, even if they are provided with high-quality services, the final quality will always remain questionable because, above all, elderly people need contact with other groups of people at other stages in life.

### **Integration in social services in the Czech Republic**

Ústav sociální péče v Horní Poustevně (ÚSP) (a social care institution in Horní Poustevně) is a residential service with an original capacity of 130 clients with mental disability, both men and women from early ages through to adulthood. The process of converting the traditional paternalist institutional care for clients with a mental disability started in 1996-97 with the first protected apartment for six clients in nearby Vilémov, providing all the services the clients needed.

Since then, the project has been running and proving that the life of a person with a mental disability can be enjoyed to the full if there are people who accept such a life and can negotiate seemingly impossible hurdles. At present the protected houses and apartments house a total of 108 clients for whom services are provided by 98 ÚSP (as above, social care institution) employees. ÚSP is an organisation funded by contributions from the state budget, which was founded by the Capital of Prague.

A very wide range of services are provided directly by ÚSP or by other people, for example accommodation, food, health care, education and personal development, training, supported employment, free time activities (cultural and recreational activities), rehabilitation, therapy (ergotherapy, music, pets, arts, drama), assistance with procuring (things for personal needs), assistance with property management, assistance in difficult life situations, and social and legal protection. Accommodation in apartments in various places in the Šluknov area promotes the integration of clients in the village or town society in a natural way.

There is both vertical and horizontal integration in this example. ÚSP is being gradually transformed into an organisation of social services where it is not the provider of all the services needed but plays the role of a guarantor that is ready to assist a client with selection of the necessary services. ÚSP also provides supervision and control of the services provided by various organisations and individuals and also manages the organisation's property.

The costs of integration initiatives (per user) are comparable to the costs of a bed in a traditional residential social care institution in the Czech Republic. This transformation is not more expensive than the current care model. From the point of view of satisfying the client's special needs, it is incomparably more efficient.

The project has always been struggling against hurdles in the form of misunderstandings with the administrative authorities, insufficient legislation and surprise on the part of the natural community. However, the project has managed to negotiate the hurdles and thus to shift the perception about ways of providing social services to people who more or less depend on them.

The client is involved in the creation of an individual personality development plan that should result in a contract between the client and ÚSP to define the services to be provided, the selection and extent of the involvement of ÚSP employees and other persons in the client's active life. The services are provided with one intention only, which is the client's integration and inclusion in social life. The contractual relationship between the client and ÚSP should lead towards the gradual reduction in the quantity, or intensity, of social services provided to the client to the necessary minimum or even (if possible) towards complete relief from dependence upon the institution.

## **Finland**

Finland has a relatively long history of combined health and social services at the regional level, although not all regions have adopted this type of integration – it is a local decision. Now Finland has launched a programme to reform its social services during the period 2003-07. The purpose is to redesign the entire comprehensive service system. Along with the national programme to reform health care, this programme is one of the most important projects of the present government. A key

issue is to improve the availability and quality of services. The project aims at reforming the municipal service structures and operations. Services are being modernised to be more timely, flexible and client-orientated. More effective methods for the provision of services are being sought and the introduction of new working practices and operational models is being promoted. Co-operation between different authorities at national and local levels is being intensified and closer co-operation between the local authorities, the third sector and private service providers is being promoted. One example is the development of family centres, where not only the social and health sector is combined but also the third sector.

New cross-sectoral joint service centres have been developed in Finland in the field of activation of the long-term unemployed. Here a more concentrated and radical approach was adopted, with elements that reached for cross-sectoral co-operation both at the operational and strategic levels. At the operational level, the most important aspect is setting up new cross-sectoral joint service centres, "one-stop shops". In the pilot phase the joint services were called joint service centres (JOIS), and when they were made official in the new national government programme, they were named labour force service centres.

Modernising public employment services is also one key aspect. Finland has for a long time pursued an employment strategy where everything has been contained under "one roof", that is the labour administration and the public employment services. Now for the first time Finland is moving away from this strategy, replacing it with a system which would make better use of a broader horizontal resource through joint service centres. In addition, the pressures on public employment services are mounting. Unemployment figures, after dropping steeply, have reached a plateau. Ideas in the ministry have started to veer more and more towards a dual strategy and new organisational structures.

#### **Integrated employment and social care services – Espoo**

Labour force service centres (LFSCs) were first introduced in 2004 in response to the specific needs of a declining but still significant number of long-term unemployed people. The state is responsible for employment services, local authorities for health and social services. The aim is to provide more suitable services for the long-term unemployed by combining both responsibilities at the local level through LFSCs (28 in total by June 2005).

The main objectives of the LFSC are to

- reduce structural unemployment and prevent exclusion;
- reduce the number of beneficiaries of unemployment benefits;
- increase opportunities for participation in active labour market policy programmes;
- develop users' confidence to control their lives and to be able to work.

Funding is provided by the state and the local authority. An evaluation of LFSCs has shown that:

- activation rates were higher than through separate employment services;
- there were positive results from users' satisfaction surveys.

Lessons from construction and operating of LFSCs: integrated strategies were elaborated at all levels to ensure involvement of all actors in planning and implementation. Key issues have been: the importance of avoiding one sector dominating another; the need to devise a shared vision of activation; and the complex task of managing a network of organisations and multi-professional teams.

## **Flemish Community of Belgium**

The integration process of social services in the welfare and health sector in Belgium, and in particular in Flanders, has been tackled in different ways and at different levels. Administrative reforms, the promotion of mergers and co-operative ventures through recognition and subsidy decrees, and the decentralisation of social services to the provincial and local level have been the most important procedures.

### *State reform of 1980 and the integration of social services*

The state reform of 1980 in Belgium led to a reorganisation and integration of different forms of health and welfare care in many fields of service provision, in particular in the field of welfare and health policy. With the state reform, assistance to people was transferred to the communities, so that the different forms of welfare and health care – developed in the various national ministries – were decentralised. The social services which depended on different national ministries were brought together in the Welfare, Public Health and Culture Department of the Ministry

of the Flemish Community. The same ministerial department recognised and subsidised the welfare and health services from 1980 onwards and carried out quality control. In 2005 the Flemish Government then created a new Flemish Ministry for Welfare, Health and Family. Walloon region and Brussels reorganised their welfare care to fulfil the social needs of their population groups.

*Integration process on the basis of regulations  
of the regional government*

After the state reform of 1980, the Flemish Community, often at the request of the sector itself, took a number of initiatives to harmonise certain sectors or to have them co-operate or merge. The first integration Flemish Parliament Act for general welfare work was approved on 24 July 1991. This Flemish Parliament Act had four different objectives:

1. greater legal security for general welfare work;
2. a better position and profile for the sector within overall welfare and care;
3. the structuring of general welfare work to create a coherent and integrated network of balanced, spread and accessible provisions;
4. the harmonisation of the regulatory framework for all the recognised provisions in general welfare work.

With the 1991 Flemish Parliament Act on general welfare work, the different forms of non-residential and of residential welfare work were brought together as follows:

a. non-residential welfare work: social welfare centres, centres for life and family issues, youth information and advice centres, centres for forensic social work, victim support and telephone assistance;

b. semi-residential and residential welfare work: supervised independent living for young people and adults, supervised independent living for adults, centres for the homeless, women's refuges, community centres for young people and crisis care.

At the end of 1994 there were still 239 centres for general welfare work which were recognised, 39 of which were incorporated in a health insurance fund, five centres for telephone support (one per province) and 195 independent centres for general welfare work, recognised on the basis of nine different regulations.

These independent or autonomous centres merged on the basis of the Implementing Order of 21 September 1994 into about a hundred polyvalent non-residential or residential centres for general welfare work.

On the basis of the 19 December 1997 Flemish Parliament Act these centres merged to form 29 independent centres for general welfare work. The non-residential and residential welfare work was integrated.

On 31 December 2003, there were 27 independent centres for general welfare work in Flanders. They employ 1 425 full-time welfare workers in 355 centres and received €49 million from the Flemish Community for their personnel and operating costs in 2003. Some 1 075 full-time equivalents are subsidised by the Flemish Government, the remainder by provinces and municipalities. Some 41 initiatives for social service provision are incorporated into the health insurance funds with about 400 professional employees and a subsidy from the Flemish Government amounting to €11 million.

### *Integrated youth support*

Integrated youth support aims to guarantee the opportunities for the development of minors, their parents and people in their living environment and promote their health and welfare. To this end, it provides a broad range of integrated support possibilities. The Flemish Parliament Act on Integrated Youth Support of 7 May 2004 provides a framework for inter-sector co-operation and co-ordination. It determines the aim and operating principles of integrated youth support, determines which sectors participate, proposes a number of concrete forms of co-operation and co-ordination and establishes an inter-sector policy sector.

The youth support provision in the following sectors forms part of integrated youth support: general welfare work, special youth assistance, integrated family care centres, mental health care centres, pupil guidance centres (Child and Family) and the Flemish Fund for the social integration of disabled persons.

An Advisory Council for Integrated Youth Support and a Management Committee for Integrated Youth Support were created. The management committee unites the leading civil servants in the participating sectors. Representatives of the working field, of minors and parents have a seat on the Advisory Council for Integrated Youth Support. Both bodies advise the Flemish Government with regard to its policies on integrated youth support.

*The integration of the school medical inspection  
and the psycho-medical-social centres to create pupil guidance  
centres to cater for a wider range of educational needs*

On 1 December 1998, the Flemish Parliament Act on Pupil Guidance Centres was signed both by the Flemish Minister for Education and by the Minister for Health Policy. This meant that school medical inspection and psycho-social-medical support were provided in an integrated way in primary and secondary education. As a result of the merging of 104 school medical inspection centres and 201 psycho-medical-social centres to create 75 pupil guidance centres, school doctors and nurses started to co-operate with psychologists, educationalists and social workers to support schools and parents.

The pupil guidance centres started to work as a whole on 1 September 2000.

*Integration of mental health care centres*

The process of integration in mental health care started with the 18 May 1999 Flemish Parliament Act on Mental Health Care and the 17 December 1999 Flemish Government Decree implementing the Flemish Parliament Act. The objectives included a broadening of scope, more room for management, a clear second line position and an emphasis on weaker groups, children and the elderly.

A large number of centres merged: of the 84 centres in 1988, 21 centres remained, evenly spread throughout Flanders. The management subsidies and the increase in salary scales to the level of salary scales in hospitals resulted in an increase in the budget. The budget increased from €28.9 million in 1998 to €41 million in 2004. In 1998, 620 full-time employees were subsidised, and 880 in 2003.

*Provincial consultation and co-operation*

The 19 December 1997 Decree governs the establishment of provincial structures, which are responsible for the co-ordination and expansion of regional consultation and co-operation forums and networking in the organisation of the welfare sector.

The creation of a single structure which co-ordinates the consultations and the co-operation at the regional level contributes to more referrals and to avoiding a duplication of work and top-heavy services, resulting in the improvement of service provision.

Therefore a provincial co-ordination commission was established where regular consultations can take place for exchanging experiences and making arrangements.

*The social house: integration of welfare,  
health and equal opportunities by municipalities*

Local social policy seeks to achieve the highest possible accessibility of the service provision to citizens and to optimally reach the weaker social groups and clients. To this end, the local authority establishes a social house. This will be the "one-stop shop" for citizens with regard to social service provision in their municipality, neighbourhood or district, as the "one-stop shop" function of the social house provides integrated access to the social service provision of both the municipality and the public centre for social welfare. This allows citizens to gain easier access to their social rights and to be helped in an effective way. Whenever appropriate or necessary, the social house will refer the client to the correct service.

*Conclusion*

The most important objectives of integrations are quality policy and result-orientated management and client-friendliness. Improving access to social rights, in particular for the most vulnerable social groups, and strengthening social cohesion are the results.

## **France**

In France, debate on the improvement of relations between the users of public services and social services<sup>2</sup> is closely linked to state reform. In addition to a demand for efficiency of government and of private bodies fulfilling a public service mission, there is a major concern to ensure access to services and guarantee their quality. Since the beginning of the 1980s, therefore, the public authorities have been engaged in a process of "public service renovation".

The promotion of a "quality culture" and the desire to simplify administrative formalities and facilitate access for individuals to information

---

2. Definition of social services by the World Health Organization (WHO): "services and programmes aimed at providing social support to people who, because of age, poverty, unemployment, health condition or disability, require public assistance in the areas of shopping, housework, transport, self care and care of others, in order to function more fully in society".

and public services have resulted in a profusion of initiatives. Moreover, a concern to fine tune services to meet users' needs has brought recognition to local services. The emergence of "one-stop" facilities bringing together a range of public and social services in one and the same place is therefore one of the distinctive features of this reform. The modernisation of the state and its services also incorporates the new resources represented by new information and communication technologies (NICTs).

The experience with municipal and inter-municipal social action centres seems emblematic in this respect. The concern to meet the needs of local residents is combined with the concern for high-quality support to facilitate the integration of vulnerable individuals into the local social fabric.

*Modernisation of the state and public services  
through the promotion of high-quality local public services*

*Promoting the integration of public and social services  
in a rapidly changing economic and social context*

The late 1980s saw the beginning of a debate in France on the modernisation of public services. The aim was to bring government closer to citizens and provide cheaper and more effective public services.

Four main objectives have been set for the policy for receiving members of the public and providing them with a service:

– Promoting public information

The aim was to improve public information through the production of electronic handbooks and the possibility of obtaining detailed information within the shortest possible time. Encouragement was therefore given to the development of multi-purpose facilities in the form of helplines manned by staff from different ministries. The use of other information media such as the Internet, audiovisual media and facts is also mentioned.

– Personalising relations between staff and users

The personalisation of relations between staff and users calls for traceability with regard to files and the persons dealing with them. The staff member's name and the address and telephone number of his or her department must therefore appear in all administrative correspondence. Multidisciplinary provision and the possibility of offering a comprehensive

response to the user's needs are goals towards which all public and social services should strive.

– Simplifying administrative formalities and procedures

The aim was to make things increasingly easier for users by simplifying administrative formalities and procedures and harmonising and making more flexible the requirements set by different departments for proving one's identity, income and address, and to improve access to administrative documents and reduce the time taken to obtain them.

New technologies are also perceived as a means of simplifying administrative procedures, through simplification of online forms and the development of e-mail correspondence. There have been significant developments in the area of electronic forms, particularly as regards public procurement.

– Promoting user participation

Users must be seen as partners of government departments, public institutions and private bodies fulfilling a public service mission. Their involvement in public projects is regarded as an essential prerequisite for improving public services. The guidance therefore recommends the promotion of user committees or associations in order to obtain an assessment of the efficiency and quality of services from the people who use them.

*Institutional integration of public and social services*

A Committee for the Simplification of Administrative Language (Comité d'orientation pour la simplification du langage administratif – COSLA) and a Commission for Administrative Simplification (Comité d'orientation pour la simplification administrative – COSA) have been set up to give expert advice in connection with all plans to simplify administrative wording and regulations.

The setting up of a Directorate General for Modernisation of the State has been given the threefold task of promoting activities to take fuller account of users' expectations, and to ensure and evaluate the quality of the service provided, to co-ordinate activities for simplifying law and making administrative formalities less unwieldy, and to participate in work to improve the quality of regulations and the clarity of administrative language.

*Tools for renewing relations between “users”  
and public/social services*

*Promoting quality of personal contacts in public services:  
the “Marianne Charter”*

While the Marianne Charter is, first and foremost, a common core of commitments in terms of personal contacts, responsiveness and prompt handling of queries, it is also a set of methodological reference points (a “Marianne Charter” handbook, a handbook on honouring of commitments and a handbook on how to receive persons in difficulty), and a visual identity. The fifth section of the charter, entitled “listening to you in order to move forward”, stresses the need for each department to assess its results and regularly question its users. In addition to these local measures, the Secretary of State for State Reform called for the introduction of external evaluation arrangements based on the principle of “mystery users”.

*Services tailored to specific needs*

The logic behind the “one-stop” approach is to address the situation of users in their globality and to simplify procedures by offering them prompt attention and direct access to the appropriate services.

The common feature of these “one-stop” facilities is that they bring together different operators, be they institutional or voluntary, in the same place to facilitate direct access for users to the right service so that they can obtain the desired information and advice. Closeness to the user is one of the fundamental principles of these “one-stop” facilities. Although they are all built on the same logic, “one-stop” facilities sometimes have specific target groups.

The primary function of the *maisons de services publics* (public service centres) is to cover urban or rural areas devoid of services (depopulation, scattered settlement pattern, sensitive urban areas). They pursue the general-purpose aim of responding to any query from members of the public. They have been followed by the *maisons de l’emploi*, aimed at job-seekers, and *maisons du handicap*, designed to receive and provide information and support to persons with disabilities. In addition to the general-purpose “one-stop” facilities, there are therefore some of a more specialised nature which deal with particular target groups.

A new type of centre, the “networked centres for access to social rights” (*pôles d’accueil en réseau pour l’accès au droit sociaux* – PARADS), has been set up. These centres are in line both with the “one-stop” service project and with the objective of setting up centres to act as a “first port of call” for persons seeking advice on social rights. Further characteristics of these centres are an area-based approach and a concern for local social development. Their design must therefore be based on a diagnosis of the local area and strategic siting in relation to the institutional, administrative and voluntary sector environment. Their activities must be co-ordinated with those of other general-purpose centres and more targeted information centres such as family information centres, employment centres or health care access points.

The purpose of the PARADS centres is therefore to remedy a shortcoming by giving a greater say to those facing hardship and social exclusion. Their role is to facilitate access to information for these persons and to assist them in securing entitlement to social rights. Moreover, they meet the concern for quality and efficiency of services, and the specifications by which they are governed contain requirements in terms of user participation and evaluation of activities. There is also a section relating to the use of new technologies. It is specified that the various players need not be physically present in the same facility: networking is strongly encouraged.

We are therefore seeing an increasing number of “one-stop” facilities in the French institutional landscape, but they can only hope to survive if they have a strong foothold in the local area, sound partnerships and reliable sources of funding. Furthermore, the network of municipal social action centres defends the idea of “local service centres” rather than “one-stop” facilities.

## Greece

### **Integrated interventions for women in Greece**

The initiative to provide integrated services for women who are unemployed or at risk of social exclusion has grown from work started ten years ago. The General Secretariat for Equality and the Research Centre for Gender Equality set up a pilot project staffed by an interdisciplinary team providing counselling and information services. The unit’s methodology has three major pillars:

- provision of a complete set of services (for example, psychological and legal counselling, career advice) to enable the unit to function as a “one-stop shop” for women to receive different but integrated services relevant to their employment search;
- a gender-sensitive approach allowing women to understand, negotiate and – if needed – redefine their social role;
- networking among related agencies.

The unit started in Athens but eventually spread to other cities. Key findings were that government agencies found it difficult to inform women about policies and services to help them into employment; and what was needed were (a) effective networks to distribute information, (b) decentralised services tailored to local needs, and (c) a commitment from the top.

Based on this initial experience, in 2003 the original sponsoring actors designed the Integrated interventions for women programme. Central features of this programme include:

- an integrated unit (as above) in all 13 prefectures in Greece;
- units to form public-private partnerships between agencies experienced in this field;
- units to draw up action plans to implement integrated interventions with specified services – not just counselling as previously;
- action plans to be monitored centrally.

Evaluation of this programme is under way with early indications showing that:

- commitment from the top is essential to success. The main barrier to progress has been the unwillingness of local authorities to support the programme;
- not all partnerships are working effectively, for example disputes among partners;
- an underlying cost reduction from the integration of services.

This integrated services model may have application to other target populations in need, for example rehabilitation of mentally-ill people.

## **Iceland**

For more than a decade there has been a lively discussion in Iceland among politicians, policy makers as well as at grass-roots level about the need for integration of social services with other personal services, for example with education, health and services for the handicapped.

From 1994 there have been experiments in some regions on integrating health, education and handicap services with social services but there is no one official policy on integration. The Icelandic Government has recently made it clear that it will not make any more agreements with local governments about further integration of family/social services until changes have been made concerning the size and strength of the municipalities.

In Reykjavík municipality, however, the policy is quite clear as the city council has decided to integrate all family services granted by the municipality such as social services, specialist services for pre-school children and primary schoolchildren as well as youth counsellor services within six service centres around the city of Reykjavík. This policy followed previous integration on social services, with social housing, housing benefits and services for the elderly and the handicapped. The aims are: to improve the services; to make them more accessible for the users; and to make it possible for those responsible for services to achieve a holistic view on the situation of the individual and especially the family.

There is no legislation on integration as such but this is the spirit of many social acts, namely the Social Services Act, the Act on the Rights of the Handicapped as well as the Child Protection Act, as all recommend integration of services especially for those who have complex needs.

The experiments mentioned above include vertical integrated social services between the municipalities/local governments and the state. These are now permanent arrangements which have been rather successful. A two-year pilot programme on integrating home service (granted by the municipality) and home nursing (by the state) for the frail elderly in Reykjavík has also been completed. This integration could be considered more as a partnership than genuine integration. One of the findings of this pilot programme is that both these tasks should be the responsibility of and performed by either one of the partners. On the other hand, it is argued that this partnership of integration is better than the previous separation of services.

Intended beneficiaries of integration in Iceland are the most vulnerable people (for example, the handicapped and the elderly) and people with multiple problems. In Reykjavík the policy of prevention is also highlighted in order to reach out early to children at risk and/or with special needs and their families.

There have been some studies of outcomes and they indicate that the users are more pleased with the way services are given to them.

There have been two studies on vertical integration where costs were taken into account. These studies indicated that the costs were no higher than in the previous system and at least public money might be spent in a way where there was more value for money.

One might argue that in the regions mentioned in this publication where vertical integrated social services have been practised for the last decade, the approach is on step 2 of the ladder of integration – whole-system working – as it is working well in these areas but is not practised in other parts of the country. This is also the case of the service centres in Reykjavík municipalities (step 2) as this is not the practice in the whole country.

The pilot programme in Reykjavík on home help and home nursing might now be on step 5 – planned and sustained service co-operation and co-ordination – as the services are better planned and there is good co-operation, but there are still two kinds of services.

The main problems facing integration is the attitude of the staff, especially the professionals who tend to defend their status and professional identity. It is often a question of power and status connected with different cultures within different fields of work.

One should not underestimate these problems and the fact that some user groups, especially the most powerless and weak users with multiple problems, often have less status than others that might have more accepted needs and some even temporary ones. This could result in failing to meet the needs of the people who are in the most difficult situations.

## **Italy**

Italy is at a particularly interesting stage in the integration of its social services because of new legislation and a major national programme to integrate services. Currently, there are three levels of integration

of social services. First, integration between social services and health services. Secondly, integration of social services with related sectors of other services, such as education, training and employment. The last level is integration among all these diverse dimensions into substantial programmes of local development.

A major advance in the integration programme has been introduced through the Framework Law for the Development of the Integrated Systems of Interventions and Social Services. A range of factors have made it necessary to introduce new models and make organisational procedures less bureaucratic and more open to interaction with external surroundings. Greater orientation towards quality and service users has produced a slow process of rearrangement of the policies from an integrative point of view.

In Italy, the management of the process of redefining social policies is the responsibility of the municipalities who provide co-ordination of the entire process in their own areas. The instrument dedicated to this is represented by the so-called "Zone Plan" – a document of local programming agreed upon with the stakeholders and constituting a first level of integration of policies and social interventions. The principal social actors from the main sectors participate in "negotiation tables" and make a major contribution to local "intervention plans".

### **Integrated social services in Italy**

The Framework Law for the Development of the Integrated Systems of Interventions and Social Services was introduced in 2000. This law – with national application – specifies two levels of integration:

- integration between different policies, namely health, education, training, employment, culture and leisure and territorial recovery programmes, in order to define macro programmes of intervention;
- integration processes among social services directed towards different groups of users, for example the elderly, disabled, children and families, etc. At this second level, integration concerns all services which can co-operate with regard to the diverse aspects in which the individual needs of citizens are articulated (social assistance, health, education, training and employment).

A practice well established in some areas of the country is social health assistance for the elderly, the disabled and disadvantaged minors. In this case the Social Services Office and the local health agency together prepare a plan of intervention to deliver integrated social and sanitary assistance. Another practice regards the policies for children as provided by Law No. 285 dated 1997, which establishes programmes agreed upon between the municipalities, the local health agency and schools for "scholastic recovery", "intercultural education", "integrated social assistance" and "social promotion" (free and open to all children and teenagers at territorial social-educative centres).

A central aspect of this national programme of integration will be arrangements and actions at the territorial level. For example:

- the "mobilisation of all actors involved" such as social health integration through co-operation of municipalities and local health agencies;
- also, "concerted actions and co-operation between all public and private actors";
- a "social secretariat" will be appointed to guarantee users "one-stop" access to the services system; and to act as a go-between linking different local agencies into an integrated network.

In 2001, the revision of Title V of Italy's Constitution led to further considerable changes in the social welfare system as it conferred exclusive competence to the regions in the social assistance sector and also provided that the state assume competence in setting out "basic welfare levels" (BWL).<sup>3</sup> Regarding municipalities, the revision recognised their competence to provide personal social services. This gave rise to a redefinition of competences and tasks pertaining to state, regions and municipalities, which makes it all the more necessary to co-ordinate and integrate social policy actions.

Considering this innovative institutional, as well as regulatory, framework the issue of integration has become yet more relevant, in particular as regards vertical integration between institutional actors, for example the state, regions and municipalities.

---

3. The state's main task is to ensure availability of a homogeneous set (an "essential level") of social services (services and monetary transfers) to be developed throughout the entire country.

Taking into account such a complex, multifarious policy framework, a project 'Planning to pact': integration processes in local welfare services was initiated by central government to survey implementation of the national integration programme. The project investigated integration with special regard to vertical integration between regions and municipalities; horizontal integration among the various stakeholders at local levels; and integration between social and health care policies in municipalities and local health care units.

This project had been evaluated with particular emphasis on how political, institutional and organisational variables can impact on processes and mechanisms of integration in social policies.

The research activities are aimed at understanding whether and how local integration and participation processes can contribute to the planning and implementation of "Zone Plans".

The final report has highlighted innovative, good practice procedures and activities for dissemination throughout Italy.

One relevant aspect of what is going on with integration at local level, where the services are delivered, is the attention given to integration at the beginning of the entire process. A positive strategy is to start working at the planning stage through an integrated approach between the political, institutional and third sector actors. The achievement of an integrated planning action can promote a local network of welfare services.

At the first level there are "negotiation tables" at which all the social actors, for example administrations, public services, social bodies, third sector organisations and citizens, participate and where the principal issues are defined and discussed.

At a second level, "groups of integrated work" (discussing different social issues) play a fundamental role in defining, in a technical way, the principal projects and actions concerning the local programming agreement. They are composed of professionals from various backgrounds, such as social, health, educational and local services.

At the third stage, institutional and political subjects decide on which of these to adopt as the official document. Working with this circular approach opens up dialogue at different stages, which can ensure integration at the point of delivery.

Finally, political and institutional considerations seem to be important in achieving positive results in terms of integration, and in improving the standard and quality of services.

## **Latvia**

There is some, although limited, progress in working towards the integration of social services with the health sector. The overall system has been characterised by delegation of responsibilities by law to different administrations, with diverse sources of funding. Each service type has been developed on its own. Significant integration requires delegation of service responsibilities and financing to local government.

However, some integration between social services and the health care sector at local government level has been achieved, with the development of uniform health care and social services structures. As there is a lack of state budget resources for total provision of health care services (including compensatory medicines), social assistance benefits provided by local government partly compensate for the expenditure of needy people on contributions to the cost of health and medicines.

## **Malta**

Social services in Malta have up to now been characterised by a separate rather than an integrated delivery of service. The closest policy that the Maltese Government has regarding integrated social services is reflected in the recently launched National Action Plan on Poverty and Social Exclusion 2004-06. Along with the other EU member states, Malta will co-ordinate its social inclusion programme to increase employment levels and improve education as a means of reducing poverty and social exclusion, hence promoting access to social rights. The strategic approach of the plan reflects how entities have been working together to tackle poverty and social exclusion. It also outlines how they will continue to work and merge together to address these major issues.

At present, the social service in Malta that most resembles a combined/integrated service for a specific user group is the community centre pilot project called ACCESS. This project was launched in November 2002 under the auspices of the Ministry of Social Policy, as it was named then (now known as the Ministry of Family and Social Solidarity, MFSS).

### **The ACCESS complex – A family and community resource centre in Malta**

Started in 2002 as a “one-stop shop” service centre in a high-density area with multiple needs. Planning the centre involved government and NGO organisations, resulting in a multi-service centre with social and community work; childcare and family support; employment and training; social security; housing; and an adult and training centre for people with disabilities. A board of directors oversees the strategy and policy of the centre. A management committee is responsible for operational matters and monitoring of the service.

Service users are seen as holistic individuals with often interdependent needs which are best met through an integrated service centre. Examples of integrated working on joint projects/services include:

- the “Job Club”, a joint project between Cottonera community service and the employment and training service corporation. This targets school-leavers, providing skills-based training and support towards employment and integration in society;
- the Women in Work project, run by the same service partners. It focuses on the issue of low employment of women, providing a tailor-made course to increase participants’ self-esteem and readiness to enter employment. An important facility is a mentoring scheme for women;
- a “parenting skills” course for people with a disability, organised jointly by the childcare centre and the adult training centre.

A key aim of the family and resource centre is to involve the local community as much as possible so as to ensure that they have a sense of ownership. Methods used to achieve this include: a literacy project; ACCESS fairs and open days for local people with information provided by all centre services; campaigns on road safety and safety in the home; and a theatre group working in local schools on social issues. A future project will be a computer/Internet cafe to develop computer literacy skills.

Results and evaluation: the main benefits include easier access to social rights and a more holistic, co-ordinated service delivery; more efficient referrals between services; and shared expertise between services resulting in a more complete, effective service. A formal evaluation of the centre’s work has yet to be conducted. Ideally, there should be a single point of assessment for users although this has yet to be established.

## Netherlands

On 1 July 2006, the Social Support Act (*Wet maatschappelijke ondersteuning, Wmo*)<sup>4</sup> was introduced in all municipalities in the Netherlands. Under the act, policy responsibility for setting up social support lies with the municipalities, which are accountable to the citizens in the execution of this responsibility. The municipality is the natural party to play the role of director because of its (verifiable) public responsibility. The municipality is the only party that is able to channel developments at local level and pursue an integrated policy that takes proper account of local conditions and the wishes of the public. The municipality is better placed than any other party to promote cohesion between the services that are relevant and tailored to individuals and their requirements. "Direction" means the following in this context: taking the initiative and calling parties to account with regard to their responsibility. However, that does require the co-operation of housing corporations and care administration offices, for example. It is believed that the tasks and responsibilities of housing corporations and care insurers are sufficiently well anchored in law and thus offer sufficient points of departure for achieving objectives jointly. If it should become apparent that cohesion is sometimes not achieved, the government is willing to take action under administrative law together with the Minister for Housing (on the basis of his supervisory powers) to help get the collaboration going.

Important social service target groups have complex needs and require an integrated programme of interventions. The necessary care needs to be accessible and at a low threshold, with unambiguous information, rapid detection of problems, quick intervention for more serious problems and guided referral.

Municipalities must provide a good cohesive system of support for their residents who are not sufficiently able to handle their problems either on their own or together with others. Examples are helping with house-keeping, offering social support, adapting the home and transport for a wheelchair. Municipalities have to decide for themselves how they provide this support; one municipality will go about it differently from the next, but they must involve the public and make it clear to people exactly what they are offering and what results will be achieved in a number of specific areas.

---

4. In common with the General Guide to Wmo Implementation (SGBO, March 2005) social support is defined as "Supporting people if necessary in their social contribution, restoring their ability to cope, equipping people to participate socially ...".

The act allows the municipalities sufficient freedom to develop and implement policy locally. The law contains the obligation to develop a local plan. The costs involved in implementing the municipal tasks will be financed from the Municipalities' Fund. The law allows individuals to choose between care in kind and patient fund holding/personal budgets.

Apart from the Social Support Act there is no special legislation in the present situation or in the official legislative planning of the present coalition government that deals explicitly with integration of social services. However, integration it is one of the guiding ideas behind the Social Support Act.

Vulnerable individuals from the following target groups are the expected beneficiaries of integration:

- people with a severe physical limitation, among them the elderly at the limit of being able to cope with life on their own and those in institutional care;
- people with chronic psychological problems, including the homeless and those sleeping rough;
- people with intellectual limitations, especially when in combination with behavioural problems;
- people with severe psychosocial or material problems;
- people experiencing severe problems growing up, including youngsters who repeatedly come in contact with police and law courts for criminal offences;
- people involved in domestic violence (victims, offenders, families);<sup>5</sup>
- other people with multiple problems.<sup>6</sup>

The costs involved in implementing the municipal tasks that result from the Social Support Act are financed from the Municipalities' Fund. The law allows individuals to choose between care in kind and patient fund holding (personal budgets). The AWBZ<sup>7</sup> and the Social Support Act complement each other. The modernisation of the AWBZ will take place over the next few years and implies that more and more provisions and services will shift from AWBZ to the Social Support Act. This is also neces-

---

5. Particularly abused women, elderly people and children.

6. Generally without a clear individual demand, the so-called "OGGZ" (public mental health care) target group.

7. Exceptional Medical Expenses Act.

sary in order to enable the financing to be completed on the basis of functions (costs met on a function-related basis).

The idea of an intergovernmental “ladder” (a hierarchy of formal or enforceable forms of integration) is not at all endorsed in the social welfare policy of the Netherlands. The leading idea is rather this: municipalities must “perform”. The so-called “performance fields” specify what the municipality must include in its deliberations. Not every municipality needs to do everything specified in the performance fields, although they will have to be able to present their residents with a good reason for their decisions as to what they will and will not do. Performance of course does not involve implementing detailed central legislation at local level; nor is it simply a question of determining policy in complete autonomy. A system of centrally prescribed services to be provided on an individual basis and therefore individual rights does not fit in with this. Local shaping, local discussion and local support form a basis that is at least as sturdy.

Bureaucracy and managerialism are the main obstacles facing effective integration of services. Even those who try to improve integration in a scrupulous way often end up spending their precious time in meetings about the exchange of referrals and experiences, and the drafting of protocols and guidelines for managers. The professionals, who are supposed to work together to establish integration of services, are of course always employees: they work under the managers of their institutions and foundations. Unfortunately managers have their own problems: cash flow, satisfying the members of their boards, budget cuts and the like. Therefore they generally tend to make a list of priorities: the most important task should be done first. Most important tasks are of course agency-centred tasks, tasks that contribute directly to the continuance and safety of the institution or the foundation. Spending time in working together with other professionals, outside the jurisdiction of managers, never belongs to the priorities.

There are lots of replies to questions like why and how to perform integrated social services, for whom and with what kind of specialists and institutions, but there is hardly any description of the “what” question. What is a ready-made integrated social services product and what does it look like in specific situations? For example, how many hours’ help at the client’s home, how many hours counselling at the office of the professional, how much help with administrative procedures and how many hours domestic help? Of course it should be tailor-made. But if we could describe, more or less in detail, what really happens in situations of

successful integrated social services delivery, how long it takes and what costs are involved, this would probably raise more awareness about the importance of integrated services.

Overall, there is a lack of evidence-based best practice. There are good practices in many places, but they tend not to be transferable because of specific local and personal circumstances.

Politicians in all developed countries are trying to deal with the problem of fringe groups – long-term consumers of social allowances (without being disabled or old), those who misbehave in the neighbourhoods where they live, who get addicted to alcohol and drugs, who leave school too early or those who get entangled in criminal activities. Social service is not very successful with these target groups, partly because these groups are too often looked upon as losers, as victims of a system.

Of course people cannot be forced into risk-avoiding behaviour. Prevention is always the best solution, but not always achievable. So politicians appeal to social services. But it is never clear whether it will help or not. Unlike housing or education it is often not even clear what you receive (evidence based) for the price you pay. What they see is that the social service is always divided; it is always small scale. Also because of the fact that alternatives are lacking, there is a wide belief that results will be better when social services are integrated with one another (and therefore bigger) and with related services in fields like housing, security and education.

### **Community schools**

Community schools started in the Netherlands ten years ago. Now there are over 500. They started at a time when welfare and educational policy were decentralised to municipalities, allowing for local integrated youth policies.

This model for integrating local services within schools is not unique to the Netherlands; there are similar developments in Scandinavia, the UK and USA. Basically, community schools are alliances of schools, childcare, welfare institutions, sports clubs, libraries, health institutions and others. In broad terms, the co-operation of various disciplines increases children's opportunities for development and strengthens social cohesion in the community. Most community schools are located in disadvantaged neighbourhoods.

There are four main phases in setting up a community school: initiative, preparation, implementation and consolidation. Community schools are not essentially a means of providing a cheaper alternative to previous service arrangements. Funding has to be obtained for accommodation, co-operation and activities. The rationale for community schools is their added value for pupils, their families and local communities through integrated or co-operating services in local schools.

Useful websites on community schools are [www.communityschools.org](http://www.communityschools.org) (American) and [www.bredeschool.nl](http://www.bredeschool.nl) (a Dutch site about community schools).

## **Norway**

The overall picture in Norway has been for local and regional authorities to enjoy considerable discretion in how social services should be organised, as well as how they should be co-ordinated with other services. The role of central government has been through legislation, funding and dissemination of good practice to encourage co-operation and co-ordination between different services and professions, where this is needed. The government has now launched a major public service reform aiming at integrating public employment services, social security and social assistance into one unified service. Whereas the first two are state agencies, the latter is presently the responsibility of municipalities. The government presented a White Paper to the Norwegian Parliament early in 2005. New legislation was passed by parliament in spring 2006.

There have been several pilot programmes over the last ten to fifteen years concerning the integration of social services with other major services such as health and education. There have also been programmes aimed at modernising the public sector as a whole, such as local information centres providing "one-stop" services – helping and guiding people where and how to access services. None of these efforts have so far resulted in any permanent changes in the way services are delivered. In addition, 17 pilot projects have been especially organised to provide evidence on better co-ordination and integration among the municipal social services, the public employment service and social security.

### **A new employment and welfare administration**

In 2004 Norway established a new Ministry of Work and Social Affairs, merging responsibilities for social services, social security and labour market policy into one new ministry. The Labour Market Administration and the National Insurance Service are merged into one state unit, closely co-ordinated with the social service administration in each municipality. The main purposes were: to help people to return to work more quickly, where appropriate, with cost savings through less benefits payments; added value for the welfare system through more people in employment; and a more holistic approach to users' needs together with better-quality services.

There will be a joint, integrated front-line service with an employment and welfare office in every municipality, providing a co-ordinated service focused on users' needs to replace the existing service of several different offices. The new service will be based on a close partnership between the state and local authorities, with each office providing services for the unemployed and enterprises, people on sick leave, disabled pensioners, and recipients of financial social assistance, pensions and family benefits. The division of authority between the state and the municipalities will not be changed.

A central feature of this service will be respect for and close attention to the needs and interests of individual users. There will be individual plans, co-ordinated services tailored to the individual, and a rights and obligations contract.

Costs and benefits: it is estimated that savings from this reform will cover the considerable reorganisation costs, along with reductions in lost income by better co-ordination and long-term improvements in administrative efficiency.

Evaluation: evidence so far suggests that:

- organisational reforms are expensive in terms of time and finance;
- teamwork produces good outcomes for users but is time-consuming;
- different cultures are not a problem;
- users are more satisfied, but less so those needing only one service;
- too early to assess if more people are entering the labour market.

## **Portugal**

In Portugal the integration process of social services is still in a relatively early stage as services have been separated rather than integrated. The need for various public social services to be integrated is becoming a major policy concern and priority.

Currently, there is a reform of social services as a result of concerns about the social and economic challenges and the future financing of the system. This reform is based on three main goals: first, to improve the relationship of the administration with citizens; second, to improve quality of services; and, third, to simplify procedures and make them less bureaucratic. The aim is to create an internal dynamic for modernisation and for a citizen-orientated approach to service quality. A further aim is to provide greater safeguards for citizens and to involve them more closely in the administration's decisions and in the process of administrative change.

This process is also promoting a greater commitment to an active partnership between the state and civil society organisations to share the responsibilities for a more effective implementation and delivery of social policies/services. NGOs, the private solidarity institutions and the local development associations are all playing an increasingly important role in the social protection system, as well as in the implementation of national social policy measures. In fact, such organisations are responsible for running most of the existing social services for children and elderly people, while some private organisations and local authorities are partners with the public social services in the implementation of national policies and in the development of local anti-poverty projects.

Many of these developments are crucially linked to the growing awareness that social exclusion is caused by an increasingly complex set of problems. New understandings of these multiple problems and risks associated with social exclusion are now recognised in public policy through the development of more strategic and targeted anti-poverty programmes. An important element of this policy shift is directly related to the role of social public service and the need for improved delivery of services through integrated and co-ordinated policy responses and improved resources resulting from the identification of new needs.

In this context, examples of integrated social services are relatively few in number and have not yet been in place long enough for full evaluation of their impact. Even so the following example illustrates some aspects of experiments in integrating social services in Portugal.

## **National immigrant support centres (CNAIs)**

### *An administration closer to immigrants*

The CNAIs in Lisbon and Porto emerged as an integrated, effective and humanitarian response to the problems of integration which immigrants who have chosen Portugal as a host country were faced with.

Through the analysis of the legalisation process immigrant citizens have to carry out, it was possible to verify the complexity and dysfunction caused by their interaction with different public departments which were located in different places, with different ways of functioning, and sometimes with incompatible schedules. This dispersion and fragmentation of departments was often pinpointed as being a factor of great inefficiency, leading to immigrants giving up the process of legalisation and the subsequent impediment to social integration which this caused.

### *Description of the project*

Given these needs, it was decided to bring together the various departments related to immigration (Service for Border Control and Foreigners) within one space, and with the same operating philosophy, allowing them to interact in a co-operative manner. It was also decided to establish other innovative departments which would meet the concrete needs of immigrants not satisfied by the many existing departments

The idea was for an innovative project, focusing on the conception and management of space (emphasising a comfortable stay along with functional flow), and with the sociocultural mediators who would deal with the public (providing a cultural, linguistic and affective bridge with the users, within a public third sector partnership) and in the common and shared computer management aspect of the visit (enabling the digitalisation of data and documents, communication between departments and a combined user-centred solution).

The CNAIs have been designed and are managed to provide quality for the user and maximise efficacy and efficiency in dealing with each case on the basis of its particular needs, within a friendly environment and providing a user-centred platform. In order to fulfil this design specification, whilst being dynamic entities which were learning on the job, the CNAIs have permanently sought to provide a better service and this core philosophy is present throughout their activity as a whole.

The following bodies are located with the CNAIs: the Inspectorate General of Work (IGT); Social Security; the Service for Border Control and Foreigners (SEF); the Ministry of Education; and the Ministry of Health.

## **Romania**

In Romania, the development of social services, as a part of the social assistance system, began after 1990 and has accelerated during the last five years. Reform in the field is being fully implemented on the basis of a national network of social services addressed to the needs of all vulnerable groups.

Presently, the majority of social services are targeted at solving the problems of abandoned children or those at risk of leaving their families; disabled and elderly persons; chronically-ill persons; victims of domestic violence; the homeless; and drug addicts. However, all these services are not developed in an equitable way all over the country; there are major discrepancies between urban and rural areas because of the lack of human and financial resources.

The management of the system has been decentralised to local public authorities in order to provide more appropriate services, according to the identified needs, the decisions and the priorities of the community. The delivery of social services is shared between public services and NGOs.

The central authority responsible for social assistance policies, including social services, is the Ministry of Labour, Social Solidarity and Family – MoLSSF (social benefits and social services system). In relation to social protection policies, MoLSSF co-ordinates the following: the National Authority for the Protection of Children’s Rights, the National Authority for Disabled Persons, the National Agency for Family Protection (domestic violence), the National Agency for Employment and the National Agency of Social Insurance (public system of pensions).

The first steps in setting up integrated social services were initiated by the law on social assistance in 2001 when it was decided to unify public services for children and adults’ protection – organised at county level – into a single unit, the General Directorate for Social Assistance and Child Protection, under the co-ordination of the county councils. In this way, it has been possible to integrate all type of services addressed to all vulnerable groups under a unique structure, more flexible and managed in a

more effective and efficient way. The process was only finalised in 2005. At the community level, each town hall has to organise its own public service to manage all types of primary social services (social work assessment, counselling, personal care services, emergency services and social aids).

Integrated social services as a new concept were introduced in 2003 by the law on social services, which provides that social services can be organised and delivered in an integrated system with health services. In fact, the first provisions related to this subject were promoted by the law on elderly social assistance approved in 2000, which defines care services as socio-medical ones.

The programme of the government for the period 2005-08 clearly underlines the aim of creating integrated care services for vulnerable groups. In 2005 the government approved national strategies for: social assistance development for elderly persons; disabled persons; and social services development. All these documents define the new directions of social policy development, including the need to integrate social services in order to respond quickly to individuals' needs, to solve efficiently the complexity of all the potential problems of a person in a difficult situation or at risk of social exclusion. At the same time it was decided, as a strategic objective, to develop assessment procedures and methodologies for the evaluation of the impact or effectiveness of social services programmes, including integrated care services.

Specific legislation is now sufficiently developed, but it is important to state that the implementation of the strategic plans needs a medium-term time frame. So far there is only the basis of a real national network of social services which could be organised and delivered in an integrated way. Even in the ideal situation of having all the necessary financial and human resources, there are many other aspects which could interfere with the process of building the system.

In relation to specific social services, residential centres for children, the disabled, the elderly and those who are chronically ill are organised so as to provide social and health care. There are also centres for disabled people that provide services for rehabilitation, special education, vocational training and occupational therapy. Domiciliary care services for the elderly and disabled are more developed but they are not managed well enough due to the limitations of health regulations.

In the new package of proposed health legislation adopted in March 2006 there is a chapter regarding community health assistance (care)

to promote the development of an appropriate integrated system of long-term care. During the last two to three years, local authorities and NGOs have started to organise part of the residential and day centres as complexes of services, providing a diverse range of services such as counselling and advocacy, special education, personal health and social care, rehabilitation, employment facilities, advice on housing and social aids.

The problem of integrating services is not focused on personal social services only. In Romania, the payment of social benefits is divided between several organisations, both central and local. The new legal regulations establish the setting-up of a single national agency to administer social benefits with services organised in each county.

Presently, integration is focused primarily at the horizontal level. The emphasis is expected to shift towards an improvement at the vertical level, in close relation to the present process of decentralisation, which facilitates the integration of social services with health services, education and employment services at county level (Romania has 41 counties and Bucharest municipality six sectors, with an average population of around 500 000 inhabitants per county/sector), and according to the reform in public administration.

## **Spain**

The integration process of social services in the welfare and health sector in Spain has been the result of several reforms that translated into the new Law on Dependency established on 1 January 2007. The aim is to promote the basic conditions of personal autonomy and care for dependent people, including the integration of financial benefits, social services and the prevention of situations of dependency.

The National System of Dependency will integrate the different services, providing benefits and assistance for dependent people. It will facilitate the collaboration and participation of the public administrations in promoting personal autonomy and the protection of dependent persons, optimising public and private resources for a better quality in citizens' life.

The Law on Dependency provides a series of mechanisms of co-operation between the General State Administration and the *comunidades autónomas* (autonomous regional authorities). A *Consejo Territorial del Sistema Nacional de Dependencia* will be created.

The budget for the care services for older persons in 2004 was €1 672 million and for services for disabled people was €709 million,

whereas the total expenditure for social protection on dependency was €2 356.9 million of gross domestic product (source: *Libro blanco de la dependencia*, December 2004, Ministry of Labour and Social Affairs).

Spain's level of integration corresponds to the second step on the ladder of integration. The difficulties encountered are those that arise from the very decentralised system that is evident in Spain.

## **United Kingdom**

The integration of social services with health services in particular has been a major concern for UK Governments from the 1960s onwards. An historical perspective is illuminating in that before 1971 social services for adults were set in an administratively integrated health and welfare department of the major local authorities. Social services for children were in a separate department. The health and welfare departments were dominated by the health interests to such an extent that legislation in 1971 separated the two services, creating a social services department at the local level, to include social services for children.

The disadvantages of the 1971 disintegration of the two services has increasingly become apparent, resulting in a government policy to introduce new forms of integration (Department of Health, 1998, chapter 1, section 6.5):

The Government has made it one of its top priorities since coming into office to bring down the 'Berlin Wall' that can divide health and social care, and create a system of integrated care that puts users at the centre of service provision.

Social security (cash benefits) have been organised quite separately from social services and will remain so. Various devices to achieve greater collaboration/integration have been introduced, particularly trusts – see below. These are new, separate organisations with responsibilities for forms of health and social services at the local level, for example a mental health trust. They can both commission and provide services. More recently children's trusts have been introduced to combine certain services previously provided by social, health and education services.

Three main factors account for service integration becoming a government priority:

- the growing acceptance that separation of services tends to act against the interests of service users;

- the cost-efficiency drive in public services as part of the modernisation agenda, namely it should be cheaper to integrate separate services – but is it?
- a reaction to public enquiries into service disasters when a serious lack of co-ordination of health and social services has been a main cause.

It is sometimes forgotten that Northern Ireland as an integral part of the UK has had an integrated health and social care system for over thirty years. Even more, it is said to have “one of the most structurally integrated and comprehensive models of health and personal services in Europe” (McCoy, 1993). Unfortunately there has been very little research into the outcomes for service users of this integrated service, nor is there data on comparative costs.

Heenan and Birrell (2006) carried out some empirical research with senior staff in the service which showed strong support for two key aspects of integration. First, their programmes of care which are “divisions of health and social care into which activity and finance data are assigned to provide a management framework” (p. 53). These programmes are seen as the key feature of the whole system. Secondly, “an efficient and timely system of hospital discharge was perceived as one of the real benefits of the integrated structure” (p. 58). In non-integrated systems elsewhere the lack of co-ordination of services at the critical point of hospital discharge is seen as a major, costly disadvantage – both for users and their carers, and the individual services.

### **Trusts**

“Care trusts” have been introduced in the UK as a structural vehicle for delivering improved, integrated health and social services for patients and users. They are part of the government’s overall modernisation programme for public services. Their main features are:

- they are new organisations, separate from but related to existing health and social services bodies;
- they are voluntary – partners can withdraw. But government can oblige health and social services bodies to set up trusts when there is evidence that joint working has not otherwise been established;
- health and social services functions are delegated to them – not transferred;

- they can commission and/or provide services;
- they deliver integrated (whole-systems) services in a single organisation;
- so far, care trusts have concentrated on specialist mental health services and services for older people, namely for people with complex needs;
- funding is provided by the statutory organisations that set up the trust.

#### *Northumberland Families and Children's Trust*

Northumberland is a county local authority in the north of England. It has responsibility for social services, including for children and young people. Northumberland Care Trust has certain delegated health and social services functions, including some for children and young people (CYP).

Following a joint review of CYP services in 2003 the decision was to establish a single organisation to plan, commission and deliver all services for CYP and their parents/carers. Before the trust was set up, the services which it now takes responsibility for were under the separate control of two different local authority departments – social services and education. This new organisation is the Northumberland Families and Children's Trust. The trust has two parts:

- Children's Services Directorate: it combines all education and social services for children functions under the leadership of the Director of Children's Services. Other statutory services may second front-line staff and managers to work in this directorate to provide integrated services;
- Families and Children's Trust Partnership: it includes all stakeholders (for example, NGOs, statutory organisations) in services for CYP in Northumberland. Its purpose is to enable stakeholders to work together to improve outcomes for all children and young people in the county.
- In line with central government's policy to set detailed "targets" for all public services, those services responsible for children's services must meet targets in five key areas:
  - being healthy;
  - staying safe;
  - enjoying and achieving;
  - making a positive contribution;
  - achieving economic well-being.

Children's trusts follow the earlier and more numerous mental health and primary care trusts, again with responsibility for planning, commissioning and delivering clearly defined health and social services in their localities.

## References

- "About integrated working"  
([www.integratedcarenetwork.gov.uk/themes/integration1.php](http://www.integratedcarenetwork.gov.uk/themes/integration1.php)).
- Attwood, M. et al. (2003), *Leading change: a guide to whole systems working*, Policy Press, Bristol.
- Audit Commission (1998), *A fruitful partnership: effective partnership working*, Audit Commission, London.
- Banks, P. (2004), "Case management", in Nies, H. and Berman, P. (eds), *Integrating services for older people: a resource book for managers*, European Health Management Association, Dublin.
- Benson, J. (1975), "The interorganisational network as a political economy", *Administrative Science Quarterly*, 20, pp. 229-249.
- Benson, J. (1983), *A framework for policy analysis*, in Rogers, D. and Whetton, D. (eds), *Interorganisational co-ordination*, Iowa State University Press, Ames, IA.
- Bernabei, R. et al (1998), "Randomised trial of impact of model of integrated care and case management for older people living in the community", *British Medical Journal*, 316, pp. 1348-51.
- Challis, D., Darton, R. and Traske, T. (1995), *Care management and health care of older people*, Arena, Aldershot.
- Council of Europe (2002), *Access to Social Rights in Europe*, Council of Europe Publishing, Strasbourg.
- Council of Europe (2004), "Report on user involvement in personal social services", Council of Europe Publishing, Strasbourg.
- Delnoij, D., Klazinga, N. and Kulu Glasgow, I. (2002), "Integrated care in an international perspective", *International Journal of Integrated Care*, 1 April.
- Department of Health (2003), *Changing places: report on the work of the Health and Social Care Change Agent Team 2002/3*, London.
- Evers, A. (2003), "Current strands in debating user involvement in social services" (paper commissioned for the project User involvement in personal social services).

Heenan, D. and Birrell, D. (2006), "The integration of health and social care: the lessons from Northern Ireland", *Social Policy and Administration*, Vol. 40, No. 1, February, pp. 47-66.

Hudson, R. (2004), *Whole systems working: a discussion paper for the Integrated Care Network*.

Integrated Care Network (2004), *Integrated working: a guide*, UK.

Julkunen, I. (2005), *Integrated social services in Europe – approaches and implementation: a scoping research review*, paper commissioned by the Council of Europe.

Kalpa Kharicha *et al.*, "Social work, general practice and evidence-based policy in the collaborative care of older people : current problems and future possibilities", in *Health and Social Care in the Community*, 12, 1, pp. 134-141.

Leichsenring, K. (2004), "Providing integrated health and social care for older persons – a European overview", in Leichsenring, K. and Alaszewski, A. (eds), *Providing integrated health and social care for older persons: a European overview of issues at stake*, Ashgate, Aldershot.

Leutz, W. (1999), "Five laws for integrating medical and social services: lessons from the US and UK", *Milbank Quarterly*, 77(1), pp. 77-110.

Levine, S. and White, P. (1962), "Exchange as a conceptual framework for the study of inter-organisational relationships", *Administrative Science Quarterly*, Vol. 5, pp. 583-601.

Lewis, J. (2005), "Integrated and fragmented care observed from two case studies", *International Journal of Integrated Care*, 1 November 2005.

McCoy, K. (1993), "Integration: a changing scene in Social Services Inspectorate", in *Personal social services in Northern Ireland: perspectives on integration*, Department of Health and Social Services, Belfast.

Meyerson, D. and Martin, J. (1987), "Cultural change: an integration of three different views", *Journal of Management Studies*, 24, 6, pp. 623-43.

Midland Health Board Executive Summary (2003), parents "Olive and Peter" in *Developing a model for integrated primary, community and continuing care*.

Nies, H. (2004), "Integrated care: concepts and background", in Nies, H. and Berman, P. (eds), *Integrating services for older people: a resource book for managers*, European Health Management Association, Dublin.

Peck, E., Towell, D. and Gulliver, P. (2001), "The meaning of culture in health and social care: a case study of a combined trust in Somerset", *Journal of Interprofessional Care*, 15, 4, pp. 319-27.

Skelcher, C. and Sullivan, H. (2002), *Working across boundaries: collaboration in public services*, Palgrave, Basingstoke.

#### *Some useful websites*

[www.integratedcarenetwork.gov.uk](http://www.integratedcarenetwork.gov.uk)

[www.pr-soc-incl.net/peer/en/index.html](http://www.pr-soc-incl.net/peer/en/index.html)

[www.minvws.nl/en/themes/social-support-act/default.asp](http://www.minvws.nl/en/themes/social-support-act/default.asp)

[www.awalraven.com/search/](http://www.awalraven.com/search/)

[www.docbank.nl/search.html?keywords=english&searchtype=simple](http://www.docbank.nl/search.html?keywords=english&searchtype=simple)

[www.pgb.nl/showpage.php?pa=235&menu=0,316](http://www.pgb.nl/showpage.php?pa=235&menu=0,316)

[www.euro.who.int](http://www.euro.who.int)

[www.ijic.org](http://www.ijic.org) (*International Journal of Integrated Care*)



## Appendix I

### Policy guidelines for the design and implementation of integrated models of social services

#### 1. Introduction

1.1. These guidelines aim to assist stakeholders (that is, principally, policy makers at the national and local levels, service organisations and those who use their services) in designing and implementing effective integration policies. An important purpose of service integration is to improve access to social rights, reduce the social exclusion of vulnerable groups, and contribute to the overall objective of strengthening social cohesion. In developing integrated services, an essential consideration is the mainstreaming of issues such as gender, ethnicity, age, disability and poverty.

1.2. There is growing evidence that the integration of major services is becoming a prominent policy issue in many European countries, as seen in new legislation, research projects, European conferences and information on integration initiatives. The focus is substantially upon social and health services and to a lesser extent includes other public services, such as education and employment.

1.3. These guidelines are based on the findings from commissioned research work and the discussions and proposals of the Group of Specialists on User Involvement in Social Services and Integrated Social Services Delivery (CS-US), set up by the European Committee for Social Cohesion.

1.4. For the purposes of these guidelines, the term integration is defined as a range of approaches or methods for achieving greater co-ordination and co-operation between different services in order to improve their delivery to users. These approaches include: merger of two or more separate services into a new single service structure; service co-ordination; co-operation; partnerships; collaboration; inter-professional or joint working. The degree of integration may vary and therefore it should be seen on a continuum.

1.5. There is a strong consensus that there is “no one size fits all” in integration work. The particular approach to integration has to be chosen to suit specific needs, circumstances and possibilities.

## *2. Advantages of integrating social services*

In designing integration policies, decision makers should clearly justify the need for integration. They should take into account the main arguments in support of integrating social services with one or more other services, namely that it would:

- 2.1. deal more effectively with the diverse and complex problems related to social exclusion;
- 2.2. facilitate access by service users to a range of services;
- 2.3. allow the adoption of a more holistic approach in meeting the needs of service users;
- 2.4. foster the development of more personalised relationships between users and providers, and increase user involvement;
- 2.5. contribute to ensuring continuity and sustainability of service delivery;
- 2.6. simplify and accelerate the decision-making process in service delivery;
- 2.7. improve efficiency and effectiveness of service provision;
- 2.8. reduce overlapping of the different services.

The example of integrated interventions for women in Greece (see box pp. 53-54) illustrates the value of integrated services for one major marginalised group in many countries – unemployed women.

## *3. Critical success factors of integration programmes*

In order to design integration policies which meet the expectations of the main stakeholders and go on to achieve valuable and realistic outcomes, the policy makers should consider a number of important requirements.

- 3.1. A fully inclusive, open and transparent process of consultation with stakeholders, and particularly with service users/beneficiaries, should be undertaken. Reliable information should be provided regularly.
- 3.2. The problems which have led to a proposal for service integration as a solution should be clarified and assessed.
- 3.3. A feasibility study of possible positive and negative effects of the proposed integration should be undertaken. This might include:

- a pilot study;
- a study of expectations of stakeholders;
- an analysis of likely outcomes;
- an assessment of costs.

3.4. The methods for monitoring and evaluating the outcomes of integration should be determined.

3.5. The necessary resources to carry out the integration initiative should be calculated, for example finance, human resources and “know-how”.

3.6. Arguments against the proposed integration should be assessed and seriously considered.

Moreover, the following preconditions should be taken into account when an integration initiative is being considered:

3.7. a political environment which is favourable to integration and is supported by important decision makers;

3.8. a willingness among leaders to put the common interest beyond the needs of their own organisation and a commitment to find solutions;

3.9. a common working culture of shared principles, objectives, planning, responsibilities, accountability and concrete national policies with legislation, namely for national programmes;

3.10. a proper and equitable balance of power between parties within the new integrated service;

3.11. a shared and standardised system of assessing the problems of service users based on mutual understanding. The system should clearly identify the roles of all the professionals;

3.12. new skills and competences demanded by the complexity and specificity of the integrated services must be acquired by the staff;

3.13. a new, common quality-management system, which involves distinctive leadership, consultation and participation of providers and users, building trust between stakeholders and setting up a monitoring system.

#### *4. Challenging elements in the integration of social services*

In designing integration policies, policy makers should evaluate the challenges involved and consider how to address them.

4.1. While recognising the positive elements brought about by integrating services, partners need to adapt to a new working culture in order to break down institutional domains.

4.2. There is a relative lack of formal evaluations of integration projects and, where they exist, not all are positive. Consequently, it is difficult to provide clear evidence of the benefits of integration with scientific certainty.

4.3. The funding and other resources required for introducing new and more efficient integrated systems of service delivery may be substantial and should not be underestimated.

4.4. The initial stages of the process may be time-consuming in terms of designing frameworks, information technology, financial and other procedures.

4.5. Entrenched interests of bureaucracy and professional groups may hinder successful integration.

Various elements related to costs should be considered:

4.6. The main justification for integrating services is to produce better outcomes for service users. Reductions in service costs can also be achieved but as yet there is insufficient evidence to guarantee this benefit in all cases.

4.7. Cost-effectiveness studies of integration are challenging to construct and implement, for example accurate comparisons of costs of separate compared with integrated services. This also entails comparing the costs of providing the same improved service delivery without integration since they could be higher than those generated by an integrated approach.

4.8. Initial start-up costs in structural integration can be quite high. These costs may be considerably less for countries without a system of well-established separate services requiring expensive reorganisation. In the long term, however, cost savings may be achieved in both cases.

## 5. *Integration models and methods*

Policy makers should examine the various integration models and methods in order to determine which one suits their particular needs. A number of examples from different countries are described below.

5.1. Integration at different levels. Social services may be integrated with one or more major services at the macro (national); mezzo (regional); or micro (local) level. There are no indicators to determine at what level(s) integration should be introduced – so much depends on particular circumstances in individual countries. The most important level for integration of some kind is at the level of the individual service user (see “Case management” below).

5.2. Structural integration. This can be seen as the most complete or radical form of integration as it involves bringing together staff and resources from different services into a new organisation under a single unified structure. It is also a particularly difficult and costly approach to integration. It may be introduced as a radical solution to the negative consequences of service separation which are unlikely to respond to more informal approaches to integration. An advantage of successful structural integration is that it can provide a lasting, stable solution to problems of service co-ordination, resulting in a more effective use of staff in the interests of service users.

5.3. Whole-systems working. The whole system may be defined as “not simply a collection of organisations that need to work together, but a mix of different people, professions, services and buildings which have patients and users as their unifying concern, and deliver a range of services in a variety of settings to provide the right care, in the right place at the right time” (Department of Health, United Kingdom, 2003).

5.4. Process-centred collaboration. This is one of several approaches designed to improve co-operation or collaboration between services and their staff – without the major organisational disturbance and costs involved in structural integration. This approach focuses on caring activities rather than their organisational context. A key feature is the introduction of incentives for closer working between professionals across professional boundaries, for example new forms of funding such as client budgets and long-term care allowances.

5.5. Inter-disciplinary working. This is a form of process-centred collaboration as it involves staff from two or more professions working as a multidisciplinary team, for example in a community mental health centre.

It can be a particularly effective form of service integration if it is carefully planned with full consultation and preparation of staff concerned.

5.6. Partnerships. This is a form of integration in which service organisations and their professionals agree to participate in specific and ad hoc collaborative relationships. Partnerships can be formal, which often involves changing organisational arrangements, with associated costs, or informal where organisations act as partners without structural changes.

5.7. "One-stop shops" or single service centres. This approach to the integration of several separate services at the local level is becoming increasingly popular, for example in France, Armenia and Malta. Basically, the "one-stop shop" enables users to access in one building various different services previously housed in geographically different centres. The convenience to users is obvious, together with the strong potential for greater collaboration, information sharing and joint working between staff of the different services.

"One-stop shops" may vary in the extent of service integration. Many may operate in the model of the modern city department store where various companies rent space and sell their products unco-ordinated with other companies in the same building. Others may function closer to the supermarket model where the one company offers a wide range of products to the customer in a highly integrated operation. "One-stop shops" can move closer to the second model when they offer an initial needs assessment to users as a necessary basis for selecting a package of services from those available.

The Integrated Social Services Centre in Vanadzor in Armenia (see pp. 40-41) illustrates the "one-stop shop" approach.

5.8. Case management. The importance of integration of services at the level of delivery to the individual user is strongly emphasised in international work on integration. The notion of "seamless care" indicates how ideally the user should experience the delivery of, say, health and social services for their particular needs. Case or care management is a well-developed model for integrating services for individual users, especially for those with complex, long-term needs, for example dependent elderly people. This model is operating extensively in some countries (for example, the United Kingdom) but not others. It does not seem to be a culture-specific form of service and may well be adaptable for use in countries where it is yet to be introduced.

The randomised trial of the impact of a model of integrated care and case management for older people living in the community illustrates the real potential for the use of case management to produce good results for elderly people – and with financial savings (see box pp. 18-19).

## *6. National integration programmes*

6.1. Many initiatives to integrate social services with other services have been relatively small scale, local and often experimental. In countries where there is a highly decentralised political and administrative system, social services may be integrated at a regional level in some areas but not others. An argument for integrating social services with, say, employment services is that social aspects of activation and employment become more influential.

6.2. Some member states have integrated social services at a national level, or are in the process of doing so. Reasons for/expected outcomes of nationwide integration include:

- reduction in bureaucracy;
- improved access to social rights and strengthening of social cohesion;
- greater openness and accessibility for user organisations and individuals;
- improved quality of services;
- reduced service provision costs.

6.3. Typical core “good practice” features of national integration programmes include:

- full consultation with interested parties at all levels;
- inclusion of a monitoring and evaluation component;
- involvement – beyond the consultation stage – of public and private sectors;
- appropriate legislation;
- merging of previously separate ministries.

The new employment and welfare administration in Norway is an illustration of the merger of separate ministries into one (see box p. 67).

## *7. Evaluation and monitoring*

7.1. A common feature of the diverse material available is the paucity of completed evaluations and hard evidence as to whether and to what

extent integration actually works in terms of producing better outcomes for services users and for the services themselves (for example, lower costs).

7.2. Nevertheless, there have been positive findings from well-conducted evaluations. An evaluation of a care management project in the United Kingdom showed that “providing services in this co-ordinated way enabled vulnerable older people to stay at home; that the services were felt to be more reliable, effective and sufficient than other arrangements; that the older people had high morale; that the distress of carers was reduced; and that the costs were no more expensive than the alternative arrangement”.<sup>8</sup>

7.3. A control group experiment of the impact of integrated care and case management for older people in part of Italy showed similar advantages (see box pp. 18-19). Admission to hospital or residential care was delayed and less common in the control group; there were physical and mental health gains for the control group, and there were significant financial savings.

7.4. The regular and routine collection of information on integrated working is necessary for both systematic monitoring and evaluation. Objective measures of positive outcomes for integration are necessary but sometimes lacking. In integrated care services such measures may include clinical effectiveness; effectiveness of social interventions; cost-effectiveness; user satisfaction; and increased job satisfaction of care providers.

---

8. Challis, D., Darton, R. and Traske, T., Care Management and Health Care of Older People, The Darlington Community Care Project, Arena, Aldershot, 1995.

## **Appendix II**

### **Members of the working group**

#### *Albania*

Ms Natasha Hodaj  
General Director  
State Social Services  
Rr. Durrës No. 83  
Tirana

Mr Thanas Poçi  
General Director  
State Social Services  
Rr. Durrës No. 83  
Tirana

#### *Austria*

Ms Alexandra Werba  
Federal Ministry of Social Security, Generations  
and Consumer Protection  
Franz Josefs-Kai 51  
AT-1010 Vienna

#### *Czech Republic*

Ms Ivana Janišová  
Social Services Conception Unit of the  
Department of Social Services  
Ministry of Labour and Social Affairs  
Na Poříčném právu 1  
CZ-128 01 Prague 2

Ms Markéta Kateřina Holečková  
Social Services Conception Unit of the  
Department of Social Services  
Ministry of Labour and Social Affairs  
Na Poříčném právu 1  
CZ-128 01 Prague 2

*Estonia*

Mrs Sirlis Sömer  
Head of Department of Social Welfare  
Ministry of Social Affairs  
Gonsiori 29  
EE-15027 Tallinn

*Holy See*

R.P. Stanisław Opiela, S.J.  
Olecka 30  
PL-04984 Warsaw

*Iceland*

Ms Lara Björnsdóttir (Chairperson)  
Director  
Department of Welfare in Reykjavík Municipality  
Tryggvagata 17  
IS-101 Reykjavík

*Italy*

Ms Patrizia de Felici  
Ministère du Travail et des Politiques Sociales  
Via Cesare de Lollis, 12  
IT-00185 Rome

*Latvia*

Ms Daina Calite  
Project Co-ordinator  
State Agency "Social Integration Centre"  
Dubultu Prospekts 71  
LV-2015 Jurmala

*Malta*

Ms Maryanne Gauci  
Service Manager  
Adult and Family Services  
Appogg Agency  
36 St Luke's Road  
MT-G'mangia

*Netherlands*

Mr Floris O.P. de Boer  
Senior Adviser International Affairs  
Ministry of Health, Welfare and Sport  
PO Box 20350  
NL-2500 EJ The Hague

*Norway*

Mr Odd Helge Askevold  
Ministry of Labour and Social Affairs  
Postboks 8019 Dep  
NO-0030 Oslo

*Portugal*

Ms Gisela Matos  
Instituto da Segurança Social, I.P.  
Rua Castilho, No. 5 – R/c  
PT-1250-066 Lisbon

*Romania*

Ms Carmen Ileana Manu  
Director – Social Services Directorate  
Ministry of Labour, Social Solidarity and Family  
2B. Dem.I Dobrescu Str. Sector 1  
RO-70119 Bucharest

*Spain*

Mr Javier del Castillo Pintado  
International technical adviser from IMSERSO  
C/ Ginzo de Limia, 58  
ES-28029 Madrid

*Turkey*

Mr Tanju Bilgic  
Deputy Permanent Representative  
of Turkey to the Council of Europe  
23, boulevard de l'Orangerie  
FR-67000 Strasbourg

### **Researchers**

Dr Lyudmila Harutyunyan  
Head of Sociology Department  
Yerevan State University  
36 Abovian Street  
Pa 39  
AM-375009 Yerevan

Pr Matti Heikkilä  
STAKES  
National Research and Development  
Centre for Welfare and Health  
Lintulahdenkuja 4  
PO Box 220  
FI-00531 Helsinki

Ms Ilse Julkunen  
STAKES  
National Research and Development  
Centre for Welfare and Health  
Lintulahdenkuja 4  
PO Box 220  
FI-00531 Helsinki

### **Non-governmental organisations**

Mr Daniel Zielinski  
Délégué Général UNCCAS  
(Union Nationale des Centres Communaux d'Action Sociale)  
344, rue du 19 mars 1962  
FR-30520 Saint Martin De Valgagues

### **CDCS representatives**

Mr Jerzy Ciechanski  
Counsellor to the Minister  
Department of Economic Programmes Forecasting  
Ministry of Labour and Social Policy  
Ul. Nowogrodzka 1/3/5  
PL-00513 Warsaw

Mr Jef Mostinckx  
Jan de Trochstraat 180  
BE-1703 Dilbeek-Schepdaal

**CDEG representative**

Ms Iphigénie Katsaridou  
Director General  
KETHI (Research Centre for Gender Equality)  
51, Harilaou Trikoupi and Valtetsiou Street  
GR-106 81 Athens

**Consultant**

Professor Brian Munday  
EISS – Keynes College  
University of Kent, Canterbury  
GB-Kent CT2 7NP



## Sales agents for publications of the Council of Europe Agents de vente des publications du Conseil de l'Europe

### BELGIUM/BELGIQUE

La Librairie Européenne -  
The European Bookshop  
Rue de l'Orme, 1  
B-1040 BRUXELLES  
Tel.: +32 (0)2 231 04 35  
Fax: +32 (0)2 735 08 60  
E-mail: order@libeurop.be  
<http://www.libeurop.be>

Jean De Lannoy  
Avenue du Roi 202 Koningslaan  
B-1190 BRUXELLES  
Tel.: +32 (0)2 538 43 08  
Fax: +32 (0)2 538 08 41  
E-mail: jean.de.lannoy@dl-servi.com  
<http://www.jean-de-lannoy.be>

### CANADA

Renouf Publishing Co. Ltd.  
1-5369 Canotek Road  
OTTAWA, Ontario K1J 9J3, Canada  
Tel.: +1 613 745 2665  
Fax: +1 613 745 7660  
Toll-Free Tel.: (866) 767-6766  
E-mail: order.dept@renoufbooks.com  
<http://www.renoufbooks.com>

### CZECH REPUBLIC/ REPUBLIQUE TCHÈQUE

Suweco CZ, s.r.o.  
Klecakova 347  
CZ-180 21 PRAHA 9  
Tel.: +420 2 424 59 204  
Fax: +420 2 848 21 646  
E-mail: import@suweco.cz  
<http://www.suweco.cz>

### DENMARK/DANEMARK

GAD  
Vimmelskaftet 32  
DK-1161 KØBENHAVN K  
Tel.: +45 77 66 60 00  
Fax: +45 77 66 60 01  
E-mail: gad@gad.dk  
<http://www.gad.dk>

### FINLAND/FINLANDE

Akateeminen Kirjakauppa  
PO Box 128  
Keskuskatu 1  
FIN-00100 HELSINKI  
Tel.: +358 (0)9 121 4430  
Fax: +358 (0)9 121 4242  
E-mail: akatilaus@akateeminen.com  
<http://www.akateeminen.com>

### FRANCE

La Documentation française  
(diffusion/distribution France entière)  
124, rue Henri Barbusse  
F-93308 AUBERVILLIERS CEDEX  
Tel.: +33 (0)1 40 15 70 00  
Fax: +33 (0)1 40 15 68 00  
E-mail: commande@ladocumentationfrancaise.fr  
<http://www.ladocumentationfrancaise.fr>

### Librairie Kléber

1 rue des Francs Bourgeois  
F-67000 STRASBOURG  
Tel.: +33 (0)3 88 15 78 88  
Fax: +33 (0)3 88 15 78 80  
E-mail: francois.wolfermann@librairie-kleber.fr  
<http://www.librairie-kleber.com>

### GERMANY/ALLEMAGNE AUSTRIA/AUTRICHE

UNO Verlag GmbH  
August-Bebel-Allee 6  
D-53175 BONN  
Tel.: +49 (0)228 94 90 20  
Fax: +49 (0)228 94 90 222  
E-mail: bestellung@uno-verlag.de  
<http://www.uno-verlag.de>

### GREECE/GRÈCE

Librairie Kauffmann s.a.  
Stadiou 28  
GR-105 64 ATHINAI  
Tel.: +30 210 32 55 321  
Fax: +30 210 32 30 320  
E-mail: ord@otenet.gr  
<http://www.kauffmann.gr>

### HUNGARY/HONGRIE

Euro Info Service kft.  
1137 Bp. Szent István krt. 12.  
H-1137 BUDAPEST  
Tel.: +36 (0)61 329 2170  
Fax: +36 (0)61 349 2053  
E-mail: euroinfo@euroinfo.hu  
<http://www.euroinfo.hu>

### ITALY/ITALIE

Licosa SpA  
Via Duca di Calabria, 1/1  
I-50125 FIRENZE  
Tel.: +39 0556 483215  
Fax: +39 0556 41257  
E-mail: licosa@licosa.com  
<http://www.licosa.com>

### MEXICO/MEXIQUE

Mundi-Prensa México, S.A. De C.V.  
Río Pánuco, 141 Delegación Cuauhtémoc  
06500 MÉXICO, D.F.  
Tel.: +52 (01)55 55 33 56 58  
Fax: +52 (01)55 55 14 67 99  
E-mail: mundiprensa@mundiprensa.com.mx  
<http://www.mundiprensa.com.mx>

### NETHERLANDS/PAYS-BAS

De Lindeboom Internationale Publicaties b.v.  
M.A. de Ruyterstraat 20 A  
NL-7482 BZ HAAKSBERGEN  
Tel.: +31 (0)53 5740004  
Fax: +31 (0)53 5729296  
E-mail: books@delindeboom.com  
<http://www.delindeboom.com>

### NORWAY/NORVÈGE

Akademika  
Postboks 84 Blindern  
N-0314 OSLO  
Tel.: +47 2 218 8100  
Fax: +47 2 218 8103  
E-mail: support@akademika.no  
<http://www.akademika.no>

### POLAND/POLOGNE

Ars Polona JSC  
25 Obroncow Street  
PL-03-933 WARSZAWA  
Tel.: +48 (0)22 509 86 00  
Fax: +48 (0)22 509 86 10  
E-mail: arspolona@arspolona.com.pl  
<http://www.arspolona.com.pl>

### PORTUGAL

Livraria Portugal  
(Dias & Andrade, Lda.)  
Rua do Carmo, 70  
P-1200-094 LISBOA  
Tel.: +351 21 347 42 82 / 85  
Fax: +351 21 347 02 64  
E-mail: info@livrariaportugal.pt  
<http://www.livrariaportugal.pt>

### RUSSIAN FEDERATION/ FÉDÉRATION DE RUSSIE

Ves Mir  
9a, Kolpachnyi per.  
RU-101000 MOSCOW  
Tel.: +7 (8)495 623 6839  
Fax: +7 (8)495 625 4269  
E-mail: orders@vesmirbooks.ru  
<http://www.vesmirbooks.ru>

### SPAIN/ESPAGNE

Mundi-Prensa Libros, s.a.  
Castelló, 37  
E-28001 MADRID  
Tel.: +34 914 36 37 00  
Fax: +34 915 75 39 98  
E-mail: libreria@mundiprensa.es  
<http://www.mundiprensa.com>

### SWITZERLAND/SUISSE

Van Diermen Editions – ADECO  
Chemin du Lacuez 41  
CH-1807 BLONAY  
Tel.: +41 (0)21 943 26 73  
Fax: +41 (0)21 943 36 05  
E-mail: info@adeco.org  
<http://www.adeco.org>

### UNITED KINGDOM/ROYAUME-UNI

The Stationery Office Ltd  
PO Box 29  
GB-NORWICH NR3 1GN  
Tel.: +44 (0)870 600 5522  
Fax: +44 (0)870 600 5533  
E-mail: book.enquiries@tso.co.uk  
<http://www.tso.co.uk>

### UNITED STATES and CANADA/ ÉTATS-UNIS et CANADA

Manhattan Publishing Company  
468 Albany Post Road  
CROTON-ON-HUDSON, NY 10520, USA  
Tel.: +1 914 271 5194  
Fax: +1 914 271 5856  
E-mail: Info@manhattanpublishing.com  
<http://www.manhattanpublishing.com>

Council of Europe Publishing/Éditions du Conseil de l'Europe  
F-67075 Strasbourg Cedex

Tel.: +33 (0)3 88 41 25 81 – Fax: +33 (0)3 88 41 39 10 – E-mail: publishing@coe.int – Website: <http://book.coe.int>

This report is the result of a two-year project carried out by a group of specialists, whose task was to examine the integration of social services with other selected public services. The concept of 'integration' covers various approaches and methods intended to increase the co-ordination and effectiveness of different services in order to serve the best interests of their users and their families or carers.

Addressed to policy makers at national and local levels, service organisations and users, the report provides examples taken from different countries in Europe and guidelines on designing and implementing effective integration policies and practices.

It complements *Access to social rights in Europe* (2002) and is an integral part of the Council of Europe's Strategy for Social Cohesion.



[www.coe.int](http://www.coe.int)

*The Council of Europe has 47 member states, covering virtually the entire continent of Europe. It seeks to develop common democratic and legal principles based on the European Convention on Human Rights and other reference texts on the protection of individuals. Ever since it was founded in 1949, in the aftermath of the Second World War, the Council of Europe has symbolised reconciliation.*

ISBN 978-92-871-6209-0



€10/US\$15

<http://book.coe.int>  
Council of Europe Publishing