Ministry of
Social Affairs and the Interior

Social Policy Report – In Brief

2016

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Summary

The analyses presented in this report take a closer look at social policy initiatives in Denmark. The focus is on a systematic charting of the target groups, the initiatives themselves, their content and results.

There are three main social service target groups: disadvantaged children and young people, marginalised adults and people with disabilities. These are all very complex groups. Some people may need help to deal with a single, clearly defined problem, but otherwise lead independent lives with education, work, friends and family. Others need a tremendous amount of long-term support in various areas.

Disadvantaged children and young people are subject to social service measures. If a child or young person needs special support the municipality concerned has to investigate their circumstances and take one or more appropriate measures. Such a measure could, for example, involve a designated contact person, respite foster care or other residential care outside the home. There are approximately 57,000 disadvantaged children and young people in Denmark.

Marginalised adults are defined as people over the age of 18 who are receiving a social service intervention due to mental disorders or particular social problems. There are around 65,000 marginalised adults in Denmark. Of these, marginalised adults receiving social service support form the largest group, comprising approximately 32,000 people. Around 16,500 are undergoing treatment for drug abuse and almost 13,500 are undergoing treatment for alcohol dependency. To these can be added residents of care homes, hostels, crisis centres and the like.

People with disabilities receive support or help due to physical or cognitive impairment, under the terms of the Danish Social Services Act. The term ‘physical disability’ covers different forms of visual or hearing impairment and mobility inhibiting handicaps resulting from congenital disease (e.g. muscular dystrophy) or injury (e.g. spinal injuries). Brain damage and intellectual disability are examples of cognitive impairment that can affect language, motor and social skills. This group comprises approximately 52,000 people aged 18 and over.

Social interventions are tailored to suit each person’s challenges and needs. The point of these interventions may be to prevent or resolve social problems. In cases where this is not possible, the intervention will aim to minimise the consequences of the social problems or the person’s impairment and meet the person’s needs, thus improving their quality of life.

For disadvantaged children and young people, an intervention could bring progress in the form of close, stable relationships with adults, greater self-confidence and well-being and improved scholastic performance. These are all examples of progress which prepares the child or young person for an independent adult life.

For marginalised adults, interventions can bring progress in other ways. Treatment for drug abuse can, for example, lead to a drug-free life, facilitate the reforging of social relationships that have suffered due to the drug abuse or pave the way for an active working life. One scheme, which combines the provision of a new flat with a housing allowance, can enable a homeless person to live in their own home despite having a serious mental disorder. Later, the focus can be shifted to education and employment.

Some people with disabilities are provided with aid which render them self-supporting, by making it possible for them to get around their homes and use public transport unassisted. In other cases this may not be a realistic option, but in such cases rehabilitation and training can make the person less dependent on help.

The target groups and the content of the interventions are too diverse for all of the results to be assessed according to the same standard. The analyses presented in this report have therefore employed a range of indicators to measure whether the progress necessary for interventions to succeed is being made. A successful social intervention will tackle a person's specific problem, improve their quality of life and increase the chances of them taking charge of their own life and becoming self-supporting.

For many people, education and employment are realistic goals. This year's report focuses particularly on how well the target groups perform in the education system and the labour market in the years after receiving an intervention.

This report draws the following main conclusions:

- The social service target groups receive comprehensive interventions, which are run mainly by the municipalities. The total expenditure for 2015 was DKK 45 billion.

- Social interventions are in many cases successful. But there is a definite potential for greater progress to be made within all the target groups – both in terms of preventing and remedying social problems and promoting opportunities for education and employment, where this seems realistic.

- Disadvantaged children and young people tend to exhibit lower levels of well-being and higher rates of school absenteeism than their non-disadvantaged contemporaries. They are also more likely to be less proficient in reading and maths. Only 36 pct. have completed a course of upper-secondary education by the age of 25. The corresponding figure for non-disadvantaged young people is 73 pct.

- The majority of those receiving treatment for drug or alcohol abuse do not succeed in controlling their addiction, and 60 pct. of residents in care homes do not have a home of their own after one year. This lack of progress is an obstacle to helping

people to move on with their lives; lives which will also take them into education and employment.

- Approximately half of all people with disabilities have been receiving disability pension since their early twenties. In many cases, these are people with severe congenital disabilities. With this group, the point of the intervention is to render the person more self-sufficient and improve their quality of life.

- With the other half, interventions can also aim to render the person less dependent on help, but for a large proportion support must be geared towards developing their working capacity. Only 17 pct. are in employment while 23 pct. are receiving temporary social benefits or allowances and 60 pct. are on disability pension. There are, though, some signs of employment potential: many people do, for example, have previous experience of employment.

- It is particularly difficult to detect progress among socially marginalised persons with complex problems. Just under 40 pct. of disadvantaged children and young people are struggling with more than one problem. Of all socially marginalised adults 60 pct. have complex problems.

- A complex problem may consist of several, concurrent problems. For example, a person might have problems with drug abuse and a mental disorder. In many cases the level of drug abuse cannot be reduced without also addressing the mental illness. At the same time, the drug abuse may interfere with the psychiatric treatment offered, if this treatment is designed for patients suffering only from a mental disorder.

- In recent years, social service interventions have increasingly been based on methods with a documented effect, but there is still a need for more knowledge on what works and how it works. There is also a need for a concentrated effort to widen the use of methods and interventions that have proved effective.

- The government's 10 goals for social mobility have been established to support the development and dissemination of documented interventions throughout the social services. Work on goals is underpinned by an ambitious data strategy designed to produce adequate data. More and better data will also allow for a wider and more qualified analytical approach within the social services, which in itself will reinforce effective intervention.

The rest of this summary presents a number of analyses supporting the above main conclusions.

Target groups and social service interventions

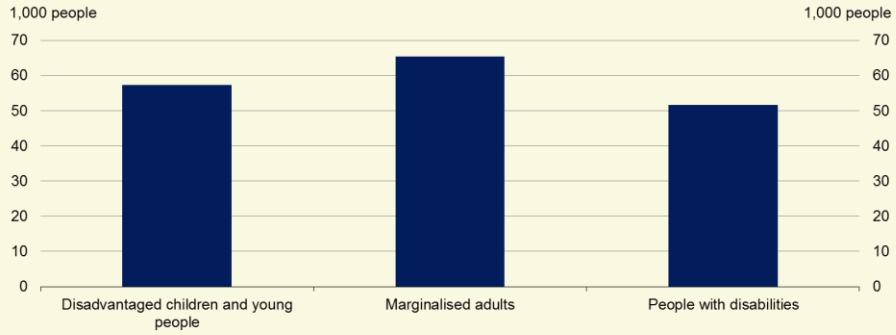
There are three main social service target groups. Disadvantaged children and young people, marginalised adults and people with disabilities. Common to all of them is that, under the terms of the Danish Social Services Act, people in these target groups receive support and

help because of social problems or some form of impairment. However, the general profile and the challenges facing each of the three groups vary widely: a diversity which is also found within each individual group.

In this report, disadvantaged children and young people are defined as children and young people for whom preventative measures have been initiated or who have been taken into care. It may, for example, be a case of a child who has been placed with a foster family because the parents, for various reasons, cannot care for the child. Or of a young person who receives a preventative intervention due to behavioural problems that threaten to become an obstacle to schooling, to upper-secondary education and a good adult life. In 2014 there were 57,000 disadvantaged children and young people in Denmark, cf. figure. 1.1.

Figure 1

Main social service target groups



Note: Figures for 2014, apart from marginalised adults (2013). For further information see *Socialpolitisk Redegørelse 2016* Chapter 2 on target groups and social service expenditure.

Source: Own figures based on register data from Statistics Denmark.

In this report marginalised adults are defined as those receiving, under the terms of the Danish Social Service Act, support and help because of mental disorders or particular social problems: those living with domestic violence, for example, or people with an addiction, or those who are involuntarily homeless.

This group comprises approximately 65,000 people and is extremely complex in nature. Some of these people have one clearly defined problem, such as alcohol dependency, that needs to be tackled, but otherwise they lead well-functioning lives complete with employment and good social networks. The majority in this group do, however, have several problems – drug abuse combined with a mental disorder, for example.

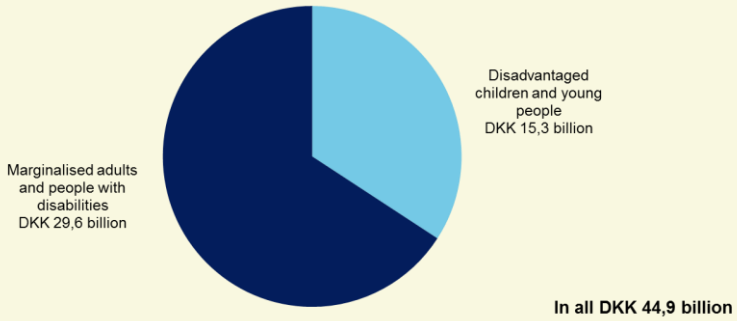
In this report people with disabilities are defined as those receiving a social service intervention or allowance due to some form of physical or cognitive impairment. Here, it might be a case of someone with a physical disability receiving an allowance to cover the extra expenses resulting from their handicap. Or a person suffering from intellectual disability living in

assisted housing and receiving interventions in the form of social work support and activity and social interaction allowances.

These social service target groups receive comprehensive support, the lion's share of which is provided by the municipalities. In 2015 the total service expenditure for these groups was DKK 45 billion. Of this, one third was spent on disadvantaged children and young people, and the other two thirds on the two adult groups, cf. figure 2.

Figure 2

Social service expenditure in 2015



Note: 2016 WPI. For further information see *Socialpolitisk Redegørelse 2016* Chapter 2 on target groups and social service expenditure.
Source: Own figures based on municipality accounts.

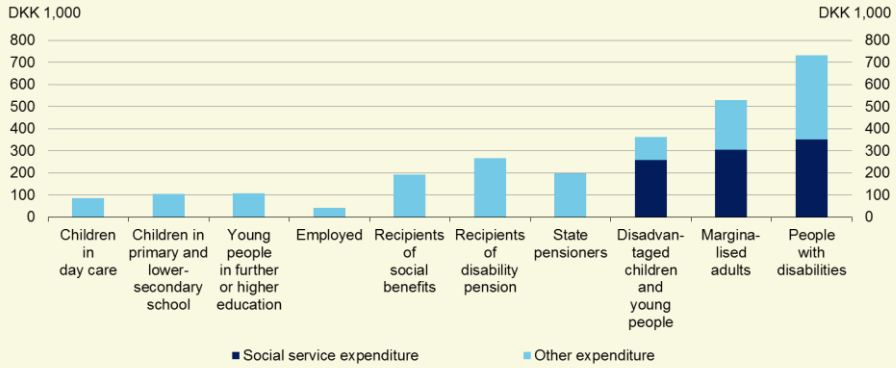
At some point in their lives the large majority of Danes will receive public support and benefits of one sort or another, be it day care, schooling or treatment under the national health service. The support or benefits which an individual receives in any given year are among others determined by means testing and age. So the expenditure on one person in a single year can vary greatly.

Expenditure on the social service target groups is however, considerably greater than that incurred by those who do not have social problems or some form of impairment. Here one has to take into account the amount spent on social interventions and the fact that many adults in the target groups are receiving social benefits because their working capacity has been temporarily or permanently reduced.

The average annual expenditure for children and young people is between DKK 80,000 and DKK 110,000 per head. For disadvantaged children and young people annual expenditure amounts to around DKK 360,000 per head, cf. figure 3.

Figure 3

Expenditure for different groups



Note: 2016 WPI. For further information see *Socialpolitisk Redegørelse 2016* Chapter 2 on target groups and social service expenditure. 'Other expenditure' defined as other services, including day care, education and health, as well as social service benefits and allowances.

Source: Own figures based on register data from Statistics Denmark.

The average expenditure on the adult target groups is also significantly higher than on other adults. Average expenditure on socially marginalised adults is approximately DKK 530,000 per head; for people with disabilities the figure is approximately DKK 730,000 per head. If the target group for people with disabilities also included those who are most self-reliant, as in those who only receive help with additional expenses or allowances for disability aids, the average expenditure per head would be lower. In comparison, the average annual expenditure on recipients of social benefits and disability pensions who do not receive social interventions is DKK 190,000 and DKK 265,000 respectively.

The framework for publicly financed social interventions is established primarily under the terms of the Danish Social Service Act. Interventions are designed and monitored chiefly by the municipalities. However, other bodies also play an important part: the health service, for example, which has responsibility for the treatment of mental illness. And then there are the programmes initiated and run by foundations and voluntary organisations.

Some interventions are intended to prevent social problems from occurring. Others aim to resolve existing social problems. Sometimes it may not be possible to resolve a problem and in such cases the long-term aim will be to improve an individual's personal circumstances. Here, the intervention will concentrate on minimising the consequences of the social problems or impairment, meeting the person's various needs and preventing their circumstances from deteriorating, cf. figure 4.

Figure 4

Target groups, social service interventions and succes criteria

Note: This diagram provides an overall illustration of target groups, interventions and success criteria specified in the Danish Social Service Act.

Municipal interventions are designed with due regard to the realistic success criteria for an intervention at a particular time. For some people, it may seem realistic to find a permanent solution to the problem; for them to be able to stand on their own two feet and have a life complete with education and employment. For others, the goal will be to become more self-sufficient and have a better quality of life – for example, through having a stronger social network.

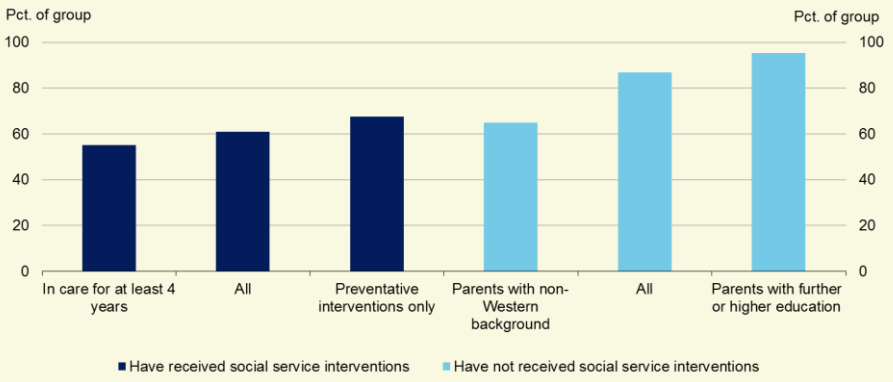
Success criteria vary from person to person and are based on a concrete evaluation – one which may change with time. In some cases, where the initial aim of the intervention has been for a person to eventually enter employment, this may have to be reassessed, should it turn out that self-sufficiency is not a realistic aim. Here, one distinct success criterion can be for the person to be able to maintain a social network. Other people may make such good progress that employment becomes a realistic goal, even though it might not have been an aim at the start. For some, for example, help might be forthcoming from new technology or new and better interventions.

For the large majority of disadvantaged children and young people, realistic success criteria will be for them to have good schooling, upper-secondary education, an independent adult life and employment. Disadvantaged children and young people are less likely to complete upper-secondary education and to enter employment than their non-disadvantaged contemporaries. But within all categories of disadvantaged children and young people a considerable proportion do complete upper-secondary education. This indicates that employment and being self-supporting are realistic goals for the large majority of disadvantaged children and young people.

About 60 pct. of all disadvantaged children and young people have completed upper-secondary education or entered employment by the age of 25. The comparable figure for non-disadvantaged children and young people is 87 pct. Of young people who have been in care for at least four years, 55 pct. have completed upper-secondary education or entered employment, cf. figure 5.

Figure 5

25-year-olds with upper-secondary education or in employment



Note: Social service interventions defined as individual social service interventions given to people between the ages 0-22.

Source: Own figures based on register data from Statistics Denmark

It is vital that the problems of disadvantaged children and young people are dealt with in time. Otherwise there is a risk that these problems will become greater and carry on into adult life, thus making the possibility of an active life with education and employment less realistic.

People who have problems in early adulthood tend not to be self-supporting, but a large proportion of this group do go on to have an active life with education and employment. Fewer socially marginalised adults in the upper age groups revert to being self-supporting, cf. figure 6 and figure 7.

Figure 6

Self-supporting 18-29 year-olds who were disadvantaged in 2010

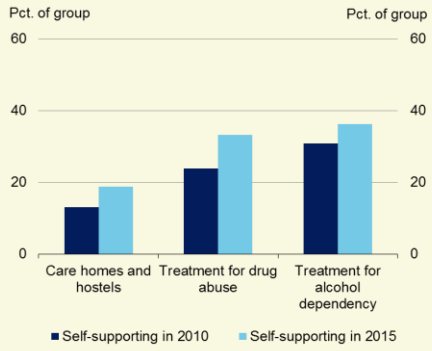
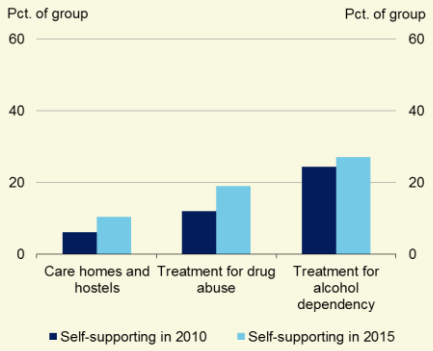


Figure 7

Self-supporting 30-64 year-olds who were marginalised in 2010



Note: Adults who completed a course of treatment or period of residence in 2010. 'Self-supporting' defined as having an activity level of at least 80 pct. in that year. For further information see *Socialpolitisk Redegørelse 2016* Chapter 5 on problems of marginalised adults and their chances of becoming self-supporting.

Source: Own figures based on register data from Statistics Denmark

This indicates that social service interventions for some groups of socially marginalised adults should focus on aspects such as social networks and on making the person more self-sufficient.

People with disabilities is an extremely complex group. Some have congenital disabilities, but still manage to complete a course of education under normal conditions and form strong and lasting attachment to the labour market. Such people need help to cope with their impairment, but by and large they lead active working lives and have strong social relationships.

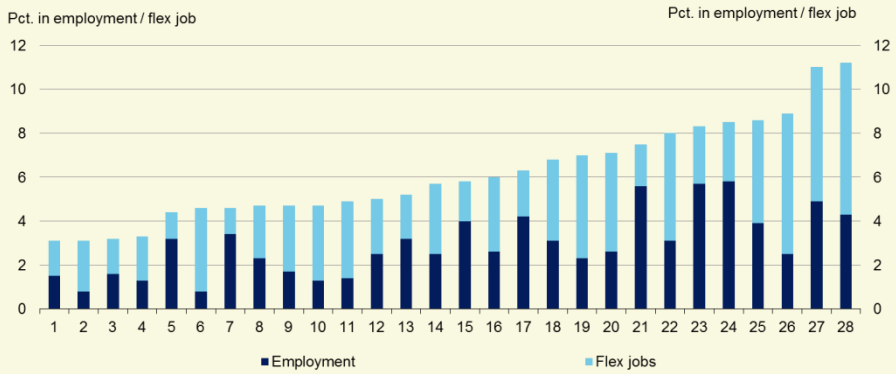
Others have much more serious congenital disabilities, which render the possibility of being self-supporting less realistic and mean that they will need intensive, lifelong support and assistance. Here, help can be designed in such a way that it underpins a good quality of life. Others have been left disabled by an accident or some other event. In such cases the severity of the disability will also determine to what degree the person is self-sufficient or self-supporting. Knowledge of interventions to aid successful rehabilitation is, however, also a vital factor here.

Detailed information on interventions related to disabilities is available to the public from 32 municipalities. In every municipality, the labour market attachment is relatively low for the group receiving interventions. This testifies, on the one hand, to the fact that for many being self-supporting is not a realistic possibility. On the other hand, there is some variation from one municipality to another, which tends to suggest a potential for employment within this group.

Between 3 pct. and 11 pct. of those receiving some form of disability allowance have strong links to the labour market, cf. figure 8.

Figure 8

Employment rates for people with disabilities in 28 municipalities



Note: Figures for people with a physical or cognitive impairment receiving some form of disability allowance. Not taken into account are four municipalities with very few people with disabilities in employment. See also Chapter 6 on Disability, education and work.

Source: Own figures based on data from Statistics Denmark

Social service intervention must create progression

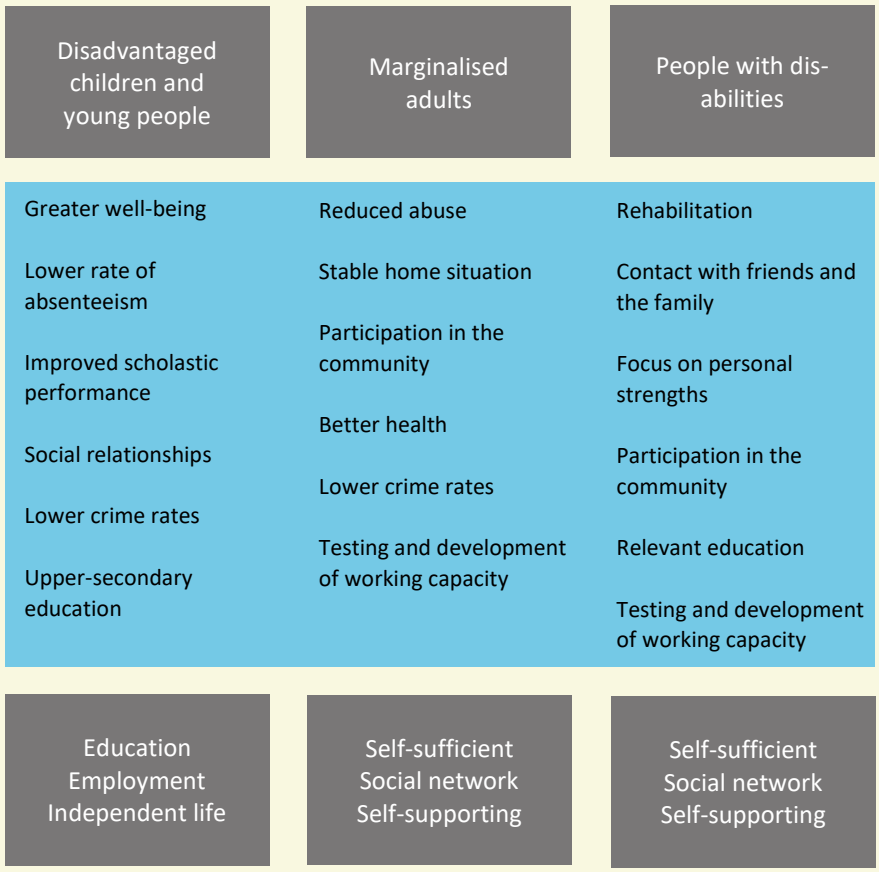
Social service intervention must be designed with a view to creating progression for the person involved. Which is to say, progress which brings them closer to the success criteria.

Progress generates value for a person in the form of better quality of life, but also for society as a whole. The development of working capacity will, for example, provide a person with the incentive and the skills to undertake sheltered or normal employment, and the need for help and support will diminish as they master more tasks. Contact with family and friends can also stimulate a marginalised person's inner resources, since interaction with other people boosts self-confidence and close relationships which can in many cases provide crucial support. The more self-sufficient a person is and the stronger their social network, the less need they will have for interventions which, in many cases, are very expensive.

With disadvantaged children and young people, relevant progress might take the form of greater well-being, stronger social relationships and improved scholastic performance. These are signs that the child or young person is thriving and, hence, better equipped to complete upper-secondary education and obtain qualifications, which in turn will increase their chances of leading an active life with lasting links to the labour market, cf. figure. 1.9.

Figure 9

Sample indicators of progression



Note: This diagram presents only selected samples. There may be many other progression goals.

For socially marginalised adults the relevant levels of progress depend to a great extent on which problem or combination of problems a person is faced with.

For people with alcohol dependency who have no other problems, the aim of the intervention is to bring the dependency under control. There may also be a need for re-establishing social relationships which have suffered due to the alcohol abuse as well as links to the labour market.

Unfortunately, many people have several problems. Homeless people will often have lost their homes due to one or more challenges, such as mental illness, addiction or both.

Today we know that where homelessness is concerned, one of the first and most effective steps is to provide the person with a stable home, since in many cases this is essential before other problems can be effectively addressed.

With marginalised adults, where links to the labour market under normal conditions or in the form of sheltered employment seems a realistic goal, it will in many cases be necessary to test and develop working capacity. This can, for example, be done within the employment system while social service interventions are working to resolve other problems, such as domestic violence or addiction. Success in bringing a person closer to the labour market can reinforce a successful social intervention. Education and a job can, for instance, help to prevent relapses after treatment for drug abuse has been completed.

With people with disabilities the levels of progression will have more to do with creating awareness of their own strengths and abilities as regards active participation in the community. But they may also include an ongoing, rehabilitation programme to help people to acquire and maintain skills and to prevent a deterioration in their circumstances. This could, for example, involve testing and improving working capacity a little at a time, participation in voluntary work or a course of education – measures which give the person knowledge of and faith in their own abilities.

Progression has not only a bearing on the design of an intervention. It is also a relevant factor when it comes to assessing the effectiveness of social service interventions. The following section takes a closer look at the question of whether current interventions do create progression for disadvantaged children and young people, marginalised adults and people with disabilities.

Socially disadvantaged children and young people

In 2014, around 4 pct. of all children and young people aged 0-22 were subject to an intervention. This may have taken the form of a preventative individual or family intervention or a placement in care.

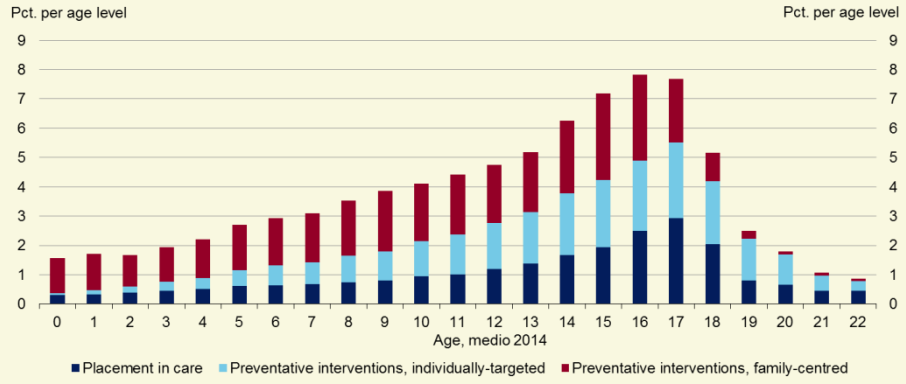
Such measures are taken within all ages, but are increasingly being employed right up into adulthood. Up to the age of 17 in particular there is a marked increase in the number receiving an intervention.

This picture may, among other things, reflect the fact that problems – be it mental illness, drug abuse or criminal behaviour – often do not manifest themselves until the teenage years. Another contributing factor may be that in some cases an intervention is not initiated until the young person is approaching adulthood and it becomes evident that, due to the challenges facing them, upper-secondary education and employment are not realistic possibilities.

Of children under the age of 6, 2-3 pct. receive an intervention. From age 6 upwards the rate increases. In the upper age groups the rate rises to almost 8 pct. per age level, cf. figure 10.

Figure 10

Interventions for disadvantaged children and young people in 2014



Note: Distribution is based on a sequence of priorities, since some people are receiving several interventions: (1) placement in care, (2) individual or (3) family. For further information see *Socialpolitisk Redegørelse 2016* Chapter 2 on social service target groups and expenditure.

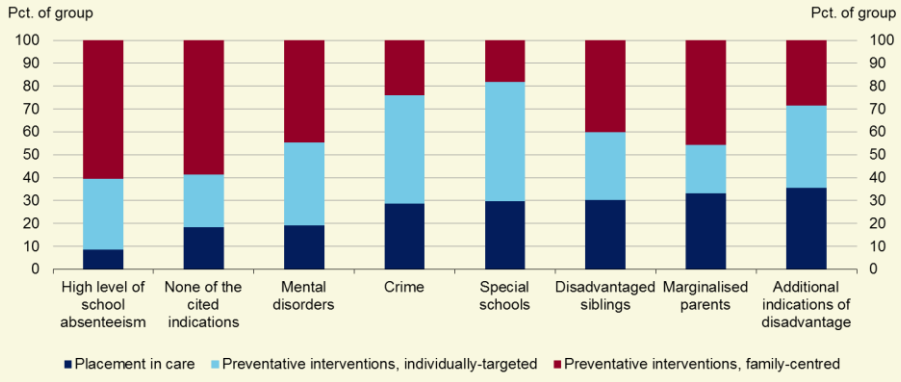
Source: Own figures based on register data from Statistics Denmark.

Family-centred preventative intervention is the most common form, while placement in care is the least often employed. The type of measure employed in each case depends, among other things, on the nature of the problem which prompts the need for intervention.

Placements in care are common in those cases where the child's parents are socially marginalised (suffering from addiction, homelessness or the like), or where there are indications that a child has several categories of problem, which make it particularly necessary to safeguard the child's well-being and development. Conversely, preventative interventions are mainly employed where it is solely a matter of a child having a high level of school absenteeism, cf. figure 11.

Figure 11

Distribution of interventions in given problem categories



Note: See note on figure 10 and Chapter 2 on Target groups and social service expenditure.
Source: Own figures based on register data.

Many disadvantaged children and young people have poor scholastic performance. This can be seen both in reading and maths and at all grade levels. This indicates that we are currently failing to generate enough scholastic progress among disadvantaged children and young people. At all grade levels, 45 pct. of disadvantaged children and young people have below-average proficiency in reading.

Figure 12

Disadvantaged children and young people with below-average proficiency in reading at all grade levels, 2014

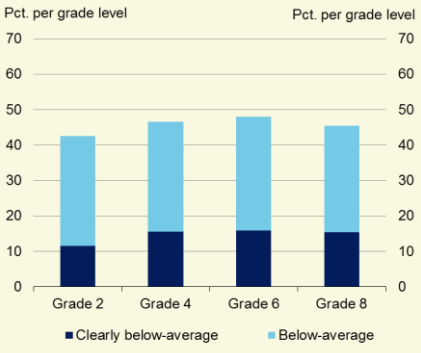
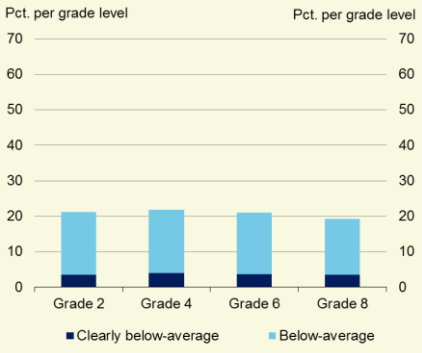


Figure 13

Non-disadvantaged children and young people with below-average proficiency in reading at all grade levels, 2014



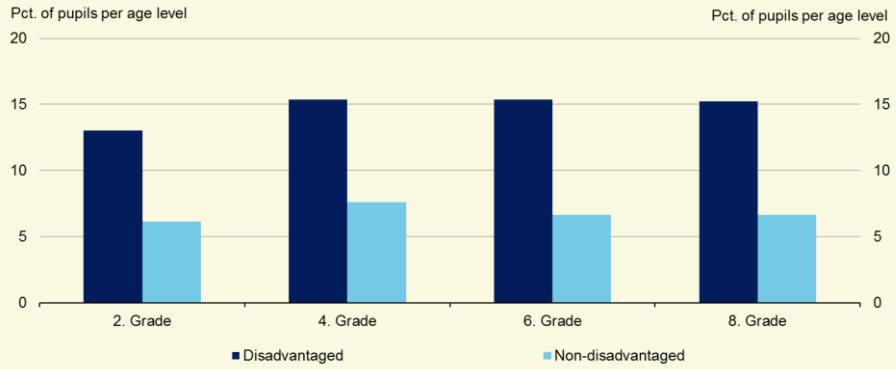
Note: Results of national tests. For further information see *Socialpolitisk Redegørelse 2016* Chapter 4 on the path of disadvantaged children and young people through the education system.
Source: Own figures based on register data from Statistics Denmark and the National Agency for IT and Learning.

This figure is considerably higher than for their non-disadvantaged contemporaries, where the figure is only around 20 pct., cf. figure 12 and figure 13.

There are also indications that disadvantaged children and young people experience a lower level of well-being than other children and young people at all grade levels. This can have considerable bearing on a child's level of absenteeism and their scholastic performance. This in turn suggests that current interventions are not generating enough progress, cf. figure 14.

Figure 14

Pupils with lower level of well-being at different grade levels



Note: Results of the National Well-Being Survey. For further information see *Socialpolitisk Redegørelse 2016* Chapter 4 on the path of disadvantaged children and young people through the education system.
Source: Own figures based on register data from Statistics Denmark and the National Agency for IT and Learning.

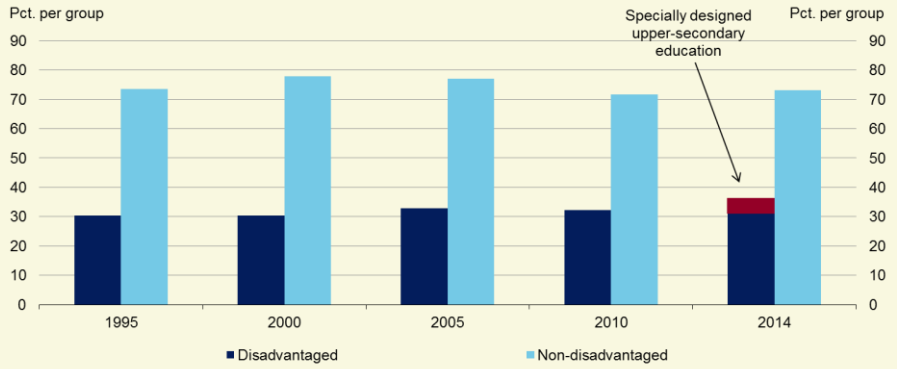
Some disadvantaged children and young people do well in primary and lower-secondary school. They have a good scholastic ballast and the motivation to go on to upper-secondary education. But all in all, disadvantaged young people are more poorly equipped to complete upper-secondary education than their non-disadvantaged contemporaries.

One explanation for this is that these young people are already at an academic disadvantage when they leave lower secondary. A bad experience of school years marked by failure and a lack of self-confidence is another. Less support and help from parents and their wider network may also be a contributory factor.

There is still a considerable challenge to be faced in terms of improving the educational levels of disadvantaged children and young people. The past 20 years have seen only a limited rise in their educational levels and these are still significantly lower than those of non-disadvantaged young people, cf. figure 15.

Figure 15

25-year-olds who have completed upper-secondary education



Note: Disadvantaged is defined as those who have received individual preventative interventions or been in care between the ages of 17 and 22. With the 'Non-disadvantaged' group in particular, variations may be due, in some cases, to undisclosed educational status. For further information see Socialpolitisk Redegørelse 2016 Chapter 4 on the path of disadvantaged children and young people through the education system.

Source: Own figures based on register data from Statistics Denmark.

Some disadvantaged young people complete upper-secondary education without a hitch, but many will start a course and then drop out, and a large proportion never go on to upper-secondary education.

Figure 16

Educational status at age 25, disadvantaged persons

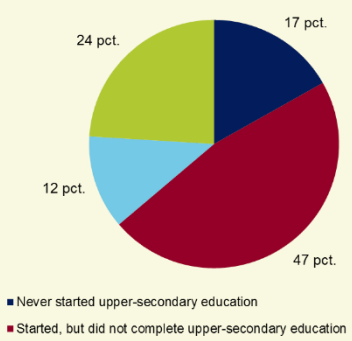
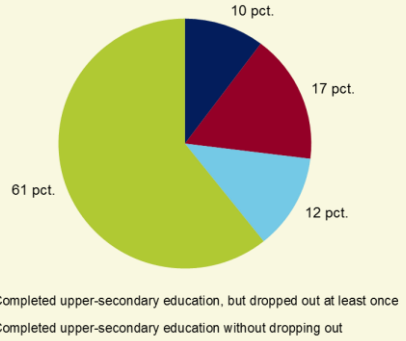


Figure 17

Educational status at age 25, non-disadvantaged persons



Note: 25-year-olds in 2014. See Note to figure 15 and Chapter 4 on The path of disadvantaged children and young people through the education system.

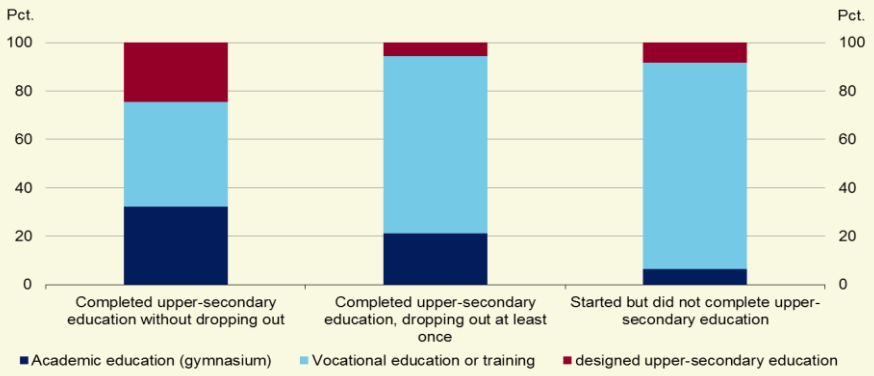
Source: Own figures based on register data from Statistics Denmark.

Almost two-thirds of all 25-year-olds who have been subject to an intervention in their teens or early twenties have never started or never completed a course of upper-secondary education. The same is true of 27 pct. of non-disadvantaged young people, cf. figure 16 and figure 17.

32 pct. of disadvantaged young people who complete upper-secondary education without dropping out at all have taken an academic education *(gymnasium)*. On the other hand, disadvantaged young people who start, but do not complete upper-secondary education are more likely to take up vocational education or training, cf. figure 18.

Figure 18

First course of education begun by disadvantaged young people according to educational status at age 25



Note: 25-year-olds in 2014. See Note to figure 15 and Chapter 4 on The path of disadvantaged children and young people through the education system.

Source: Own figures based on register data from Statistics Denmark.

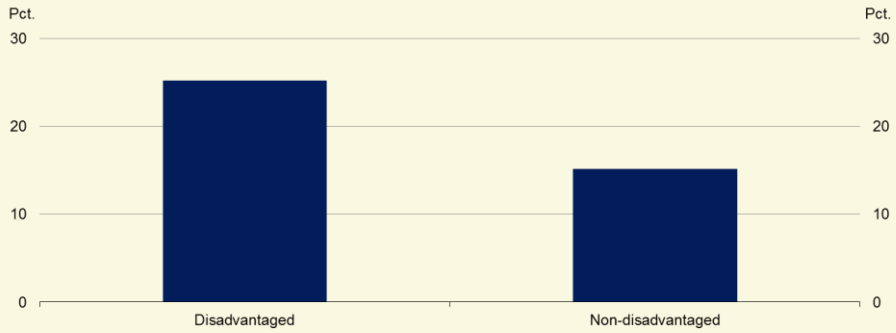
That young people who complete upper-secondary education without dropping out have a greater tendency to take an academic education can possibly be put down to the fact that only the most well-equipped and motivated disadvantaged young people choose this option.

Another feature common to disadvantaged young people is that many do not start another course of education after dropping out of the first. This is true in about 25 pct. of cases, as opposed to 15 pct. of non-disadvantaged young people, cf. figure 19.

One explanation for why young people who have been subject to interventions in their childhood and teens find it difficult to complete upper-secondary education is, as we have seen, that they leave lower-secondary school less well-equipped academically. Another explanation is that many in this category have had social problems since they were much younger. They might, for example, have had a history of drug abuse since their teens.

Figure 19

25-year-olds who do not start another course of education after dropping out of the first

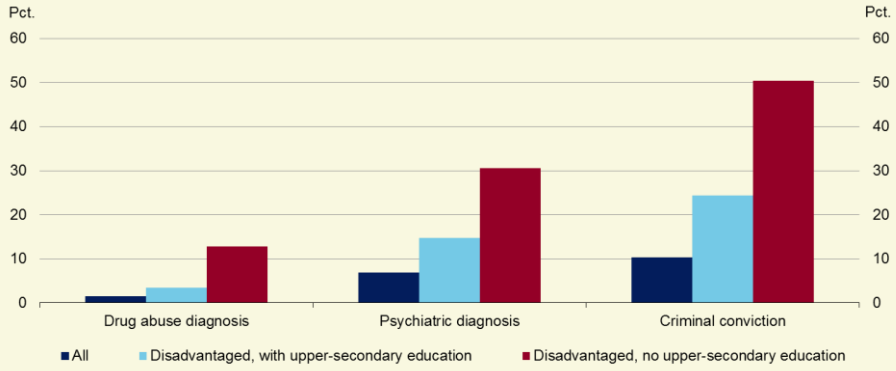


Note: See Note to figure 18
Source: Own figures based on register data from Statistics Denmark.

In many cases, disadvantaged young people who have not completed upper-secondary education suffer from drug abuse, exhibit criminal behaviour or have a mental disorder. 7 pct. of all 25-year-olds have been diagnosed with some form of mental illness. The figure for disadvantaged young people with no upper-secondary education is 31 pct., cf. figure 20.

Figure 20

Diagnoses of drug abuse, mental disorders and criminal behaviour among 25-year-olds



Note: Social vulnerability among 25-year-olds (All) and 25-year-olds who have been subject to a social service intervention at some point between the ages 17-22 (Disadvantaged). For further information see *Socialpolitisk Redegørelse 2016* Chapter 4 on the path of disadvantaged children and young people through the education system.
Source: Own figures based on register data from Statistics Denmark.

Better results can be achieved for socially disadvantaged children and young people by both employing knowledge-based methods and working generally to document the effectiveness of municipal interventions. See box 1 for examples of programmes employed in the work of reinforcing knowledge-based social policy.

Box 1

Knowledge on how best to help socially disadvantaged children and young people

Described below are some examples of programmes, trial schemes and promising methods employed in the National Board of Social Services work on disseminating knowledge of effective methods and practices.

The Incredible Years (IY): IY is a series of evidence-based training programmes for parents, children, pre-school and primary-school teachers. The most widely-used of these programmes is a course for parents of children aged 3-8 who are exhibiting behavioural problems. It focuses on the developmental milestones for children in this age group, including emotional competence, self-regulation, early social skills, forming friendships and developing school readiness.

Treatment Foster Care (TFCO): A comprehensive family treatment programme aimed at young people aged 12-18 with severe behavioural and emotional problems. A TFCO placement will usually last for 9-12 months. During this time the young person is placed temporarily with a foster family while therapy and training interventions are conducted with the young person and their family. Treatment focuses on strengthening the young person's social skills and fostering positive interaction within the family.

Parent Management Training Oregon (PMTO): A family therapy programme for children aged 4-12 who are exhibiting behavioural problems. This programme is based on active parental involvement. By changing behavioural patterns in the family and encouraging positive communication, it aims to check the development of negative attitudes and behavioural problems in the family.

Method programme for young drug abusers: This programme experiments with four treatment combinations (behavioural therapy combined with Motivational Dialogue). Treatment is conducted over a 12-week period, with weekly one-to-one conversations. The programme is also experimenting with voucher-based reinforcement therapy (e.g. cinema vouchers for keeping therapy appointments) and follow-up treatment gradually *tapering off over six months.*

Keeping Foster Parents Trained and Supported (KEEP): A family training programme for foster parents, providing families fostering children between the ages of 4 and 12 with specific tools to ensure that a foster child's behaviour problems are handled appropriately and prevent unplanned breakdowns in placement. The programme lasts for 16 weeks, during which foster parents have weekly group meetings. Foster parents also receive support with the implementation in their daily lives of the tools provided by the programme.

U-turn: A comprehensive programme for young people under the age of 25 with a problematic use of drugs. This programme involves open, anonymous counselling and a lengthy course of treatment during which the young person can be given help to resolve their problems. U-turn also provides counselling for parents, other family members and care professionals. The U-turn programme was developed by the municipality of Copenhagen. It has also been tested and implemented in the municipalities of Horsens and Helsingør and is now being introduced in three other municipalities.

The Detection Model: A method designed to ensure that children at risk are detected as early as possible. This method is intended to help professionals in day care and public health to recognise early on if a child is not thriving, thus improving the chances of early intervention. The target group is children aged 0-6. The model involves the use of four methods: well-being assessments, transition schedules, external professional sparring and a dialogue model for effective, focused meeting management. The Detection Model was developed through collaboration between researchers and care professionals in the municipalities and is based on a number of theories concerning the observation and understanding of children's well-being, the most appropriate way for care professionals to discuss the well-being of children and how to act when a child is deemed to be at risk.

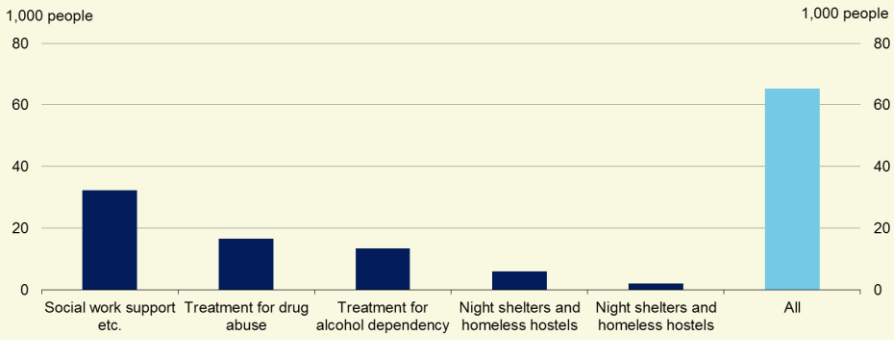
Socially marginalised adults

Around 65,000 marginalised adults in Denmark are receiving social service interventions due to particular social problems or mental disorders. The term 'socially marginalised adults' covers homeless persons making use of shelters and hostels, people undergoing treatment for drug or alcohol abuse, residents of crisis centres, those receiving social work support and the like.

Socially marginalised persons receiving social work support and the like form the largest group, amounting to around 32,000. Approximately 16,500 people are undergoing treatment for drug abuse and just under 13,500 are receiving treatment for alcohol dependency, cf. figure 21. Then come the users of shelters, hostels, crisis centres and so on.

Figure 21

Socially marginalised adults according to target group, 2013



Note: For further information see *Socialpolitisk Redegørelse 2016* Chapter 5 on problems of marginalised adults and their chances of becoming self-supporting.

Source: National Board of Social Services (2015) and own figures based on register data.

In many cases social problems can be resolved. Of those entering drug abuse programmes, 34 pct. finish treatment drug-free or with their consumption reduced. Of those receiving treatment for alcohol dependency the figure is almost 30 pct., cf. figure 22.

Figure 22

People finishing treatment drug/alcohol-free or with consumption reduced

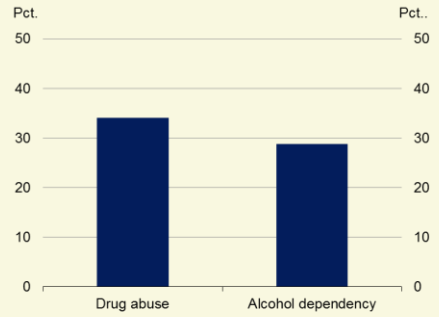
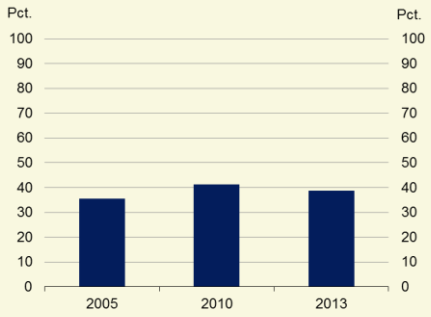


Figure 23

Homeless persons in their own home after one year



Note: 'Drug-free or with consumption reduced' refers to drug abuse treatment which results in a person being drug-free or with their consumption reduced. These figures cover all completed drug-abuse treatment programmes in 2013. In the case of alcohol dependency they cover non-anonymous, publicly-financed programmes where the person has completed treatment.

Source: Own figures based on register data from Statistics Denmark.

Of homeless persons making use of night shelters and hostels, around 40 pct. are in their own home a year later, cf. figure 23.

There is, however, a large group with problems for which social service interventions can offer no straightforward solution: homeless persons who do not end up in their own home, for example. In such cases, while a person may have received support and help to resolve the acute problem – e.g. through the provision of overnight accommodation in a shelter – it has not been possible to establish a stable home situation.

There are also people for whom an intervention initially proves successful, but who then have a relapse. This is partly due to the fact that many socially marginalised persons have complex problems that are not easily resolved and need to be repeatedly addressed.

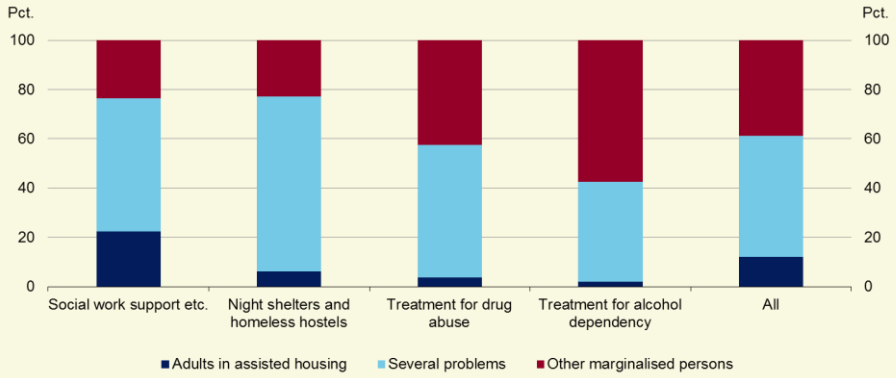
This complexity can manifest itself in various ways. Some socially marginalised people have such serious problems that an intervention will consist of, or be conducted as, part of a stay in temporary or more long-term assisted housing.

Other people have several concurrent problems, which can cause greater damage and make it more difficult to come up with good and long-lasting solutions. It could, for example, be a matter of a person suffering both from drug abuse and a mental disorder. In many cases the drug abuse cannot be reduced without also addressing the mental disorder. At the same time, the drug abuse may interfere with the psychiatric treatment offered, if this treatment is designed for patients suffering only from a mental disorder.

A large proportion of homeless persons, people undergoing drug abuse treatment and those receiving social work support etc. have complex problems. Signs of complex problems are seen mainly among those receiving social work support etc., over 20 pct. of whom are living in assisted housing, while 55 pct. have several problems. Of homeless persons in shelters and hostels more than 3 out of 4 have several problems, cf. figure 24.

Figure 24

Socially marginalised adults categorised according to complexity, 2013



Note: Residents aged 18-64 in 32 municipalities, figures projected to national level. See also Chapter 5 on Problems of marginalised adults and their chances of becoming self-supporting.
Source: Own figures based on register data from Statistics Denmark.

The number of people with several problems is slightly lower among drug abusers and alcohol dependents. A large proportion of alcohol dependents, in particular, exhibit no signs of other problems. In many cases, these are people who also have strong links with the labour market and good social networks.

All in all, around 60 pct. of socially marginalised adults exhibit signs of complex problems, in the sense that they are living in assisted housing or have more than one problem, cf. figure 25.

Figure 25

Marginalised adults in 2013 divided into three groups

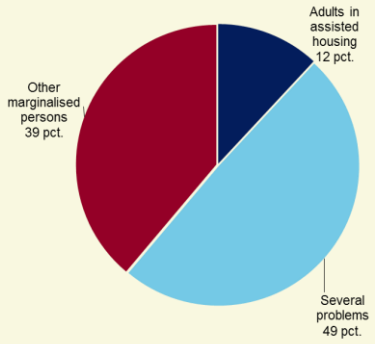
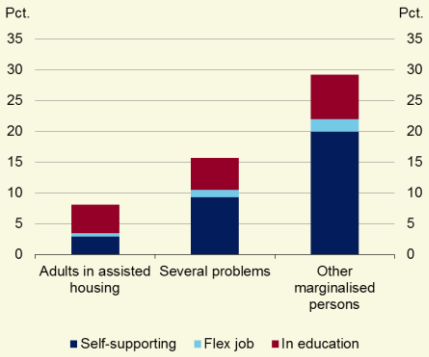


Figure 26

Activity levels of marginalised adults in 2013



Note: The activity level is the percentage of time for which a person is self-supporting, in a flex job or in education. For further information see *Socialpolitisk Redegørelse 2016* Chapter 5 on problems of marginalised adults and their chances of becoming self-supporting.

Source: Own figures based on register data from Statistics Denmark.

Socially marginalised persons with complex problems have significantly weaker attachment to the labour market and education system than other marginalised persons. For example: on average, marginalised adults with several problems are only self-supporting, in flex jobs or in edu-cation for around 16 pct. of the year. The corresponding annual figure for other marginalised persons who exhibit no signs of complex problems is just under 30 pct., cf. figure 26.

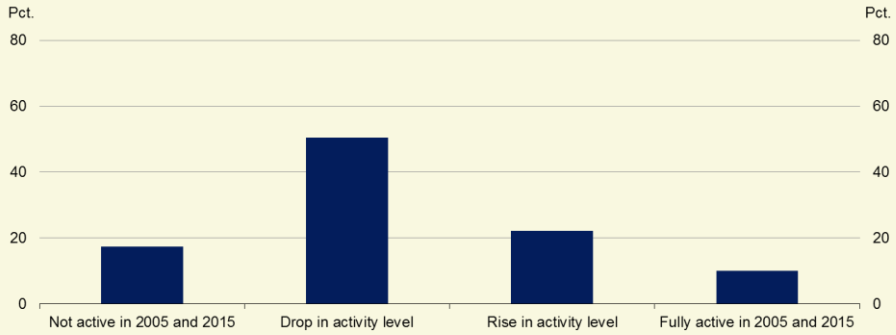
The wide range of complex problems is probably one of the main reasons why it is difficult to place socially marginalised people in employment. It is not easy to design a successful social intervention which manages both to tackle the challenges facing them and to implement an effective employment-related programme.

Generally speaking, relatively few in this group enter employment or education. Over a ten-year period, from 2005 to 2015, the rate of participation in the labour market and the education system fell for 50 pct. of socially marginalised adults. Only 22 pct. experienced an increased level of activity and only 10 pct. were fully active in both years, cf. figure 27.

In the endeavour to place socially marginalised adults in employment, good interaction between the social service intervention and the employment-related programme is essential. In the case of many socially marginalised persons, solutions to the social problems need to be found if the person is to enter and remain in employment. And a job can also reinforce successful progression in the person's life as a whole.

Figure 27

Socially marginalised adults in 2010, according to changes in activity levels between 2005 and 2015



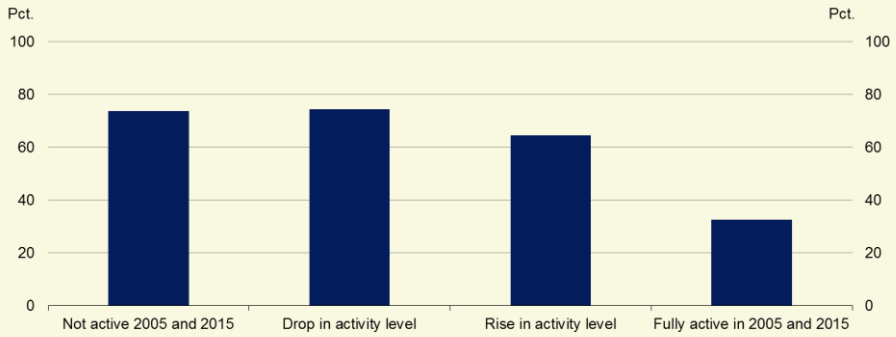
Note: 23-59 year olds who moved out of shelters or completed treatment for drug abuse or alcohol de pendency in 2010 (excluding those socially marginalised on disability pension at the beginning of 2011). See also Chapter 5 on Problems of marginalised adults and their chances of becoming self-supporting.

Source: Own figures based on register data from Statistics Denmark.

Many marginalised adults have received some degree of employment-related intervention. Between 65 pct. and 75 pct. of those groups that experienced a drop or rise in activity level during the 10-year period also received an employment-related intervention during the years 2011-2014. The same is true of those who were inactive in both years, cf. figure 28.

Figure 28

Socially marginalised adults who received an employment-related intervention for at least 4 weeks in the years 2011-2014



Note: 'Employment-related intervention' defined as counselling and upskilling, standard education, wage subsidies and work experience. See also Note to figure 27.

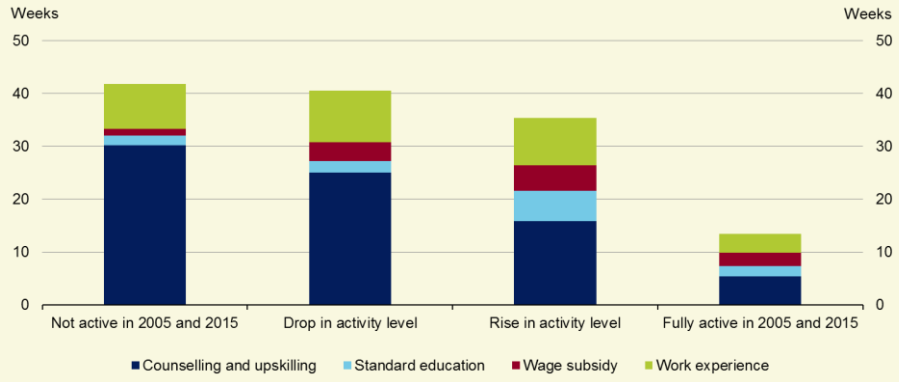
Source: Own figures based on register data from Statistics Denmark.

Employment-related interventions will often be designed to allow for occasional breaks. There could be periods when a person is in normal employment, or periods when a social problem is so great that an employment-related intervention is pointless. There can also be periods when the focus is on finding a suitable new programme.

Members of this group were, however, receiving an employment-related intervention for much of this time. Over a four-year period, the three groups which were not fully active in both years received an employment-related intervention lasting for almost a year, cf. figure 29.

Figure 29

Number of weeks of employment-related intervention for socially marginalised persons in the years 2011-2014



Note: See Note to figure 28
Source: Own figures based on register data from Statistics Denmark

The aim of an employment-related intervention is first and foremost to increase and test a person's working capacity. The type of intervention deemed relevant depends on a number of individual factors, among them the relative closeness of the person's connection to the labour market. For some people a wage subsidy will prove a good solution, while others will need to upgrade their skills, for example through AVT (Adult Vocational Training) courses. In certain cases, testing of working capacity will have been going on for some time and is currently being conducted in order to ascertain whether a disability pension should be granted.

For much of the time, people will be receiving counselling and help with *upskilling* – a term used for a range of programmes designed to uncover or develop professional, social or linguistic skills, thereby paving the way for a job.

Upskilling and job-related schemes such as work experience and wage-subsidised jobs accounted for the rest of the time spent on employment-related interventions. Socially marginalised persons who have formed stronger links to the labour market are particularly likely to

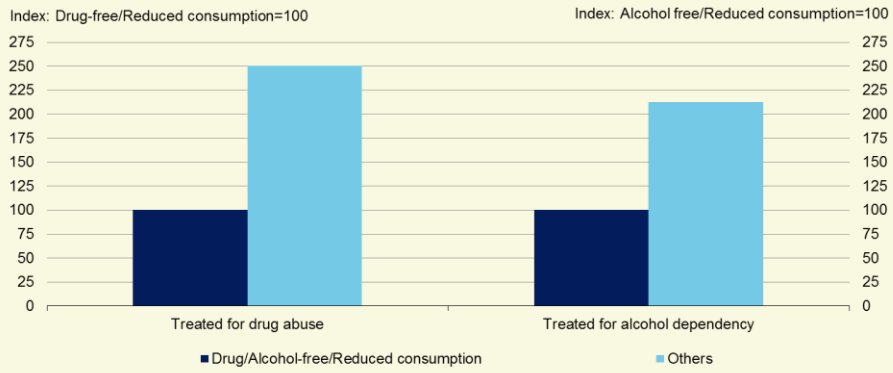
have received such interventions. This may reflect the fact that some employment-related interventions are effective in helping the unemployed to find jobs, and that such interventions are primarily used with people who have relatively close links with the labour market.

A successful social service intervention is not only crucial to a person's chances of returning to an active life with education and employment. It is also vital for social networking and good health.

The mortality rate for those who have received successful treatment for drug abuse or alcohol dependency is, for example, significantly lower than for those for whom treatment has not been successful, cf. figure 30.

Figure 30

Mortality among persons who have completed treatment for drug abuse or alcohol dependency



Note: Mortality rate two years after finishing treatment. Persons who died before finishing treatment not included in these figures.

Source: Own figures based on register data from Statistics Denmark.

Many socially marginalised adults also find that their children need help and support. In such cases, intervention might take the form of a family-centred programme or placement in care. A successful intervention which addresses the parents' problems will often also have a beneficial effect on their children's well-being and development.

Better results can be achieved for socially marginalised adults if knowledge-based methods are combined with more general work on documenting the results of municipal social-service interventions. See Box 2 for examples of programmes employed in the work of reinforcing knowledge-based social policy.

Box 2

Knowledge on how best to help socially marginalised adults

Described below are some examples of programmes, trial schemes and promising methods employed in the National Board of Social Services work on disseminating knowledge of effective methods and practices.

Housing First. This approach works from the premise that everyone needs a permanent place to live. The best way to help homeless people is to start by providing them with a home in normal housing. Only once a person has a stable home can they become eligible for a housing allowance; together these two things can help to stabilise and improve other aspects of their situation, e.g. as regards mental disorders, drug abuse or social networks. Housing First is a comprehensive programme based on the recovery approach.

Open Dialogue: An integrated, network- and recovery-oriented approach, aimed at people with severe mental disorders. This approach draws on relevant professional and personal networks and is based on seven principles for speedy and coordinated support for a person and their support system. Members of their support system are involved only with the consent of the person concerned and all opinions are considered equally valid. The therapist's role is to provide the professional point of view, to supplement the person's own point of view and those of the others in their networks.

Social Skills Training: A psycho-social education programme aimed at people with severe mental disorders and based on social learning theories and cognitive behavioural theory. The person is coached in developing and maintaining social skills. The overall aim of this method is to improve the person's interpretation of inter-personal signals and train their social capacity. In this way the method boosts participation in the community by enhancing cognitive skills and social options.

Exit Prostitution: The Critical Time Intervention (CTI) model is being tested in a programme for people working in prostution who wish to leave prostitution or to improve their personal circumstances. This model is used where homelessness is also involved and is designed to support people during critical periods of transition by strengthening and extending their professional and personal support systems and by providing them with intensive practical and social support for a limited period of time. Results have so far proved positive.

CTI for women in crisis centres: In this project, CTI is being tested as a means of providing coordinated counselling for women moving out of crisis centres (see the Danish Health Act § 109, sub-section 7). The CTI model is based on the recovery approach and involves structured, comprehensive work with the person concerned. The aim of the project is for women to make a successful transition to a life free of violence. The project will run until the end of 2018 and is regularly evaluated.

Acute social care model: A 24-hour support service which people in acute mental crisis can contact without prior examination or an appointment. People are given support and care as well as the offer of a short course of counselling. They can phone the service helpline or visit the Acute Social Care centre in person and can choose to remain anonymous. The aim is for more people with mental disorders or fragile mental health to go on leading a secure life in their own home, thus preserving social relationships and key aspects of their daily lives (e.g. work and education).

People with disabilities

People with disabilities need support and help to live as well as they can with their impairment. Here, one of the main aims of an intervention is to render a person more self-sufficient and help them in various ways to become more self-supporting.

An impairment may be physical or cognitive. There are many different degrees of impairment and the severity of a person's particular disability will determine the form and the objective of an intervention.

Half of all people with disabilities included in this study had been granted a disability pension by the age of 25: a strong indication of impairments that are congenital and of considerable severity, cf. figure 31.

Figure 31

People with disabilities split into two groups

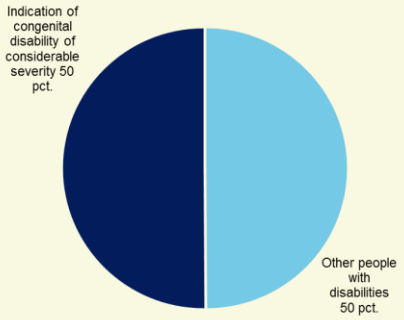
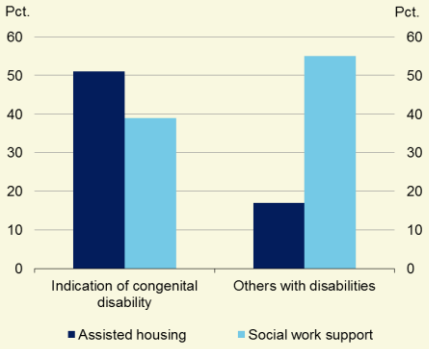


Figure 32

People from these two groups living in assisted housing



Note: 25-58 year-olds only. See Chapter 6 on Disability, education and work.
Source: Own figures based on register data from Statistics Denmark.

One of the key features of this group is that 50 pct. live in assisted housing, cf. figure 32. For many, the goal of improving their working capacity to the point where they can undertake normal or sheltered employment will not be a realistic one.

People in the other group are far less likely to live in assisted housing. In these cases, the disability may have been incurred after the age of 25. Or it may be a matter of people with congenital disabilities mild enough in their youth to allow them to take an education under normal conditions and enter normal employment; or who have the prospect of developing their working capacity.

At the moment, however, a large proportion of this group are receiving disability pension. Approximately 60 pct. are on disability pension, while around 17 pct. are in employment and 23 pct. are on temporary benefits, cf. figure 33.

Figure 33

Other people with disabilities split into three groups according to source of income

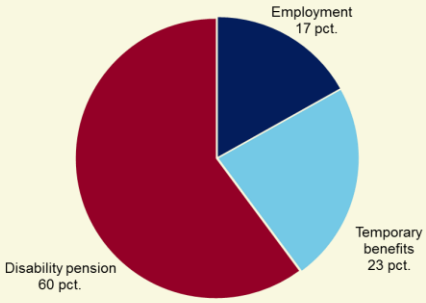
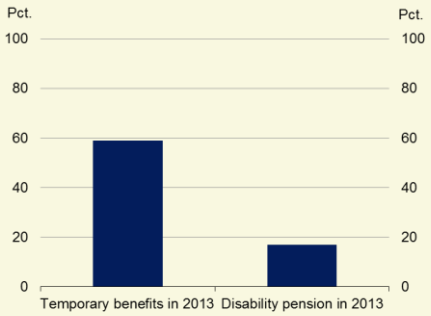


Figure 34

Min. one year with employment as source of income during years 2008-2013



Note: 25-58 year-olds and only those *not* granted disability pension by age 25. See Chapter 6 on Disability, education and work.

Source: Own figures based on register data from Statistics Denmark.

A large proportion of those who received temporary benefits in 2013 had previously had employment as their source of income. This is true of almost 60 pct. of this group, cf. figure 34. This could suggest that a considerable number in this group do have the chance of re-establishing strong attachment to the labour market, thanks to previous experience and contacts, including former colleagues and employers.

This potential is reinforced by the fact that, in general, attachment to the labour market and the education system have improved between 2013 and 2015 for the group which received temporary benefits in 2013. There can be several explanations for this, one of these being a better financial climate. But whatever the reason, such progress indicates that within the group as a whole the potential for a more active life does exist.

A large proportion of this group has received an employment-related intervention in the intervening period. Around 60 pct. became active in the labour market during 2014, cf. figure 35.

Figure 35

People on temporary benefits

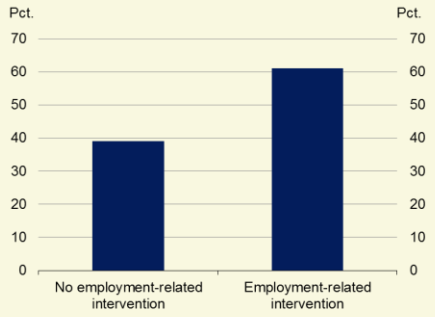
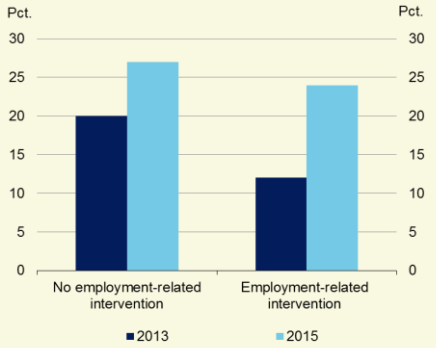


Figure 36

Activity level and employment-related interventions



Note: Extent of employment-related interventions in 2014. See also Chapter 6 on Disability, education and work.

Source: Own figures based on register data from Statistics Denmark.

There are signs that the activity level – the attachment to the labour market and the education system – has risen most for people with disabilities who have received an employment-related intervention, cf. figure 36. This could be because the employment-related intervention has helped people to find employment and/or because municipalities are more likely to offer places on activation programmes to those people with the greatest chance of being employed.

Most people with disabilities who are receiving temporary benefits and the like have had no education beyond lower-secondary, but a large number have also completed some form of vocational education, cf. figure 37.

Figure 37

People with disabilities on temporary benefits

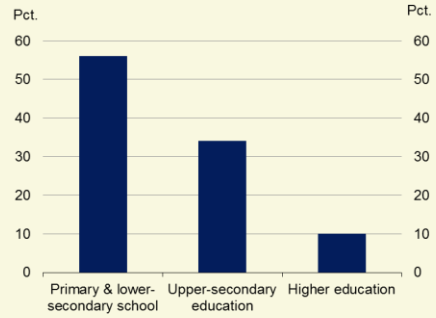
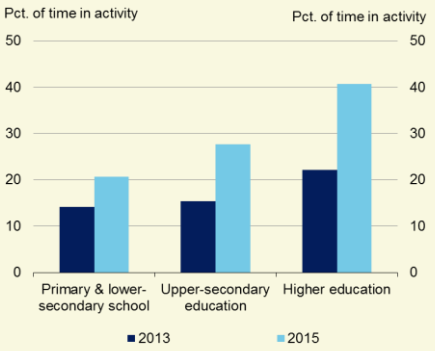


Figure 38

Activity level according to education



Note: See also Chapter 6 on Disability, education and work
Source: Own figures based on register data from Statistics Denmark.

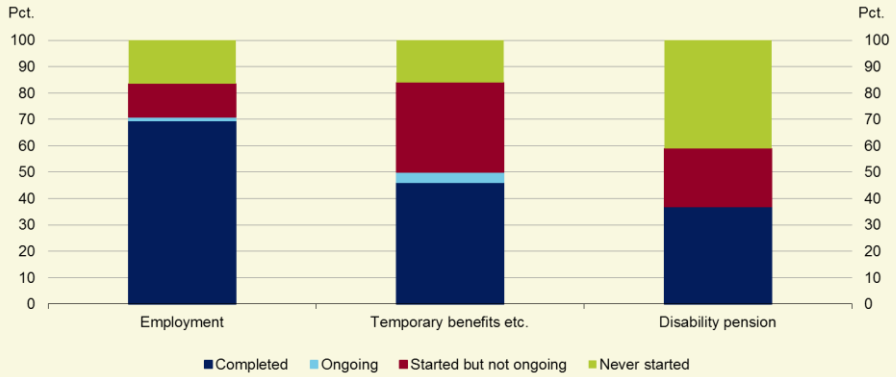
Employment potential is greatest for the group with a vocational education. From 2013 to 2015 the rise in employment is significantly less for the group with no education beyond lower-secondary level, cf. figure 38.

This has to be seen in the light of the fact that the group with educational qualifications is more liable to be affected by temporary unemployment, while the others are possibly considerably more distanced from the labour market and have more serious disabilities.

The general picture presented here is that people with educational qualifications have a stronger attachment to the labour market. This is true both of the population as a whole and of people with disabilities. Education levels are highest among those with employment as their source of income and those receiving temporary benefits etc., cf. figure 39.

Figure 39

Upper-secondary education for people with disabilities according to source of income in 2013



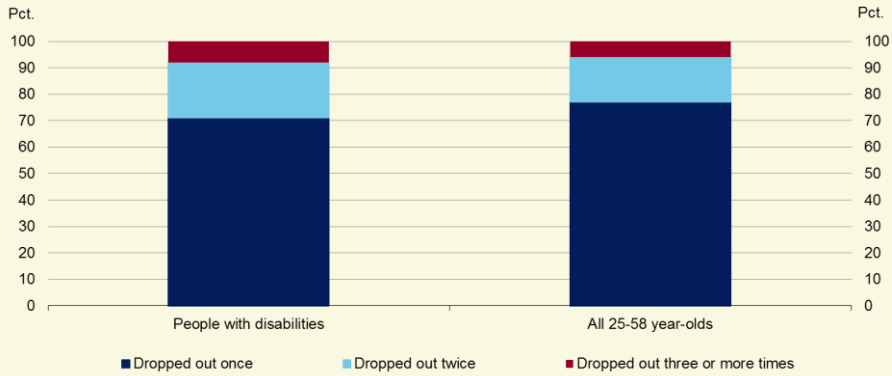
Note: 25-58 year-olds. See Chapter 6 on Disability, education and work.
Source: Own figures based on register data from Statistics Denmark.

This may be seen as one indication that educational qualifications can make it easier to maintain attachment to the labour market if one incurs a disability. It is very important that people with a congenital disability choose a course of education appropriate to their impairment. A good match increases the likelihood of completing education and of finding and keeping a job afterwards.

People with disabilities have only a slightly higher drop-out rate, cf. figure 40.

Figure 40

Upper-secondary drop-out rate for people with disabilities and all



Note: Applies only to those two groups that start upper-secondary education and drop out at least once. See Chapter 6 on Disability, education and work. 'Drop-out' defined as complete cessation of study. It does not cover those cases where people have simply taken a break from their studies or switched to another course at the same/another educational institution.

Source: Own figures based on register data from Statistics Denmark.

Greater results can be achieved for people with disabilities through the use of knowledge-based methods and general work on documenting the results of municipal interventions. See box 3 for some examples of programmes employed in the work of reinforcing knowledge-based social policy.

Box 3

Knowledge on how best to help people with disabilities

Described below are some examples of programmes, trial schemes and promising methods employed in the National Board of Social Services work on disseminating knowledge of effective methods and practices.

The Stepping Stones programme: Stepping Stones is a positive parenting programme for parents of children (aged 2-12) with permanent physical or mental impairments, intellectual disability or communicative and social difficulties. Stepping Stones provides the tools to help parents learn different strategies for coping with family life, having happier children (both the child with the disability and siblings), dealing with conflict with their partners, looking after themselves, as adults and parents, dealing with stress, participating in the surrounding community, developing strategies for tackling difficult situations etc.

Individually Prioritised Problems Analysis: IPPA analysis is used to ascertain which everyday activities those applying for disability aids find difficult to manage and with which they most wish the help of such aids and/or interventions. A picture can thus be built up of a person's overall need for rehabilitative intervention, according to what the person concerned considers important and is, therefore, motivated to accept.

Reasoning and Rehabilitation for ADHD and the Young-Bramham Programme: A programme based on cognitive therapy that focuses on and is tailored to address the challenges and difficulties faced by young people and adults with ADHD. With the aid of these two programmes people achieve a greater degree of control and self-sufficiency, which in turn gives them a more solid footing in education/the labour market, a stable financial situation and lasting social relationships.

Drive Well: The driving skills of adults requiring wheelchairs or electric mobility scooters are tested by means of the standardised 'Drive Well' programme. Where driving skills are poor or non-existent, training is given with the aid of a manual. Users are trained and tested until they are proficient enough to drive safely.

Cognitive, Resource-focused and Appreciative Training: The CRAT method reinforces the positive development of functional capacity and the perceived quality of life of adults with intellectual disability living in assisted housing. This method is based on an appreciative approach and the systematic use of cognitive theories, and is rooted in a resource-focused view of human nature.

Course manual for parents on collaboration between municipalities and consumer organisations: Currently under preparation, a course manual and partnership model for the use of municipalities and consumer organisations wishing to provide collaborative parental education courses (co-creation) for this target group. This model for parental education courses is being tested in a number of municipalities; it will be evaluated at the halfway stage and adjusted in line with experience gained.

Goals for social mobility and data to generate more knowledge

The analyses presented in this report have revealed a lack of progression in several areas for the target groups. For greater progress to be made, there is a need for more knowledge on how best to help socially marginalised people and those with disabilities.

Various measures are being taken to extend the use of initiatives that have proven effective, by documenting the results of existing interventions and experimenting with promising new programmes.

To provide direction and to ensure greater progress, the government has established 10 ambitious goals for social mobility. The two overall objectives are for there to be more people in the labour force and fewer socially marginalised people.

These goals apply to all three main target groups and focus on a number of those areas in which large groups covered by the social services today feel that current initiatives do not make generate enough progress, cf. Table 1.

Table 1

Baseline and status regarding the 10 goals for social mobility

	Number in target group	Most recent status
More people in the labour force		
Improved proficiency in reading and maths for disadvantaged children in primary and lower-secondary school	30.000	Average score: 41
More 18-21 year-olds who have been subject to social service intervention in the past five years to be in or have completed upper-secondary education	21.000	50 pct.
More people receiving social service interventions due to reduced physical or mental capacity to enter education and employment	46.000	9 pct.
More people receiving support for social problems or mental disorders, under the Danish Social Services Act, to enter education and employment	35.000	7 pct.
More victims of domestic violence to enter education and employment	-	-
Fewer marginalised people		
Fewer disadvantaged 15-17 year-olds to receive a criminal conviction	14.000	9 pct.
Fewer homeless	6.138	-
More people finishing treatment for drug abuse to be drug-free or have their addiction reduced or stabilised.	17.500	40 pct.
More people receiving public treatment for alcohol abuse to finish treatment alcohol-free, with reduced alcohol consumption or a relevant referral	13.500	37 pct.
More people outside the labour market and not in education to be involved in voluntary activities	370.000	26 pct.

Note: *) The proficiency levels of disadvantaged children and young people in reading and maths are calculated according to the average scores in national tests (norm referenced results 0.100). The average score is a simple average of results of national tests for different age groups at different grade levels, each covering three profile areas. See also Note to figure 3.1.

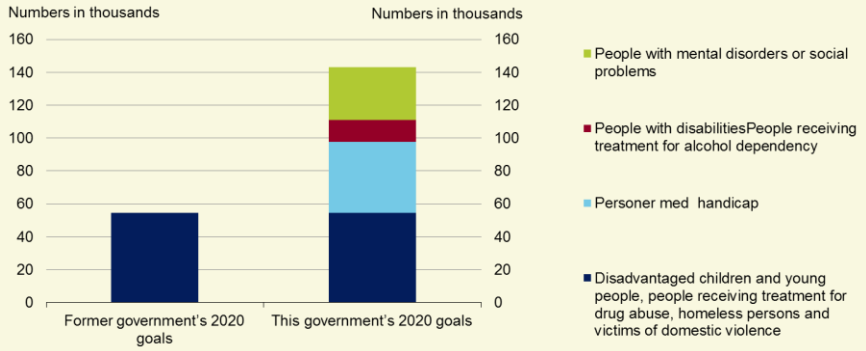
Source: See Chapter 3 on Monitoring the social goals.

Earlier in the past the social area have operated with goals. These new goals were established in close collaboration with voluntary organisations and Local Government Denmark (KL), following a service review of previous goals. Social service interventions are largely decentralised and conducted within the established legal framework. If centrally established social service goals are to work they need to be supported and adopted by a wide range of different parties. The service review has therefore concentrated on ensuring that the goals are considered relevant to the municipalities, case workers, voluntary organisations and users.

The new goals are geared towards many more groups covered by the social aera. New goals have now been set for large groups, such as people with disabilities, people with mental disorders and those receiving treatment for alcohol dependency, cf. figure 41.

Figure 41

People covered by the social goals before and after the service review



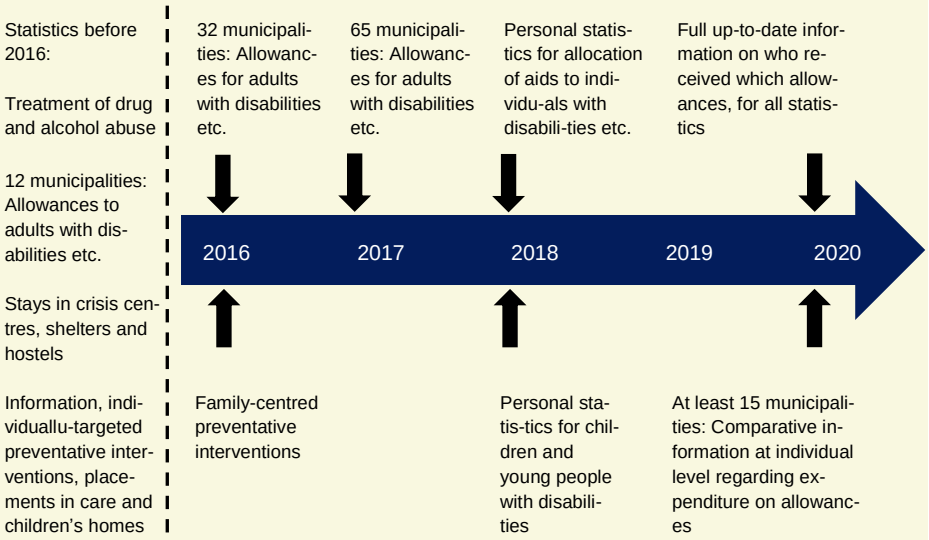
Note: See Chapter 3 on Monitoring the social goals.
Source: See Chapter 3 on Monitoring the social goals

Among other things, these goals will determine the government's priorities for negotiations concerning the National Social Fund (*satspuljemidler*) and other social service initiatives. They will also have a bearing on the instigation of analyses to provide fresh knowledge.

One of the crucial hurdles to acquiring more knowledge within the social sector is the lack of current high-quality data on those interventions that are initiated. Not enough is known today about who receives which interventions and allowances, when and at what cost. Consequently, a data strategy for the social area has been drawn up, designed to produce better data in the years to come: a strategy which will result in a regular supply of fresh statistics and knowledge, cf. figure 42.

Figure 42

Data on the social services



This publication is a translation of the first chapter of Socialpolitisk Redegørelse 2016. The other chapters in the report have not been translated.

The subsequent chapters provide detailed descriptions of the main results presented here and a number of other related topics:

Chapter 2 describes the social service target groups and takes a closer look at expenditure on different interventions and sub-target groups.

Chapter 3 expands upon and explains the government's social goals.

Chapter 4 explains interventions relating to children and young people in various age groups, with particular focus on this group's path through the education system.

Chapter 5 looks in more depth at the marginalised adults group, the diversity of the prob-lems facing this group and their complexity.

Chapter 6 takes a closer look at the potential for employment and education of people with disabilities.

Chapter 7 describes the data strategy and takes stock of progress so far.