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The role of training

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The **European Centre for the Development of Vocational Training** (Cedefop) is the European Union's reference centre for vocational education and training. We provide information on and analyses of vocational education and training systems, policies, research and practice.
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Foreword

Invest in people! Never before has this been so pertinent as nowadays.

In present times of rising unemployment and economic slowdown, investing in people's educational, health and social wellbeing, presupposes strong commitment to people as Europe's most valuable asset in the 21st century. This commitment over time should secure full participation in society for vulnerable groups.

The year 2010 was declared 'European year for combating poverty and social exclusion' to raise awareness of and remedy the weaknesses of our social systems in which between 83 and 84 million Europeans face the risk of poverty, representing 16.5% of the population ([1]). 'Combating poverty' figures among the 'five measurable EU targets for 2020' proposed in the communication from the Commission *Europe 2020. A European strategy for smart, sustainable and inclusive growth* of March 2010 (European Commission, 2010) and further consolidated by the Council conclusions on the social dimensions of education and training of 11 May 2010 (Council of the European Union, 2010).

With the above two initiatives, the European Union wishes to reaffirm the importance of collective responsibility for combating poverty and social exclusion and in reducing substantially the number of Europeans living in poverty. There are particular vulnerable groups more exposed to poverty and social exclusion than others, often with health problems too.

To give one example, in 2002 people with a disability' represented 16.2% of the EU population aged 16 to 64. People with disability showed employment rates (50%) significantly lower than people without disability (68%). In particular, employment rates were very low for people with severe (41%) and very severe disability (19%) ([2]).

In 2008, according to Eurostat ([3]), some 17% of people aged 15+ in the EU reported health-related limitations in performing daily activities (limitations of at least six months). People with health-related limitations are overrepresented in the poorest groups of the population (21% of the population with an income below 20% of the median income and 21% of the population with an income between 20% and 40% of the median income).

([1]) *Source:* data for 2008, Cedefop's calculation based on Eurostat, survey on income and living conditions [cited 22.7.2010].

([2]) *Source:* Eurostat, labour force survey, 2002 ad hoc module on employment of disabled persons [cited 22.7.2010].

([3]) *Source:* survey on income and living conditions [cited 22.7.2010].

Despite our social protection and security schemes, too many people fall under the category of 'vulnerable groups' since new groups such as the elderly, single-parent families, people with mental health problems or the homeless have joined the list of people with a disability, migrants and asylum-seekers or the long-term unemployed. At the same time, fundamental societal changes such as ageing of the population, globalisation and growing cultural diversity increase the need for social services for almost all categories of the population.

They all need targeted action plans and programmes, specialised services and support schemes, if they are to (re)-integrate into society and employment. The social care sector is called upon to provide them. As it is related to public health, national health care systems and to social protection, it should not be reduced to a mere economic activity given its importance for both human wellbeing and social cohesion. Ultimately, what differentiates it from the other sectors is it refers to people servicing other people in need. Therefore human rights, empowerment, codes of ethics and practice standards enter into play and have to be observed seriously.

However, it is widely agreed that current financial turmoil is putting funding of social services under extreme pressure. It is therefore very important to deliver services most effectively and efficiently or, in other words, provide good services at the right time and at a good price.

In parallel, the sector is expanding into one of the largest and a very important job providers. According to Eurostat ([4]), in EU-27, 21.5 million persons are employed in the health and social sector. Employment in this sector registered a rise of 24% since 2000 and represented in 2009 around 10% of total employment. This figure refers to a larger population of professionals in which social care is included. According to EASPD, the European Association of Service Providers for Persons with Disabilities, there are currently eight million formal carers to which an estimated equal number of informal carers should be added. Due to often poor working conditions the sector is not sufficiently attractive to young people. Resulting labour shortages are met by importing workers from 'newer' Member States or from non-EU countries.

As reported by research partners, in Denmark for instance, half a million people from eastern European countries work in the sector. The migrant labour force often has important language problems and no – or at least difficult to assess – qualifications and diplomas. Besides, it is less if at all, exposed to modern technology, which is an important part of caring. All these issues require major

([4]) *Source:* 2009 labour force survey [cited 22.7.2010].

focus on workforce development, training and retraining with particular attention on women, who constitute the vast majority of the labour force ([5]).

In addition, the current movement for deinstitutionalising care represents a major cultural change on how society and the sector understand disability, care delivery, recovery and patient autonomy. Care services need to be delivered in the community instead of institutions and new soft skills and competences are expected from professionals besides their specialised knowledge.

Against this complex and competitive background, and in conformity with Article 2 of the Treaty establishing the European Community – which lays down the tasks of promoting, inter alia, a high level of employment and social protection, raising the standard of living and quality of life and economic and social cohesion and solidarity throughout the Community, that Cedefop decided to analyse the skill needs and quality of service provision in the social and health care sectors.

The present study focuses on the competence needs of two groups of professionals, front-line workers and service managers/leaders in community-based services. Both groups' performances impact on the quality of care provided. Cedefop decided to focus on the professionals working with three most vulnerable and disadvantaged groups all with multiple, complex and long lasting needs in different key life domains: the elderly, the homeless and persons with disabilities.

Six generic competences for front-line staff, middle management and management were identified and further verified in discussions of focus groups set up in five European Member States representing different European social models and traditions: Scandinavian, continental, central-eastern, Mediterranean and Anglo-Saxon.

The six generic competences were further studied by analysing 18 innovative training and lifelong learning practices, selected in the above-mentioned Member States. Particular attention was also paid to the quality and transferability elements inherent in them.

The work produced a scenario on future skill demands based on a strategic vision of VET and lifelong learning in the social care sector. The scenario was validated by key European service organisations, as well as by the Disability Unit of DG Employment, Eurofound and DG EAC.

Finally, the study proposes a series of recommendations for policy-makers at European level, service-providers and VET providers to develop further the sector's human potential and increase its employability by alleviating handicaps for better socioprofessional inclusion of those in need.

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([5]) According to 2009 Eurostat labour force survey data, 78.5%, [cited 22.7.2010].

Acknowledgements

This report is a team effort, reflecting the work of Tina Bertzeletou, Cedefop's senior expert in charge of the project, and a research consortium led by both Professor Dr Chantal Van Audenhove, Director of LUCAS (Centre for Research and Consultancy in Care, KUL-Leuven) and Mr Luk Zelderloo, Secretary-General of EASPD (European Association of Service Providers for Persons with Disabilities) and composed of AWO (Arbeiterwohlfahrt), EPR (European Platform for Rehabilitation), FEANTSA (the European Federation of National Organisations Working with the Homeless), and Workability International – the European section ([6]).

Cedefop thanks project partners in the five Member States (Germany, Poland, Portugal, Sweden and the UK), who organised national focus groups to discuss research hypotheses, provide information on the care needs of the three target groups (the elderly, the homeless and persons with disabilities), define and compare the competences of innovative front-line workers and service managers and analyse three cases per country. The full list of consortium members can be found in Annex 1.

Cedefop also expresses its gratitude to those working in the sector who agreed to participate in the focus groups.

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([6]) The work was carried out under Cedefop's service contract No 2008-0175/AO/ECVL/TB/Quality-in-VET/021/08 Lot 1.

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Executive summary

Health and social services are one of the largest growing economic sectors. The European Union (EU) uses a very broad definition of social services. They can be grouped into two broad types: statutory and complementary social security schemes and other services provided directly to a person. The latter play a preventive and socially cohesive role, such as social assistance services, employment and training services, childcare or long-term care services for the elderly and disability services. This study focuses on this second type. These sectors are challenged by fundamental societal changes (such as the ageing population, globalisation, growing cultural diversity) and new policy trends such as deinstitutionalisation of social care, new public management and evidence-based practices. These fundamental changes demand new skills and competences of front-line workers and managers in the social and health services. They also challenge current vocational education and training (VET) programmes to adapt to these changes.

This study has three goals:

- identification of the main societal and policy changes and their consequences for the social care sector;
- identification of generic competences of front-line workers and management;
- gathering and analysis of good practices of VET in the social care sector.

Societal and policy changes

The EU is experiencing significant ageing of the population. As a result, less active people will be available on the labour market. These demographic changes also lead to growing and changing demands for care and for care workers (OECD, 2005b). On the labour market, there are fewer low-skilled jobs available so unemployment is more strongly related to educational status. Delaying marriage and births is an expression of citizens' new life priorities as well as constraints since families hesitate to have children because of the difficulties of combining a job with raising children. Family breakdown is a relatively new social risk, since single-parent families face a significantly higher poverty risk. Individualisation refers to the process where individuals have to shape their own life courses and make choices continuously. In other words, the life course is less programmed by gender, social class, religion or

neighbourhood. More people find it difficult to create their own place in society. Europe has also become more culturally diverse because of migration. Cohabitation of people of different cultural backgrounds is one of the most compelling challenges for the EU. It is estimated that if our approach to climate and environmental protection does not change profoundly, by 2050 there may be 200 million 'climate migrants' in the world (Brown, 2008). Scientific evidence also shows the negative impact of social inequality in health, psychosocial problems, crime and less social cohesion. One of the new vulnerable groups are those with mental health problems. Mental disorders constitute a major part of the European burden of disease (European Commission, 2008c). In any given year, a quarter of Europeans are likely to be affected by mental disorders, while less than half will have contact with health services. In addition, projections show growing psychic vulnerability. In 2020, depression, alcohol abuse, dementia and self-inflicted harm will be among the 10 leading causes of disability-adjusted life years and will contribute to more than one quarter of the total disability burden in developed countries. Minorities, migrants and asylum-seekers are also relatively new vulnerable groups (Huber et al., 2006).

Policies towards social and health services are characterised by new public management, the growing importance of the European method of coordination, deinstitutionalisation of social care, the breakthrough of evidence-based practice and new, more emancipatory approaches based on human rights, empowerment and inclusion. Deinstitutionalisation of social care deserves special attention. It refers to replacing residential institutions with community-based services to enable people to become fully participating members of the community. This causes a paradigmatic change in social care: instead of bringing the users to the institutions, services have to be brought to users. Social services also have to function more and more in a market-driven environment.

At the same time, large differences exist between health care and social care services across Member States. Social care models in the EU can be summed up in four categories:

- residual model;
- Scandinavian model;
- corporatist model;
- family care model (Eurofound, 2006).

The residual model relies on means-tested services and benefits and is most prevalent in the UK. The corporatist welfare State follows the Bismarck model and is linked to Belgium, Germany, France, the Netherlands and Austria . Labour market participation is the central guarantee for being entitled to social protection. For social services, subsidiarity is the core value. Non-profit services are

subsidised by the government to provide social care. In the family care model (Spain, Greece, Italy, Portugal), the family is the main provider of social care and the State only provides very modest services. This causes a heavy burden on informal care and drives families to the grey economy. Most central eastern countries can also be allocated to this model. In the Scandinavian model, a broad range of high-standard care is provided by the State and local authorities.

These differences in welfare State regimes also influence social and health services. In general, employment in these services is growing strongly. From 2000 to 2009, about 4.2 million new jobs were created in EU-27 (+24%). This represents around a fifth of growth of the whole services sector ([7]). Employment in the health and social care sector continued to grow (+0.6 million jobs, +2.6%) even between 2008 and 2009, despite the crisis, which provoked at the same time a drop of -1.8% in total occupation and a stagnation in employment in services. However, the share of employment in health and social services in total employment is very different throughout the EU. It is relatively small in southern, central and eastern countries, but is high in some northern and western European countries.

Due to these societal and policy changes, the need for social services will increase, while social services are confronted with a growing shortage of care workers. The public image of social care is also less valued and working conditions are not sufficient to attract enough new workers. In other words, societal and policy changes increase pressure on social care workers while these social services have to convince new workers to work in their sector. In particular, mobility of care workers from new Member States or even from outside the EU is believed to be a solution for these shortages. However, they often have language problems and no specific training. It is an enormous challenge to train these new workers and guarantee the current quality of social care.

Generic competences in the social care sector

In this study, competences are defined as the ability to use and integrate knowledge, skills and attitudes to realise specific goals. By using the term attitude, it is made explicit that care work has an important ethical component. Generic competences can be defined as shared knowledge, skills and attitudes of different occupational groups of social care staff.

([7]) Cedefop's calculation based on Eurostat, labour force survey [cited 15.7.2010].

Nowadays, specialised education and competences are highly valued. Social care workers are under pressure to specialise in specific target groups and/or specific methods. However, these specialist competences can possibly lead to neglect of generic competences, which aid cooperation between different professional groups, since they provide a common language. In addition, research shows that these generic competences increase the effectiveness of social care interventions (Wampold et al., 1997). Although the study focuses on generic competences, it recognises the importance of specialist competences to work with specific target groups or in specific social services. However, specialist competences seem already better covered in existing VET standards and in regulating the professions.

The study focuses on generic competences needed to support care providers working with difficult target groups. Their problems are related to physical, psychological or mental health, vulnerability to stress, lack of basic coping skills, limited transfer of learning experiences, addiction problems and behavioural difficulties. It concerns persons with ongoing (or even lifelong) needs for support in different key domains of life or long-term care. The OECD (2005a) has defined long-term support as a cross-cutting policy issue that brings together a range of services for persons who are dependent on help with basic activities of daily living over an extended period of time. Elements of long-term support include, medical treatment for long-term conditions, home nursing, social support, housing, employment and services such as transport or meals. Different professional groups are responsible for these various social and health interventions.

This study focuses on front-line social care workers and managers. Since front-line workers have face-to-face contact with the target group, they have an essential function in delivery of social services. Managers were selected, since they are responsible to adapt social and health services to the challenges caused by social and policy changes.

The literature review led to five generic competences of front-line workers to:

- coordinate services in different life domains;
- create an inclusive community and fight stigma and discrimination;
- empower service users based on a human rights perspective and encourage their participation;
- build a relationship of trust with service users characterised by ‘low expressed emotion’ and a recovery-oriented approach;
- build partnerships with informal support providers.

At organisational level, innovative team models were identified. In transdisciplinary teams, the aim was to pool and integrate the expertise of

different team members to develop more effective assessments and interventions. For social care leaders, the literature review pointed to the following competences: be able to centralise by mission and decentralise by operations; create an organisational culture that identifies and tries to live by key values; create an organisational structure and culture that empowers their employees and themselves and ensure that staff are trained in human technology.

Focus groups consisting of social care workers, managers, VET providers and service users were organised in five countries. Based on the rich data of the focus groups, six groups of generic competences were defined. The first are personal characteristics and attitudes, such as assertiveness, empathy, patience. Second, because the quality of the relationship between the care worker and the client strongly influences the effectiveness of social care interventions, front-line workers need to have the ability to build relationships based on trust and communicate effectively with service users. The third group of skills relates to being able to transfer knowledge into practice. Fourth, empowerment is strongly stressed in all focus groups. Fifth, brokerage skills refer to skills to assist service users to benefit from the services they need. The last category of generic competence relates to teamwork: front-line workers have to be able to work in teams consisting of different care workers in various disciplines.

Results of the literature review and the focus groups were compared and discussed with various stakeholders during a hearing. The discussion resulted in a list of six generic competences:

(a) **empowerment:**
- recognise and respect individual rights and human dignity;
- view people as subjects and as holders of rights and not as objects;
- focus on strengths instead of problems;
- improve and stimulate self-realisation, self-determination and personal mastery over one's own life;
- ensure equal enjoyment of all human rights without discrimination;
- involve service users in decision-making;

(b) **brokerage skills:**
- assist service users to identify, access and benefit from relevant community services in different life domains (social security, employment, housing, leisure activities, health services, etc.);
- assist service users to develop a natural support system consisting of friends and family;
- work with local communities to create an inclusive and accepting environment in which everyone can participate;

(c) **multicultural diversity:**
- respect different cultures and be sensitive to cultural differences;
- adapt interventions to different cultures and search for ethno-sensitive interventions;

(d) **transdisciplinary teamwork:**
- share roles systematically with team members across discipline boundaries;
- pool and integrate the expertise of team members to provide more efficient and comprehensive assessment and intervention services;
- communicate with all members in a regular, planned and continuous give-and-take way;
- teach, learn, and work together with professionals from different disciplines, to accomplish a common set of intervention goals;
- differentiate between disciplines based on the situation rather than on discipline-specific characteristics;
- carry out assessment, intervention, and evaluation jointly with team members;

(e) **knowledge management skills:**
- transfer theoretical knowledge into practice;
- transfer knowledge to other social services and social care sectors;
- integrate new technological developments into social services;

(f) **leadership:**
- create an organisational culture based on a central vision and key values;
- entrepreneurship;
- manage change.

This study identifies three essential generic competences of innovative leadership. The first relates to the way social service leaders communicate, support and reinforce an organisational vision. Leaders ensure the vision is a shared vision and identify its relevance to service users. Leaders use central values as anchors and guidelines for decisions. The second competence is entrepreneurship. Due to new public management and new steering instruments such as tendering procedures and introduction of quasi-markets, social service leaders need more entrepreneurial skills to obtain public means and show the results of their actions. The third competence is managing change. Since society is changing very fast, social services are constantly challenged to analyse their functioning and to search for other and better answers to evolving needs of changing vulnerable groups. Consequently, social service leaders ease, monitor and evaluate organisational change.

Innovative vocational education and training

Based on Cedefop's definition (2008c), VET comprises all more or less organised or structured activities – whether or not they lead to a recognised qualification – which aim to provide people with knowledge, skills and competences necessary and sufficient to perform a job or a set of jobs. Trainees in initial or continuing training thus undertake work preparation or adapt their skills to changing requirements. VET is independent of its venue, age or other characteristics of participants, and of their previous level of qualification. VET content could be job-specific, directed at a broader range of jobs or occupations, or a mixture of both; VET may also include general education elements. However, the definition of VET and continuing training (CVT) in individual countries varies considerably.

In the five selected Member States, good cases of VET programmes on generic competences were collected and analysed. Based on this material, five recent trends can be highlighted as innovative characteristics. They refer to:

- participation in VET of service users themselves;
- VET being organised at European level in the two cases initiated and reported by the European Platform for Rehabilitation;
- cooperation with knowledge-producing centres such as universities or colleges for sustainable updating of teaching content;
- importance of combining theoretical knowledge and practical experience;
- systematic promotion of innovative use of European Funds.

Involving social care workers and employers helps to customise training, while involving trainees provides valuable feedback for further development and improvement of training offered. Assessing students/trainees should form an integral part of curricula. Most of the 18 cases of good practice included in the present study have feedback mechanisms based on evaluation by students/trainees. Significantly, another group of stakeholders, namely service users, are progressively becoming interested in planning, implementing or evaluating VET, claiming an active role in this.

Policy recommendations

On the one hand, societal and policy changes increase demand for social care services. On the other, these services are confronted with growing shortages of social care workers. These fundamental changes demand new skills and competences of front-line workers and managers in social and health services as well as innovative VET programmes. VET has to play an essential role to help

these sectors face current challenges. To realise their potential, investments are needed in VET.

Generic competences are less valued, but are needed to make the social care sector more demand-oriented and effective. They apply to all professional groups operating at the front-line of social care organisations. These generic competences need more attention from policy-makers, social care workers, managers and VET providers.

Based on the good practices analysed, this study highlights six policy recommendations to make VET programmes more effective and innovative:

- involvement of service users in VET;
- VET programmes organised at the European level;
- strengthening of the cooperation with research institutions (universities, university colleges);
- European grants as drivers for change;
- combination of different learning methods;
- transdisciplinary learning between different professional groups.

To guarantee the quality of VET, this study shows at least five quality assurance measures:

- involvement of stakeholders in the different phases of the quality circle;
- flexible programmes which make a more tailor-made approach possible;
- assessment of the effects of VET on trainees, the organisation and on the quality of care (goal attainment);
- cooperation with universities or other knowledge centres to link VET to research and development;
- assess trainees' satisfaction, learning processes and (objective) learning outcomes.

One of the greatest challenges is to assess the impact of VET on social care workers and their organisations. To improve sustainability of VET programmes, more research into the effects of such programmes is needed. More cooperation between researchers and VET programmes is necessary to assess these effects more validly.

1. Introduction and methodology

This first chapter introduces into the aims of the study, its methodology and describes the content of the chapters of this report.

1.1. The goals of this study

This study has three main goals. The first is to identify current societal changes, policy trends and challenges facing health and social services. The second is to identify generic competences of front-line workers and leaders. The third is to gather and analyse innovative VET programmes in the social care sector.

First, social and health services are one of the largest growing economic sectors. The EU uses a very broad definition of social services. They can be regrouped into two broad types of services, the functions and organisation of which can vary a great deal across the EU: on the one hand, statutory and complementary social security schemes and on the other, other services provided directly to the individual that play a preventive and socially cohesive role, such as social assistance services, employment and training services, childcare or long-term care services for the elderly, disabled, or mentally ill. This study focuses on the second type of services. These sectors are challenged by fundamental social changes, such as ageing population, globalisation and growing cultural diversity. The social care sector is also steered by new policy mechanisms such as new public management and evidence-based practice. At the same time, large residential institutions are being replaced by community-based services. This deinstitutionalisation of care refers to a fundamental shift: instead of delivering social care in institutions, services have to be brought to service users in their natural environment. In other words, the social care sector is undergoing fundamental changes. These changes demand new skills and competences of front-line workers and managers in social and health services. They also challenge current VET programmes to adapt to these changes.

Second, this study focuses on generic competences which can be defined as shared knowledge, skills and attitudes of different occupational groups of social care workers. Social care workers are under pressure to specialise in specific target groups and/or specific methods. However, these specialist competences can possibly lead to neglect of generic competences, which are necessary for cooperation between different professional groups and which make social care

interventions more effective. Although the study focuses on generic competences, it recognises the importance of specialist competences to work with specific target groups or in specific social services. However, specialist competences seem already better covered in existing VET standards and in regulating the professions. Focus is on the generic competences needed to support care providers working with difficult target groups with ongoing needs for support in different key domains of life.

This study is limited to front-line social care workers and managers. Since front-line workers have face-to-face contacts with the target groups, they have an essential function in delivery of services. Managers were selected as they are responsible for adapting social and health services to the challenges caused by social and policy changes.

Innovative VET programmes which focus on identified generic competences were gathered and analysed. Special attention was paid to quality assurance through involvement of stakeholders and evaluation methods.

1.2. Methodology

Identification of current societal and policy changes was based on a literature review of evidence from scientific journals, studies commissioned by the EU, European policy documents and data from Eurostat and OECD.

Generic competences were identified by two methods: literature review and focus groups in the five participating countries (Germany, Poland, Portugal, Sweden and United Kingdom). They represent different social care models in the EU. Composition of the focus groups was characterised by large diversity which reflects the broad spectrum of the social care sector itself. Participants in focus groups work in social services and institutions for the elderly, disabled or homeless. Their diverse professional backgrounds enrich the present study. National partners took care of practical aspects, such as inviting candidates and setting up meetings. National partners received a manual on practical organisation, methodological rules and content for focus groups' work. Three topics were covered by focus groups. The first were the main societal and policy challenges and their effects on the social care sector in the countries under investigation. The second concerned the needed generic competences for front-line staff. In particular, they were asked to describe the ideal front-line worker. The third concerned the qualities and competences characterising good leadership in community-based services.

To validate the results of both the literature review on societal changes and on generic competences, a hearing group was organised composed of representatives of a broad range of non-governmental organisations (NGOs).This broadened the view on both topics and brought in new perspectives. Hearing group participants were also asked to comment on the material gathered in the focus groups.

On the third aim, national partners selected good VET practices, based on a semi-standardised questionnaire in which, a broad definition of VET was used. Thus, VET comprises all more or less organised or structured activities – whether or not leading to a recognised qualification – which aims to provide people with knowledge, skills and competences necessary and sufficient to perform a job or a set of activities. The first part of the questionnaire dealt with content of the VET programme:

- what are the main objectives of VET;
- describe how these goals are linked toone of the generic competences of this study;
- what is the target group of this VET;
- what is the main content of this VET course (different modules or topics);
- who organises the programme: a social service provider or a training institute;
- how is the VET financed;
- to what extent have learners to pay for the VET programme? Do people have to pay themselves or will employers/authorities pay;
- didactical approach: what learning methods are used to support participants to acquire new competences?

The second part of the questionnaire focused on quality assurance and was mainly based on the European quality assurance reference framework for VET (EQARF). National partners were asked to document the following six topics related to quality assurance:

- is there permanent evaluation and corrective coordination during training to fine-tune the VET process to participants' needs;
- how is the VET programme evaluated at the end;
- how do different forms of evaluation lead to quality improvement of VET training;
- how are the main stakeholders involved and consulted to identify training needs;
- certification;
- accreditation of VET?

To validate the conclusions of this study, a new hearing group was organised. They had the opportunity to discuss the main results and enrich them. In addition, they were asked to comment on the policy recommendations.

1.3. Structure of the report

The report is composed of five chapters. Chapter 2 identifies current societal changes, policy trends and challenges of the health and social services as an economic sector. These social and policy trends are illustrated with relevant research evidence from scientific journals and studies commissioned by the EU and with comparative data from Eurostat and OECD.

Chapter 3 identifies the generic competences needed in long-term care for vulnerable persons with often complex and multiple problems. It is based on literature review of scientific evidence on generic competences. The first part defines generic competences. Then an overview of recent research evidence of generic competences for front-line workers is presented. The third part focuses on the characteristics of good leadership in social care services. The fourth part summarises the main conclusions and redefines the evidence into categories of generic competences.

Chapter 4 reports on the material from the five national focus groups, which were organised in five Member States: Germany, Poland, Portugal, Sweden and the UK, because of their different cultural, social and welfare State regimes. First, the characteristics of participants inthe focus groups are described. Second, a brief overview of the challenges each country is facing is provided. Then, a comparison between countries is made to develop the main differences and similarities. Third, this information is compared with the literature review on generic competences. This comparison leads to a list of six generic competences. This chapter ends with a report on the first hearing group organised to validate the results of the literature review and the main conclusions of the focus groups.

Chapter 5 describes the gathering and analysis of innovative VET practices which are linked to the six generic competences. These VET programmes were selected in the five different Member States and analysed under a quality assurance perspective to underline their potential for implementation in other countries with different sector contexts.

Chapter 6 formulates the policy recommendations of this study. These results were validated by a broad group of representatives from European organisations.

2. Societal and policy changes: modernising social services of general interest

This chapter analyses the main societal and policy changes and their effects on social protection in general and on the social care sector specifically. Social protection systems are highly developed in the EU. They protect people against the risks of inadequate income associated with unemployment, illness and invalidity, parental responsibilities, old age or loss of a spouse or parent. They also guarantee access to health and social services essential for a life of dignity. These social services provided directly to the individual play a preventive and socially cohesive role, such as social assistance services, employment and training services, social housing, childcare or long-term care services. These services are vital to society and provide an important contribution to the fulfilment of objectives such as social, economic and territorial cohesion, a high level of employment, social inclusion and economic growth. These social protection systems are challenged by current demographic, economic and social changes such as the ageing population (Esping-Andersen, 2005). The way society will function in the future depends on how the welfare State will adapt as a response to these changes. In health and social care, societal changes are often reduced to the consequences of an ageing population. This certainly is one of the main challenges, but at the same time family and labour market changes and their impact on formal and informal care should not be ignored (Esping-Andersen et al., 2002; Ferrera et al., 2000, European Commission, 2006a; European Commission, 2008a; European Commission, 2008b, Taylor-Gooby, 2004; Huber et al., 2006). Consequently, health and social services have to deal with a growing amount of adult and elderly persons who need long-term care (OECD, 2005a; European Commission, 2008c).

Current developments and trends in society have a crucial impact on social and health services because they create new needs in education, training and human resources in the social care sector. Societal changes and their effects are discussed separately, in terms of new target groups and demands, current policy trends in health and social services and social and health services as an economic sector. As an economic sector, the health and social services are one of the strongest growing sectors of job creation and face the current challenge of growing shortages of professional workers (Huber et al., 2006, European

Commission, 2008a; European Commission, 2008b; European Commission, 2008c; OECD, 2005a; OECD, 2008; Evers, 2006).

2.1. Societal changes

Social protection systems and social services were established in the second half of the 20th century. That period was characterised by specific societal arrangements within 'primary' relationships (the breadwinner model), in the labour market (dominance of industrial and contractual labour based on contracts unlimited in time) and in labour relationships (capitalism with the safety net of the welfare State). As a consequence of transition to a post-industrial knowledge society, this situation of relative peace was disturbed. First, globalisation and increased international competition impacted negatively on public spending. The labour market is strongly affected as well, since specific groups have difficulties finding a job. Second, demographic changes challenge the welfare State in terms of financing pensions and health care for the elderly while the active population is decreasing. Third, the family as an institution changed radically. These societal changes create new needs and expectations which existing services cannot easily satisfy (changes on the demand side). As a consequence, social protection systems and social services are challenged to respond to these changes by adapting themselves and developing new services.

2.1.1. Demographic changes

The first and most compelling social change is the ageing population. As a result, a diminishing group of economically active people are and will be responsible for a growing group of economically elderly and inactive. Ageing of the EU's population is the result of four interactive demographic trends (European Commission, 2006a). First, the post-war baby boom caused a bulge in the size of the population aged 45 to 65. This will lead to a substantial increase of the proportion of old people. Second, the current fertility rate is low, estimated at around 1.5 children per woman for EU-27 in 2010, and is substantially below the replacement rate of 2.1 children per woman required to stabilise the population size. Third, life expectancy will continue to rise by at least a further five years by 2050 ([8]), causing a strong increase of the frail elderly (80+). Fourth, the effects of immigration remain unclear. Europe is already the recipient of major migration inflows from non-EU countries. The EU will probably remain a popular

([8]) Eurostat, population projections 2008, convergence scenario [cited 15.7.2010].

destination. Eurostat's conservative projection is that around 40 million people will emigrate to the EU between now and 2050, most being working-age adults. As a consequence, they bring down the mean population age. However, it remains very difficult to forecast the effects of migration, mainly because immigration is strongly influenced by political measures. Table 1 shows projections for the EU's population trends between 2010 and 2050. The total population will increase by 3.2%, but its composition will change dramatically. The percentage of children decrease is expected to be higher than 6.5%, while the percentages of elderly and especially the frail elderly are projected to increase dramatically by 44.5% and 143.6% respectively.

Table 1. **Projections for EU's population trend 2010-50**

Age group	Change 2010-50	Values
Total population	Change in thousands	15 914
	Percentage change	*3.2%*
Children (0-14)	Change in thousands	- 5 211
	Percentage change	*-6.7%*
Young people (15-24)	Change in thousands	- 9 594
	Percentage change	*-15.9%*
Young adults (25-39)	Change in thousands	-16 527
	Percentage change	*-15.8%*
Adults (40-54)	Change in thousands	-18 502
	Percentage change	*-17.0%*
Older workers (55-64)	Change in thousands	4 079
	Percentage change	*6.7%*
Elderly people (65-79)	Change in thousands	28 285
	Percentage change	*44.5%*
Frail elderly (80+)	Change in thousands	33 385
	Percentage change	*143.6%*

Source: Eurostat, population projections, Europop 2008 – Convergence scenario, national level [cited 15.7.2010].

These demographic changes will certainly result in growing and changing demand for care. The expected increase in the demand for formal care cannot be solely explained by the population ageing. First, the number of working age women able to provide informal care will decrease. Second, because of their labour market participation, women have less time at their disposal to provide informal care. Third, changing family structures such as smaller families and

single-parent families provide lesser prospects for care. These three social changes will be discussed later. As a consequence, more formal care workers will be needed, but if the active population diminishes, the amount of professional care workers will also decrease. The ageing population also draws attention to the problem of dementia and demand for early detection and well-adapted care. At the same time, the large group of healthy elderly people who are still very active and who wish to continue to participate actively in society should not be overlooked.

2.1.2. Economic changes

On the economy, two main fundamental changes in the past 20 years can be considered. Economic globalisation has caused growing economic interdependence of countries as a result of heightened cross-national transactions. Second, the industrial economy has been replaced by a knowledge-based economy.

2.1.2.1. *Globalisation*

Globalisation of the economy is characterised by the simultaneous interaction of four macro structural trends (Bucholz et al., 2009). The first refers to increasing internationalisation of markets and growth in competition between countries with different wage and productivity levels. In other words, national borders are less relevant for all kinds of economic transitions (Mills, 2009). International regulatory institutions such as the International Monetary Fund and the World Bank operate to ease capital flows and liberalise financial markets. The second characteristic is intensification of competition between nation States. States try to improve their competitive positions by reducing taxes, deregulation, privatisation and liberalisation. Third, the rapid worldwide networking of persons, companies and States through new information and communication technologies such as microcomputers and the Internet, results in increasing global interdependence. Although introduction of this technology is not unique in itself, recent ICTs radically influence the scope, (widening reach of networks of social activity), intensity and velocity (Mills, 2009). The fourth phenomenon is that these globally integrated markets are much more vulnerable to scarcely predictable social, political and economic external shocks throughout the world (such as the current financial and economic crisis).

2.1.2.2. *From industrial to knowledge society*

In recent years the concept of the knowledge economy and the network society has become dominant. Castells (1997) considers them as interrelated. One of the

key features of informational society is the networking logic of its basic structure, which explains using the concept of network society. Castells (1997) sees informationalism as a new technological paradigm. Information generation, processing, and transmission have become the fundamental sources of productivity and power. As such, informationalism has replaced industrialism which was characterised by a factory system and mechanisation; mass production, standardisation of production processes and products.

At the Lisbon Summit in March 2000, the EU acknowledged the breakthrough of the knowledge society by setting a new goal for the EU – to become the most competitive knowledge-based society in the world by 2010. The summit took place amid growing awareness of the paradigm shift in the world economy driven by globalisation and rapid technological development. Widespread application of new information technologies was considered the main driving force behind unprecedented sustained expansion of the US economy. Many economists believe that the productivity gains resulting from the spread of these technologies have shifted the US to a higher growth trajectory without fuelling inflation. EU growth rates, on the other hand, have consistently failed to match those of the US in the past 10 years and, for every percentage point of growth, Europe creates fewer jobs.

2.1.2.3. *Labour market consequences*

The move to a global economy has had a profound impact on employment opportunities and the features of careers (Spilerman, 2009, p.76). In western countries, demand for low-skilled labour has diminished because firms locate their low-skilled activities in low-wage countries and emerging economies (Marx, 2007). As a consequence, western countries have expanded economic activities in which knowledge and information technologies play a central role. However, the gap between low-skilled and high- skilled is growing, especially in western Europe. European low-skilled workers have difficulties finding a job, often resulting in long-term unemployment. A less expected trend is migration of high-skilled jobs to emerging economies. Some nations, such as China and India have been rapidly raising the education level of their workforce. As a result, these countries also attract high-skilled activities.

Thus, globalisation of the economy and transition to a knowledge society have caused a growing gap between low-skilled and high-skilled employees, a new social rift. However, education is not the only explanation for these labour inequalities; age is also a relevant factor. Buchholz et al. (2009) consider young people as the ‘losers’ of globalisation. Young people have difficulties finding a job and their first jobs are often characterised by insecurity, short-term contracts and

extreme flexibility. They are threatened to become 'permanent temporary employees' (Castel, 1995). These are employees which alternate between different short-term jobs. Because of this growing insecurity, young people develop various strategies to postpone long-term commitments and responsibilities. They search for alternatives for jobs, such as longer study instead of employment. These strategies have also a gender dimension. Male youngsters find it difficult to take up the role of the 'breadwinner' and postpone family life, while young women with less employment opportunities exit the labour market sooner or later. It can be concluded that current labour markets in the EU are characterised by a clear-cut segmentation based on education level and age. Especially young employees and the low-skilled have fewer chances on the labour market.

A third important labour market characteristic is the effect of external shocks such as the current financial crisis which has had a tremendous effect on unemployment rates. The euro area (EA16) ([9]) seasonally-adjusted unemployment rate ([10]) was 8.5% in February 2009, compared to 8.3% in January 2009. It was 7.2% in February 2008. The EU-27 unemployment rate was 7.9% in February 2009, compared to 7.7% in January. It was 6.8% in February 2008. Eurostat estimates that 19.156 million men and women in EU-27, of whom 13.486 million living in the euro area, were unemployed in February 2009. Compared to January, the number of unemployed persons increased by 478 000 in EU-27 and by 319 000 in the euro area. Compared to February 2008, unemployment rose 3019 million in EU-27 and 2.125 million in the euro area. The impact of the financial crisis in the longer term is hard to predict.

Despite this negative interpretation of the effects of globalisation, Blossfeld et al. (2009) state the impact of the welfare State is indeed weakened but not outplayed. Welfare States with a strong social safety net and education system can still absorb better the negative effects of globalisation. Some States score

([9]) The euro area (EA16) consists of Belgium, Germany, Ireland, Greece, Spain, France, Italy, Cyprus, Luxembourg, Malta, the Netherlands, Austria, Portugal, Slovenia, Slovakia and Finland.

([10]) Eurostat produces harmonised unemployment rates for individual EU Member States, the euro area and the EU. These unemployment rates are based on the definition recommended by the International Labour Organisation (ILO). The measurement is based on a harmonised source, the European Union labour force survey (LFS). Based on the ILO definition, Eurostat defines unemployed persons as persons aged 15 to 74 who are without work; are available to start work within the next two weeks; and have actively sought employment at some time during the previous four weeks. The *unemployment rate* is the number of people unemployed as a percentage of the labour force. The labour force is the total number of people employed plus unemployed. Monthly unemployment and employment series are calculated first at the level of four categories for each Member State (males and females 15-24 years, males and females 25-74 years). These series are then seasonally adjusted and all the national and European aggregates are calculated.

higher on education and training of low-skilled unemployed to improve their labour market positions. Marx (2007) has to admit that there is less evidence of the ingredients and processes explaining these positive outcomes.

2.1.2.4. *Employment trends for 2020*

Europe must focus more on skills than before the crisis. This is the message Cedefop sends to all stakeholders based on its most recent skills demand and supply forecasts covering the period from 2010 to 2020 (Cedefop, 2010).

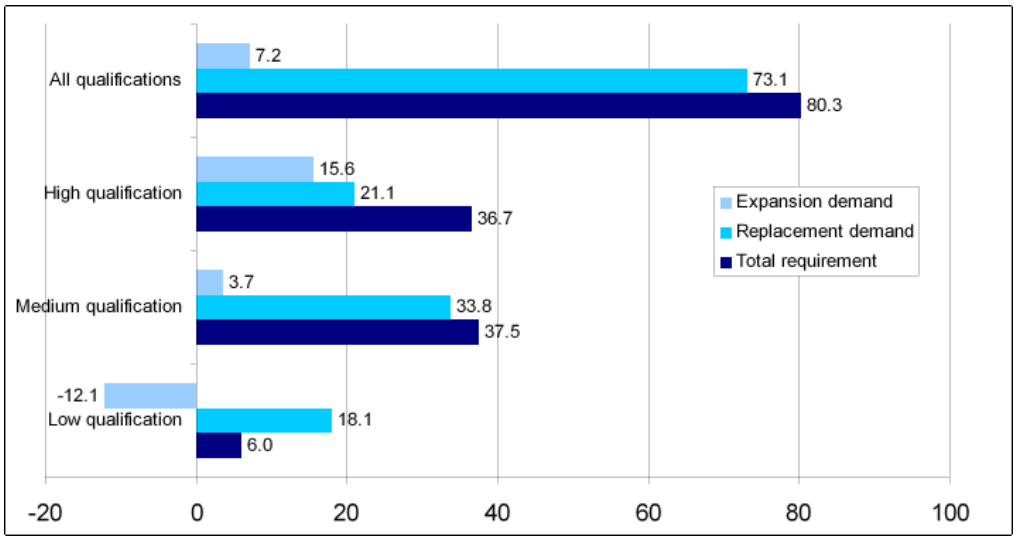
Between now and the next few years, there will be probably 10 million fewer jobs than would have been expected without the crisis. Seven million jobs are expected to be created between now and 2020, following a scenario of modest recovery.

However, recession will impact differently on qualifications, jobs and sectors.

On skill supply, a substantial increase of 16 million is projected for holders of a university or equivalent degree, whereas only one million for those with a medium-level (mainly vocational) qualification and a decrease of around 15 million for those with low-level qualifications. Decline of the low-skilled labour force will be general in all Europe and sharper for women than for men.

Future skills demand is projected to rise by almost 16 million for highly-qualified people and by more than 3.5 million for medium-level qualified. Demand for low-skilled workers is expected to decrease by around 12 million (see Figure 1).

Figure 1. **Total requirement by qualification level, change 2010-20 in millions, EU-25+**



Source: Cedefop (Cedefop (IER estimates based on E3ME, EDMOD and RDMOD).)

Conversely, the share of highly-qualified jobs will increase from 29% in 2010 to about 35% in 2020, whereas the share of medium-qualified jobs will remain significant at about 50%. However, the share of jobs for the low-qualified is expected to decrease from 20% to less than 15% for the same period.

2.1.2.5. *The knowledge economy and lifelong learning*

All these trends and challenges underscore the importance of lifelong learning, formal education and informal as well as VET. As a consequence, the EU considers VET an important factor for the EU's drive to become competitive and socially cohesive, as outlined in the Lisbon strategy. Reinforcement of a knowledge-based society underpinning the Lisbon strategy requires a more future-oriented design of VET, involving new approaches to learning in formal and informal learning environments.

According to Eurostat ([11]), in EU-27, 9.4% of the population aged 25 to 64 participated in education/training (over the four weeks prior to the survey). Such learning activities are more prevalent in Denmark, Finland, Sweden and the UK. Women, the young and the qualified participate more in education and training. About 6 out of 10 Europeans have not participated in lifelong learning during the whole year ([12]). This level is even higher in Greece, Spain, Italy, Latvia, Hungary, Poland and Portugal. As such, there is some way to go to improve lifelong learning systems in Europe.

2.1.3. The family

In the past, the second pillar of the labour market was the traditional division of roles between men and women. Full employment was often only full employment for men, since women were expected to take care of the children and housekeeping. Moreover, men and women were supposed to engage in a permanent relationship in the form of marriage. Women liberated themselves from traditional role patterns in the 1970s, and sought fulfilment of their own needs. Marriage as an institution lost its dominance.

This 'revolution' of women's roles is arguably one of the most dynamic sources of change in contemporary society (Esping-Andersen, 2005). At present, female employment ranges from less than 50% in southern Europe to more than 75% in Scandinavia. This gap may narrow sooner than expected since young

([11]) Labour force survey, 2008. Indicator 'participation in lifelong learning'. Available from Internet: http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=en&pcode=tsiem080&plugin=1 [cited 15.7.2010].

([12]) Eurostat, adult education survey, 2007. Indicator 'non-participation in lifelong learning'. Available from Internet: http://epp.eurostat.ec.europa.eu/portal/page/portal/education/data/database [cited 15.7.2010].

Italian and Spanish women's activity rates are catching up rapidly. It also implies that families' ability to internalise caring responsibilities will diminish and, hence, especially the familial tradition of the corporatist and Mediterranean welfare State must be reconsidered since families and especially women have less time for caring duties ([13]). Women's new economic role is generally good news but it also heralds the arrival of mounting welfare problems. Delaying marriage and births is an expression of citizens' new life priorities (such as more education) but also of constraints because women hesitate to have children until their job situation is secure. Fertility rates of post-war generations have been steadily declining since the mid-1960s, but in recent years it has remained stable at around 1.5 children per woman.

Partnerships are far less stable and this trend is likely to continue in tandem with women's increased autonomy. In Scandinavia, as in North America, just about half of all children will not grow up in an intact biological family. Divorce has adverse consequences for children and parents, and single parenthood can be harmful for children's achievements (Van Peer, 2007). However, evidence on the effects of divorce remains contradictory. In the short term, divorce has negative effects on both parents and children. More importantly, however, is the way parents settle a divorce. Parental conflicts before, during and after divorce have much more negative effects on the wellbeing of parents and children.

2.1.4. The individualisation process and insecurity

The process of individualisation can be seen first of all as the declining influence of all kinds of traditional social categories such as class, neighbourhood, gender, family and nation State. Second, individualisation draws attention to the growing need for individuals to shape their own life courses and continuously make choices. Traditional institutions such as the family, neighbourhood, church, political party, or union used to provide some kind of protection, which subscribed a more or less self-evident 'repertoire' for the individual. The more enforcing character of these traditional agents of control vanished. Increasing

([13]) Esping-Andersen's typology of welfare States is well known. He classifies the welfare State regime types by looking at certain crucial elements – the degree of decommodification (when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market) and the welfare State of social stratification (whether it tends to diminishes class differences or strengthen existing ones). He distinguishes between three regimes. The *neo-liberal/liberal* welfare (UK, USA) regime provides welfare for the poor only, and expects everyone else to take responsibility for their own welfare and buy it on the market. The *social democratic* type (Scandinavian countries) is essentially based on the welfare-State model of providing universal State welfare. The *corporatist/conservative* (France, Germany*)* type sought to protect traditional structures against both individualisation of the market and egalitarian tendencies of socialism. Ferrera (1996) developed a fourth type, the Mediterranean regime (Italy, Spain, Portugal, Greece), which also has a fairly low tax base and depends heavily upon provision by the family.

changeability, complexity and uncertainty of the life course also cause more risks. An active way of life planning demands certain cognitive skills – the ability to make, coordinate and execute plans. But because of uncertainty and complexity, life plans can also go wrong. To be able to make these choices, individuals need access to certain resources of social support and social capital. This capital however, is not divided equally among the population. Not every individual is able or even inclined to make choices and plan their own life courses. If individuals lack this ability, they risk being confronted with a 'breakdown-biography', rather than a biography of choice (Beck and Beck-Gernsheim, 1995). This is true for the labour market as well as for family life and education. The central question is how this new form of social vulnerability can be prevented and how individuals- and their families can be helped to handle these new social risks.

A higher educational level on average, combined with the process of individualisation, also influence the number and nature of needs and demands for health care. Patients have clearer opinions on what good care is, and they often gather knowledge from all kinds of sources, such as specialist magazines, patient associations or support groups. Patients with chronic diseases increasingly demand a more personalised approach and confront their doctors with their knowledge. As a consequence, a gap can arise between the expectations of those who seek help, and the supply of health care and medical knowledge, not to mention the 'knowledge gap' between those who have access to this technology and those who do not, in their ability to inform themselves and demand a certain standard of care.

2.1.5. Growing cultural diversity

In most EU Member States international migration plays an important role in population growth (European Commission, 2008d). In absolute terms, Spain, Italy, France and the UK reached the level of several hundred thousand in 2005. Only five of EU-27 Members States reported a negative net migration rate (Latvia, Lithuania, the Netherlands, Poland and Romania). In conclusion, the estimated total annual number of immigrants to the EU is over three million. As a result of long-standing immigration, there are important populations of non-national citizens in several Member States. Based on Eurostat estimates in 2006, the total number of non-nationals living in the EU is around 28 million, representing 5.7% of the total population. In half of the Member States, the proportion of non-nationals was between 5 and 10%. In all Member States, except Belgium, Ireland, Cyprus, Luxembourg, Hungary, Malta and Slovakia, the majority of non-nationals are citizens of non-EU-27 countries. The background of

foreign populations varies greatly for geographical reasons, historical links in terms of former colonies and former migration policies. For example, the largest non-national groups in Denmark, Germany and the Netherlands have a Turkish background. In Portugal and Spain, the largest groups originate from their former colonies. In Estonia, Latvia and Lithuania, migrants come from Belarus, Russia and Ukraine. Asylum-seekers can be considered a special category of migrants. In 2006, nearly 193 000 requests for asylum were filed. Compared to 2002, the number has been halved. However, strong differences between Member States can be noticed. In Greece, the Netherlands and Sweden, the number even increased.

2.1.6. Growing social inequality and poverty

Poverty is assessed as a relative concept in the EU. This means that it is assessed against prevalent national living standards, as assessed by median household income. More precisely, people with an equivalent income less than 60% of the national median income are considered poor. Therefore, the income of poor people can vary significantly between Member States. Based on the OECD study (OECD, 2008) some general trends can be derived. The most substantial shifts in poverty over the past two decades are between age groups. The risk of poverty for older people has fallen, while poverty of young adults and families has risen. Single-parent households are three times as likely to be poor as average. This disadvantage even increased slightly during the past 10 years.

Recently, a new measure was developed by Eurostat to make comparisons between Member States possible (European Commission, 2008d). Based on this measure, in 2008, 25.1% of the total population had an income less than 60% of the EU median before social transfer and 16.5% after it. In 2004, the median income was EUR 22 a day, and some 23.5 million people had to survive with less than EUR 10 a day and nearly seven million with even less than EUR 5 a day.

On income inequalities, the risk of poverty, that is disposing of less than 60% of the national median income, is present in several Member States, both ‘newer’ and ‘older’ ones.

Among the group of ‘newer’ Member States, the risk (after social transfer) is higher in Bulgaria, Latvia, Lithuania, Hungary and Romania. In ‘older’ countries it is higher than the European average in Spain, Greece, Italy, Portugal and the UK.

Table 2. **At risk of poverty rates before and after social transfer, 2008**
(% of population with an equivalent disposable income below the risk-of-poverty threshold, which is set at 60% of the national median equivalent disposable income)

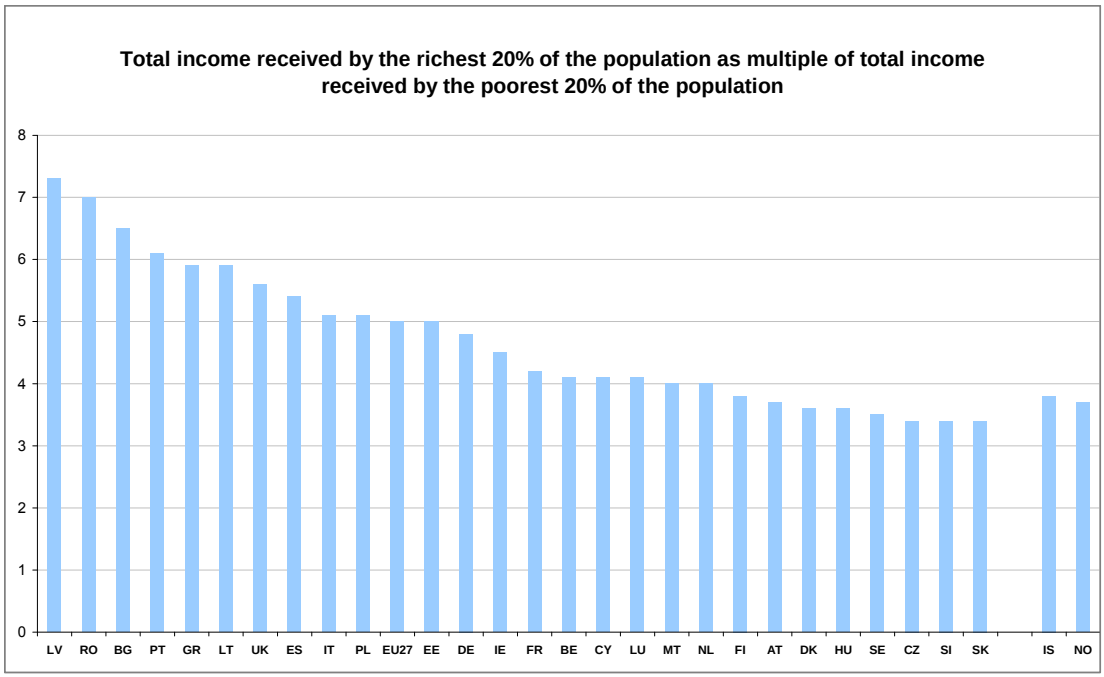
Country	Rate before social transfer	Rate after social transfer
EU-27	25.1	16.5
Belgium	27.0	14.7
Bulgaria	27.1	21.4
Czech Republic	20.0	9.0
Denmark	27.8	11.8
Germany	24.2	15.2
Estonia	24.7	19.5
Ireland	34.0	15.4
Greece	23.3	20.1
Spain	24.1	19.6
France	23.1	13.4
Italy	23.4	18.7
Cyprus	21.5	16.2
Latvia	30.2	25.6
Lithuania	27.2	20.0
Luxembourg	23.6	13.4
Hungary	30.4	12.4
Malta	23.1	14.6
Netherlands	19.9	10.5
Austria	24.5	12.4
Poland	25.1	16.9
Portugal	24.9	18.5
Romania	30.7	23.4
Slovenia	23.0	12.3
Slovakia	18.4	10.9
Finland	27.2	13.6
Sweden	28.5	12.2
United Kingdom	29.0	18.8
Iceland	19.0	10.1
Norway	25.5	11.3

Note: Data for France and UK are provisional.
Source: Eurostat, survey on income and living conditions, date of extraction 22.7. 2010.

The largest impact of social transfer is observed in Austria, Belgium, Denmark, Finland, Hungary, Norway and Sweden.

On social inequality, the largest income differences between 20% of the richest and 20% of the poorest in EU-27 were observed in 2008 in Bulgaria, Greece, Latvia, Lithuania, Portugal and Romania, followed by the UK.

Figure 2. **Differences between rich and poor in 2008**



Source: Eurostat, SILC [cited 15.7.2010].

Whether or not the scale of a society's income inequality is a determinant of population health is still a controversial issue. Wilkinson (2005) reviewed the evidence on socioeconomic inequalities worldwide and their effects on death rates, the quality of social relationships, levels of violence and trust, and the degree of involvement in community life. He presents compelling evidence that psychosocial factors such as low social status, poor social affiliations, and negative experiences in early childhood are powerful influences on health. More importantly, Wilkinson argues that absolute material standards and levels of consumption influence the health of populations in poor countries more than in wealthy ones. In developed countries, inequalities in social environments and psychosocial factors play a larger role. This can be explained by the negative feelings related to low social status and relative deprivation. Both affect people

most deeply by ranking them according to worth in comparison to others, which assaults their sense of dignity. Thus, greater inequalities in income create social distances among groups and promote dominance and subordination, competition for status, and poor social relationships.

2.1.7. Conclusion: new social risks and new vulnerable groups

European societies have gone through substantial economic and social changes. These changes create new social risks and new vulnerable groups. The EU is experiencing significant ageing of the population. As a result, less active people will be available on the labour market in the longer term. These demographic changes also lead to growing and changing demands for health and social care and for care workers (OECD, 2005b; Cedefop, 2010). On the labour market, low-skilled jobs are less available. Within the next decade, the labour force with low-level qualifications is projected to fall by around 15 million (Cedefop, 2010). As a consequence, unemployment is strongly related to educational status. Delaying marriage and births is an expression of citizens' new life priorities as well as constraints since families hesitate to have children because of the difficulties of combining a job with raising children. Family breakdown is a new social risk, since single-parent families have a much higher poverty risk. Individualisation means that individuals have to shape their own life course and have to make choices continuously. To make these choices, the individual needs certain forms of social skills and education. Consequently, more people find it difficult to conceive their own place in society. Europe has also become more culturally diverse due to migration. Cohabitation of people of different cultural backgrounds is one of the most compelling challenges for the EU. Scientific evidence shows the negative effects of social inequality in health, psychosocial problems, crime and less social inclusion.

One of the new vulnerable groups are people with mental health problems. The European Commission uses the WHO definition of mental health, mental ill health and its determinants:

> '... a state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.
> Mental ill health includes mental health problems and strain, impaired functioning associated with distress, symptoms, and diagnosable mental disorders, such as schizophrenia and depression.
> The mental condition of people is determined by a multiplicity of factors ... including biological (e.g. genetics, gender), individual (e.g. personal experiences), family and social (e.g. social support) and economic and environmental (e.g. social status and living conditions).' (European Commission, 2005, p. 4)

Mental disorders constitute a major part of the European burden of disease (European Commission, 2008e). In any given year a quarter of Europeans are likely to be affected by mental disorders, while less than half of them will have contact with health services. The projections of the World Health Organisation (WHO) show growing psychic vulnerability for the future. In 2020, depression, alcohol use, dementia and self-inflicted harm will be among the 10 leading causes of disability-adjusted life years and will contribute to more than one quarter of the total disability burden in developed countries.

Also minorities, migrants and asylum-seekers can be considered a new vulnerable group (Huber et al., 2006). Research shows that minorities are at high risk of poverty and social exclusion. They are also more affected by health problems. Providing health care in a multicultural setting remains a large challenge. Some of these challenges are similar for different minority groups: lack of knowledge of available services, language differences and varying cultural attitudes to health and health care. A very significant barrier is difficulty in obtaining documents, such as residence and work permits and health insurance papers.

2.2. Institutional and policy changes

On social and health services, four major changes can be distinguished. First, a change from government to governance is observed. Second, EU Member States are more and more obliged to share their power with the EU, including social policy and health care. Third, evidence-based practice (EBP) has gained importance. Its aim is to base the actions of social and health workers on knowledge derived from research. Fourth, one of the major changes is deinstitutionalisation of care. Community-based services will replace large residential institutions.

2.2.1. From ‘government’ to ‘governance’

In more public policy-oriented literature, a transition from ‘government’ to ‘governance’ is mentioned. When taking a closer look at the concept of governance, it becomes clear that it hides a multitude of meanings (Lynn et al., 2001). It certainly points at new mechanisms of control and steering and is contrasted with traditional hierarchical control by government.

This new model first points at the large whole of interdependent elements that are part of the ‘governance’ regime, such as jurisdiction, policy goals, organisational structures, financial streams, administrative guidelines, and

broader cultural values and norms. These are not exogenous variables that guide the policy process. They only receive their ultimate meaning during this process. Because of their interdependent coherence, they moreover are difficult to steer and control. Changes in one system automatically lead to (unintended) consequences in another. It is impossible to identify just one institution responsible for realising goals. Public and private, as well as non-profit, organisations are all involved.

Second, the government is no longer in command as a hierarchical superior, but is searching for steering instruments such as network-type mechanisms (negotiating, searching for compromise, drawing agreements, giving incentives, process management with relatively autonomous actors) and market-type coordination (subcontracting tasks). Market-type coordination systems should operate to higher efficiency, by introducing the possibility of competition. It is believed that marketisation also creates more choices for the consumer. At the same time it raises questions about justice and fairness, because accessibility of affordable services of high quality can be endangered. On social and health services, opponents of privatisation argue that these kinds of services have an intrinsic value, which can hardly be assessed in terms of costs only. Another possible disadvantage is inertia (Van Berkel and Borghi, 2008). Purchasers of services may be hesitant to take risks and renew services, leading to standardised rather than tailor-made services. Social service providers also have to invest more time and money into the tendering process, which can lead to less quality of services.

Third, governance also refers to new public management, the doctrine by which public services became modernised. This doctrine is characterised by introducing private market principles into public services. Osborne and Gaebler (1993) summarise its essential characteristics, where: most entrepreneurial governments seem to promote competition between service providers; they empower citizens by pushing control out of the bureaucracy into the community; they measure performance of their agencies, not focusing on input, but on outcomes; they are driven by their goals – their missions – not by their rules and regulations; they redefine their clients as customers and offer choices; they prevent problems before they emerge, rather than simply offering services afterwards; and they put their energies into earning money, not simply spending it.

Fourth, this paradigm points to stratification of policies and interweaving of different levels of policy-making (local, regional and national). The local level is closest to the person in need of care and is best suited to assess their needs and

react most adequately. The question, however, is how much room for decision is left for the local level. The main advantages of the local level are:

- possibility to adapt policy to local circumstances and needs;
- coordination and mobilisation of different actors and services across sectors;
- special attention for problem areas;
- development of renewing projects.

At the same time however, a strong decentralisation also has disadvantages:

- local initiatives do not suffice to tackle the national or even international span of certain problems;
- inequalities in policy efforts;
- danger of discrepancies between national policies intentions and local policy results;
- duplication of policy activities and loss of efficiency.

In many countries there is evidence of concentration of health and social care services in urban areas (Huber et al., 2006). This raises the question of how to ensure accessibility for rural populations and how social care has to be organised to reach out to the most vulnerable groups in rural areas.

2.2.2. European social policy and the open method of coordination

On 20 April 2004, the European Commission (EC) published 'Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the open method of coordination' (European Commission, 2004). This document shows the EC considers health care systems in the EU and policies in different Member States becoming more and more entwined. Growing mobility of patients plays an important role in this evolution. The EC thinks of common problems and challenges in health and health care, asking for reinforcement of policy cooperation and coordination in the EU. Therefore, the EC is in favour of introducing an open method of coordination (OMC) in health care and in long-term care. The EC first determines goals Member States should strive for. These goals are translated into several numeric indicators. Decisions on the ways in which Member States will realise these goals, are to be taken by Member States themselves. However, they have to draw up an action plan every two years in which they clarify their actions. These action plans are evaluated by the EC. Every Member State receives recommendations, but these cannot be enforced. They are considered as 'soft law'. However, the EU becomes a key agent in shaping these policies.

2.2.3. Growing importance of science: evidence-based practice and technological developments

Scientific research and development are gaining importance in social services. In health and social services, evidence-based practice (EBP) has gained importance. Its aim is to help social and health workers to make decisions based on knowledge derived from research. In the past, scientific knowledge about disabilities, diseases and interventions has grown exponentially. At the same time, these scientific insights are not always implemented by social and health care workers. The EBP movement is convinced use of scientific knowledge on what really works can increase the effectiveness of social and health interventions. However, scientific knowledge is not always available for all kinds of problems. For instance, there is less research evidence available for social problems which are treated by social services. Even when it is available, this knowledge cannot necessarily be relied upon to provide clear guidance for every decision in every client situation. Therefore, a broad interpretation of 'evidence-based' policy is necessary, one that takes account of these specific characteristics of health and social services. This broad approach seeks integration of results of scientific research and clinical expertise in terms of practice knowledge, expectations and needs of clients and users (McNeece and Thyer, 2004). Based on this broad approach, health and social professionals use the best evidence possible, the most appropriate information available, to make clinical decisions for individual patients. It involves complex and conscientious decision-making processes based not only on available evidence but also on clinical experience of professionals and patient characteristics, situations, and preferences. It recognises that health care is individualised, ever changing and involves uncertainties and probabilities. To realise this broad approach, the gap between science, policy and practice needs to be tightened and the search for new forms of cooperation between researchers, policy-makers and front-line workers needs to continue.

More scientific knowledge on what works has thus been developed. At the same time, this encompasses certain dangers in overspecialisation. Because of scientific and methodological constraints, health and social interventions tend to be developed for strongly clear-cut groups of patients and clients. Consequently, the effectiveness of interventions for these groups can be assessed, but it remains unclear to what extent these interventions also work for patients and clients outside the inclusion criteria. For instance, the positive parenting programme is an evidence-based intervention to solve parenting problems ([14]). However, Belgian evaluation research shows it is unclear if these effects are the

([14]) See: www.triplep.net [cited 26.4.2010].

result of its specialist characteristics (van den Berg et al., 2009). This new trend also puts pressure on care workers to specialise and follow training directed at specific interventions for specific groups of help-seekers. As a consequence, more generic knowledge and competences threaten to be devalued.

At present, technological developments and scientific research are expected to revolutionise health care. More specifically, genomics, new biotechnologies, nanotechnology and robotics have become important focus areas for health innovation (Eurofound, 2006). In addition, new information technologies are changing health care. Patients search for information on health issues on the Internet. More important is use of telematics and ICT for health care at a distance. A last development is use of ICT to share information between health and social professionals, through development of electronic patient records. This also means that managing circulation of all these data requires introducing new professional groups into health and social services, such as informatics specialists.

2.2.4. Deinstitutionalisation of care: community-based services

Deinstitutionalisation of care refers to the process of replacing residential services with community services. Community support is provision of services intended to maintain appropriate support for clients in their social milieus. Its main goal is to empower persons, enabling them to become fully participating members of the community. Deinstitutionalisation has been widespread in mental health care and in social and health services for the disabled and elderly.

People do not become institutionalised as a necessary side-effect of disability or mental illness. Institutionalisation occurs as a result of social processes that strip individuals of normal social roles, civil rights, choice of lifestyle and eventually their social identity. The buildings called institutions are a reflection as much as a cause of institutionalisation (Henderson and Grove, 2004). In institutions persons can remain powerless unless staff initiate and support the process of change. This is not easy because staff often share the mindset of the institution and can, in subtle ways, limit the process. When individuals internalise this role as the only one they can conceive for themselves, they become institutionalised.

The project 'Included in society' ([15]), which was based on a broad definition of disability including persons with intellectual disabilities, mental health problems,

([15]) The project was initiated, organised and cofinanced by four major advocacy organisations for disability: Mental Health Europe (http://www.mhe-sme.org/en.html), Autism Europe (http://www.autismeurope.org), Inclusion Europe (http://www.inclusion-europe.org/) and the open society mental health initiative (http://www.osmhi.org). It was supported by the European Disability Forum (http://www.edf-feph.or), the Association for Research and Training in Europe

the physically disabled, persons with autistic spectrum disorders, persons with complex dependency needs and ethnic minorities with disabilities, tried to gather comparable information about the number of institutions and their characteristics, but this appeared to be a rather complex and difficult task because of the lack of comparable data. In the second phase, institutions in four countries, France, Romania, Poland and Hungary were studied in depth. One of the central conclusions of this study is that for people in institutions life is characterised by hours of inactivity, boredom and isolation. Staff numbers are often too few to provide rehabilitation and therapy. In addition, the physical environment does not provide enough privacy and contact with other family members, friends and the broader community is rather limited.

Deinstitutionalisation represents more than a mere relocation of support from the institution to the community. It is accompanied by changes in the culture of care and in the attitudes and methods of front-line workers. The main consequence is an increasing need in primary and community support services for expertise in developing and implementing suitable support models for these target groups and an increasing trend to involve informal support providers. Informal care providers are involved in meetings with formal care workers. In other words, a new vision of care is necessary.

2.2.4.1. *A new vision of care*

Specifying the concept of 'good care' was one of the aims of the joint action project Biomed II, which focused on ethical aspects of deinstitutionalisation in mental health care (Bauduin et al., 2002; van Weeghel et al., 2005). Discussions were organised in five European countries (Belgium, England, Greece, Italy and the Netherlands), with participants representing five involved parties: patients and service users, family members, professionals, members of local communities and policy-makers. The study shows that a respectful relationship between clients and service providers is considered the most important aspect of 'good care'. Such a relationship was associated with an image of clients as responsible individuals, capable of stating their own opinions and whose experiences and decisions are taken seriously. Second, good care was seen as effective care, adapted to individual needs of clients. Third, good care was defined in terms of local availability and accessibility of services. Ultimately, good care was linked to support from informal carers (family and friends).

Their recommendations correspond with the innovative approach by Thornicroft and Tansella (1999). Based on a review of the literature and clinical

(http://www.eadi.org/), the European Association of Service Providers for Persons with Disabilities and the Centre for Policy Studies in Budapest (http://cps.ceu.hu).

and research experience, they identified nine relevant key aspects for evaluating mental care services in society:

(a) autonomy: the client should have the possibility to decide independently and make choices, notwithstanding problems, complaints or limitations;
(b) continuity: services are able to gear interventions within and between teams in the short term (cross-sectional continuity) and streamline contacts in the long term (longitudinal continuity);
(c) effectiveness: treatments and services with proved advantages can be applied in daily practice;
(d) accessibility: clients can receive care where and when needed;
(e) comprehensiveness: horizontal comprehensiveness (reaching of all target groups) implies that care is provided over the complete continuum of problems and over the broad spectrum of all client characteristics. Vertical comprehensiveness (to offer all basic care a target group needs) can be defined as provision of all basic components of care and prevention and their use by prioritised target groups;
(f) justice: means are divided evenly and the vision behind prioritising needs as well as the methods used to attribute means, are clarified;
(g) accountability: questions of clients, families and the broad public are answered, since they all have rightful expectations towards the way in which the service needs to take responsibility;
(h) coordination: the service has a coherent treatment plan for each individual client. Each plan contains clear goals, with which necessary and effective interventions are coupled. There is a plan for cross-sectional coordination (coordination within a limited period of care), as well as for longitudinal coordination (coordination over a longer period of treatment);
(i) efficiency: strive for minimal input for a certain outcome, or maximum output from a certain level of input.

2.2.4.2. *Guidance on principles of deinstitutionalisation*

Mental Health Europe developed guidelines on deinstitutionalisation as part of the project 'Included in society' ([16]). As part of this project, Henderson and Grove (2004), developed eight principles to deinstitutionalise social care:

(a) **respect for the individual**

Once people have their individual experiences listened to and valued, emotional engagement and optimism can return. Respect for the individual implies a

([16]0 For more info about this project, see: http://www.community-living.info/?page=299 [cited 26.4.2010].

relationship between the client and the professional more akin to that of collaboration between equals, rather than the 'expert' who tells the 'patient' the answers. Respect for the individual also implies enabling people to express their individual tastes and choices in creating their personal environment. One of the more important aspects of respect is the right to privacy and freedom from being observed when the individual so chooses;

(b) **helping people to reacquire the rights of citizens**

For most people, the rights of a citizen to vote, receive State benefits, have a passport or an identity card are taken for granted. For those who have lost these rights, reacquiring them is a very important sign that recovery of ordinary social roles has started;

(c) **restoring self-respect, self-confidence and mastery of roles and tasks**

For the individual to recover self-esteem it is not enough to make new social roles available. People must also acquire the confidence and competence to try them out, practice them and master them. Perhaps the most important of these roles are those around work and employment – becoming a person who does things for other people that they value and reward (and for which they may receive pay). Enabling individuals to dare to try out new social roles and to make positive choices about their lives is at the heart of the mental health worker's job and requires skills, humility and patience. Above all it requires the willingness to talk and listen to people to try to understand and work with their perspectives;

(d) **creating a dynamic atmosphere**

Group dynamics is a powerful tool for deinstitutionalisation if it is properly used and understood. A dynamic group working together to decide the way a hostel is run, how to promote and present it and its purpose to the neighbourhood or organise projects they can undertake together, will lift the spirits of residents and give them courage they would not otherwise have. The whole group can for a time become greater than the sum of its parts and carry people forward in ways they could not achieve without being part of the group;

(e) **understanding the importance of 'real' work**

Getting a job is the single most important factor leading to recovery from severe mental illness. Remunerative work is at the centre of most peoples' lives and social identities. In the UK, recent surveys have shown that the majority of people using mental health services place employment very near the top of their lists of life goals;

(f) **reengagement with life in the community and other social roles**

Although work is important, people are also in need of hobbies, leisure activities, spiritual expression and the chance to make a contribution to the life of the communities they live in. There is a rich vein of creativity in the way rehabilitees

engage in their local communities – often starting from very unpromising circumstances. It appears that when neighbours, shop-keepers, bus drivers and the like actually meet service users their views often change dramatically. They stop seeing 'mental patients' and start seeing the individual as a person. The key to successful engagement appears to be staff with patience and calm determination in the face of hostility and suspicion;

(g) **the style and quality of leadership**

This is perhaps the most important factor of all. Leadership should be strong but not in an authoritarian or commanding way. The leadership task is to empower others and to model the sort of relationships that staff should have with residents. Leadership should be open and supportive to staff, giving plenty of time for discussion and problem-solving. It should also build up team spirit by ensuring the contributions of all staff are recognised as of equal value. For deinstitutionalisation to occur, the contribution of the cook and the cleaner can be as important as that of the psychiatrist or psychologist. All of them have the tools of deinstitutionalisation at their disposal. With the right leadership the atmosphere of a residential institution can change very quickly – and permanently. Wise leaders will allow staff to grow and develop their own skills so that when they leave there is no succession crisis. Although mostly psychiatrists are at present in leadership roles, this is not necessary. Other professionals can be as or more effective, allowing psychiatrists to delegate these responsibilities to a much wider locality.

2.2.4.3. *A changed vision on target groups: human rights, inclusion and empowerment*

An explicit shift has taken place over past decades from an approach motivated by charity towards the disabled to one based on rights (Quinn and Degener, 2002). The human rights perspective on disability means viewing people as subjects and not as objects and as holders of rights instead of problems. The disability rights approach is not about granting specific rights, but about ensuring the equal enjoyment of all human rights without discrimination. The underlying values of this paradigm shift are: the inestimable dignity of each human being, the concept of autonomy or self-determination, the inherent equality of all regardless of difference and the ethic of solidarity. The shift to human rights has been authoritatively endorsed at the level of the United Nations over the past two decades.

People with disabilities want to lead a life in the community that is as normal as possible. This also demands changes in society. Tolerance towards the deviant and positive appreciation of difference are currently important points of

attention. How can we fight stigma and discrimination and at the same time make sure that people with limitations can take full part in labour, education and recreation? For people with disabilities, this trend is strongly captured with the concept of inclusion, which states that all people together create society, people with disabilities included. People with disabilities do not have to be integrated; they are already part of society.

Empowerment fits in with these trends. Research shows that people with lifelong limitations, people who live in poverty, people with mental problems and immigrants are no longer seen as passive and dependent consumers of care and welfare services planned and organised by experts. They can be addressed as experiential experts, and they have the right to organise their own lives and make choices about the care they need (Pedlar et al., 1999; Ward, 1998). They are more and more 'empowered' to express their own opinions, make choices and control their life situations and also search for strengths and act to accomplish their life goals. For services, this implies shifting from system-oriented care to person-oriented assistance (Holburn and Vietze, 2002). These target groups and their families should thus be involved and be allowed to participate in planning and evaluating their social care trajectories. They have to be informed openly, accurately and comprehensibly. They have to play a central role and participate in all plans and decisions that have an impact on their wellbeing. Also, they need to be allowed to make choices about their lives and the assistance they receive.

2.2.4.4. *Side-effects of deinstitutionalisation*

Although there is widespread consensus of the positive effects of deinstitutionalisation of care, its implementation remains difficult. Patients are sometimes discharged to the community without sufficient preparation or support. New community services are often targeted at a single issue, are insufficiently networked or coordinated and therefore unable to meet complex needs. The expectation that community support leads to fuller social integration has not always been achieved. In particular, disadvantaged groups with multiple and complex needs have insufficient access to good quality support. These groups are often homeless or at risk of homelessness. Homelessness and housing deprivation are perhaps the most extreme examples of poverty and social exclusion in society today and are found in all European countries ([17]). Among

([17]) FEANTSA, the European federation of national organisations working with the homeless, has developed a European typology of homelessness and housing exclusion (ETHOS, available from Internet: http://www.feantsa.org/files/freshstart/Toolkits/Ethos/Leaflet/EN.pdf [cited 15.7.2010]) as a means of improving understanding and measurement of homelessness in Europe, and to provide a common 'language' for transnational exchanges on homelessness. ETHOS classifies homeless people according to their living situation: (a) *rooflessness* (without a shelter of any kind, sleeping rough), (b) *houselessness* (with a place to sleep but temporary in

the causes of homelessness are relationship breakdown or bereavement, debt, lack of affordable housing, low paying jobs, substance abuse, physical, psychological or mental illness or injury, domestic violence, unemployment, poverty, leaving institutional settings such as the armed forces, prison, children's homes or fostering, change and cuts in public assistance.

The social care sector as well as health services are responsible for the cure and support of these groups. However, these services are not always successful in responding effectively to requests for help or in reaching out and engaging these groups to reintegrate them into society. This is due to different reasons. First, these persons are often perceived as 'difficult' clients, because they do not fit well into the regular categories of target groups and assistance trajectories. Second, social care and health services are more and more forced to improve their effectiveness and efficiency. Research shows that these target groups are disadvantaged by these policy trends due to their complexity leading to increased demands on time and consequent reduced 'efficiency', and decreased 'effectiveness' as defined by standard target measures. Third, successful support depends on cooperation between the social care sector and the health services. This can be difficult because different professions with their own bodies of knowledge and skills are working in these services and it takes time, effort and opportunity to develop shared language, understanding and trust. Further, traditional vocational education and training programmes which prepare for working in social care or health services often emphasise the professions' particularities and pay less attention to shared knowledge and skills.

2.3. Social services of general interest (SSGI)

Defining the European care sector is not a straightforward process. Terms such as social services, social welfare, social protection, social assistance, social care and social work are used interchangeably (Eurofound, 2003). The EU uses a very broad definition of social services. They can be regrouped in two broad types of services, the functions and organisation of which can vary a great deal across the EU: statutory and complementary social security schemes, and other services provided directly to the individual that play a preventive and socially cohesive role, such as social assistance services, employment and training

institutions or shelter), (c) living in *insecure housing* (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence), (d) living in *inadequate housing* (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).

services, social housing, childcare or long-term care services for the elderly, disability services, etc.

Both types of service play a vital role in society and provide an important contribution to fulfilment of basic EU objectives such as social, economic and territorial cohesion, a high level of employment, social inclusion and economic growth (Huber et al., 2006). These social services form an essential focus of the renewed social agenda to ensure that everyone has access to the services needed to participate fully in social life (European Commission, 2008d). Modernisation of social services is an important part of the more general process of modernising the welfare State. In the agenda, the European Commission looks at SSGIs in several ways. The open method of coordination analyses the role of social services in promoting social inclusion and access to quality health and long-term care. The EC publicises biennial reports to sketch a broader picture of what SSGIs are, what they do and how they are evolving.

The boundaries between the social care sector and health services are blurry and organised differently in Member States (Eurofound, 2006). The health care sector refers primarily to services provided by hospitals, general practitioners and community clinics in preventing, diagnosing and treating illness. Traditionally, health care and social services have been treated separately, partly because of their origins but also because interest groups have sought to maintain these boundaries. However, this is changing because of the increasingly elderly population, increased attention to prevention of disease and care instead of cure and greater demand from citizens for more integrated services.

2.3.1. Social services of general interest in Member States

Social services in Member States share some common characteristics. They are person-oriented and designed to respond to vital needs of vulnerable people. They provide support and care for both young and old people as well as for people with disabilities. They compensate for failings within families. Moreover, they are key instruments for safeguarding fundamental human rights and dignity. When responding to the needs of vulnerable users, social services are often characterised by an asymmetric relationship between provider and beneficiary. These services are often highly dependent on public financing. Non-profit providers as well as voluntary workers play an important role in delivering social services.

Apart from common characteristics, SSGIs differ strongly between Member States. Jensen (2008) stipulates that large differences exist between health care and social care services. Health care is characterised by very uniform levels of expenditure across countries, while expenditure on social care services conforms

to the welfare State typology of Esping-Andersen (1999).Thus, social care models in the EU can be summed up in four categories (Eurofound, 2006):

(a) the residual model,
(b) the corporatist model,
(c) the Scandinavian model,
(d) the family care model.

Although helpful, this typology is contested for three main reasons. First, because no single country totally fits into one category. Second, there are large differences between social services so these categories are too general to cover the specificities of these different sectors. Third, eastern European countries are a little neglected, since this typology was developed in the second half of the 1980s.

2.3.2. Social services as job provider

Between 1996 and 2005, the services sector experienced the strongest growth with 23 million new jobs. The health and social services as part of this sector experienced strong growth, too. More than 4.4 million new jobs were created in the health and social services during this period, representing a fifth of the growth of the whole services sector (Huber et al., 2006).

The present recession has already and will continue to impact on employment. Recessions tend to accelerate sectoral changes.

However, Cedefop medium-term forecasts on skills supply and demand in Europe (Cedefop, 2010) foresee that despite the crisis, sectoral employment trends will be broadly similar to those before the recession.

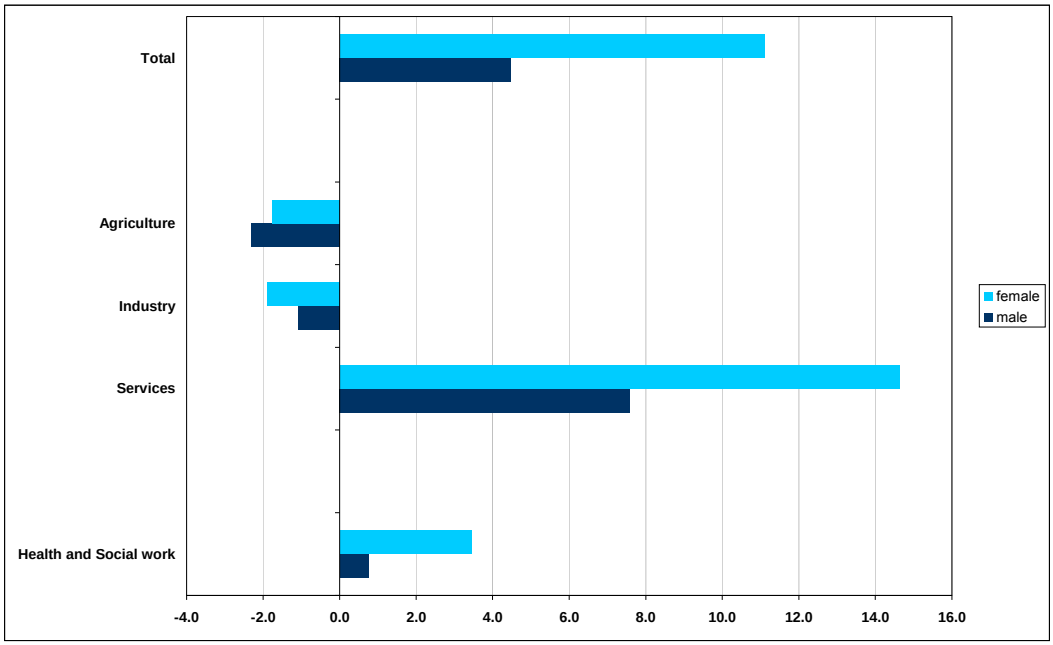
Therefore, expansion of the service sector and contraction of the primary and of some manufacturing activities are expected to continue.

It is projected that between 2010 and 2020 a substantial decline in employment of around 2.5 million jobs in the primary industries (mostly in agriculture) will occur. Job losses of around 2 million are expected in the manufacturing and production industries, also.

At the same time, growth of around 7 million jobs is expected in the tertiary sector and more precisely, in business and other services.

Employment will grow in the distribution and transport subsectors, too. Within the non-marketed services, considerable job creation is expected in the health-care and education subsectors, although it will be partly offset by reduced labour demand in public administration due to foreseeable budget restrictions.

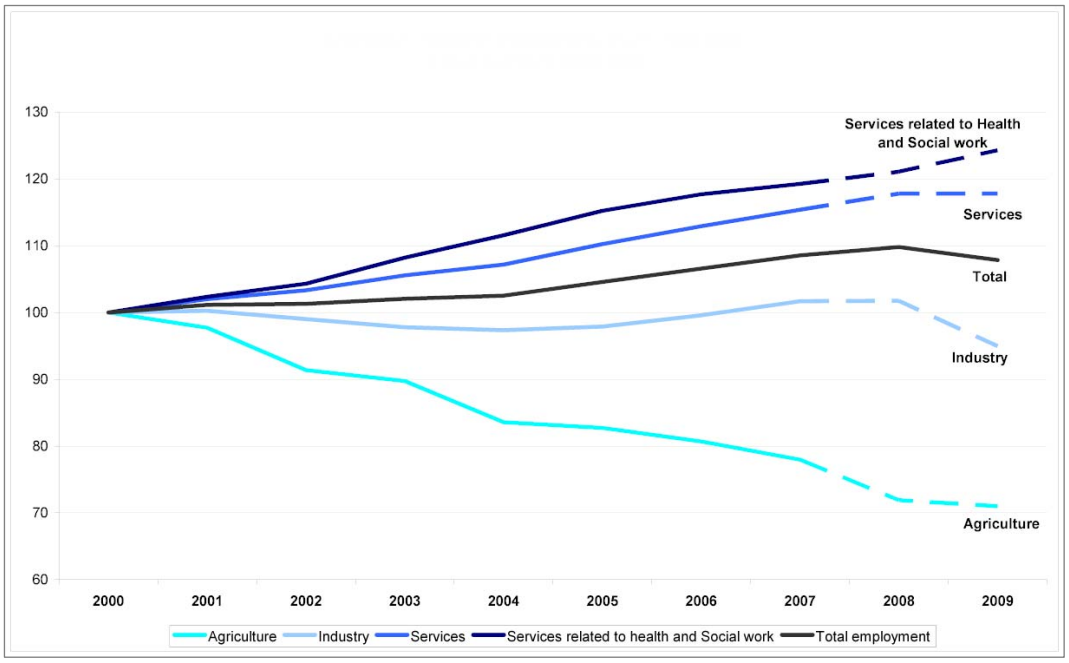
Figure 3. **Change in sectoral employment for EU-27 from 2000-09 (in millions with gender breakdown)**



Source: Cedefop's calculations based on Eurostat, labour force survey [cited 17.7.2010].

However, the share of employment in health and social services in total employment is very different throughout the EU. This is relatively small in southern, central and eastern countries, while it is high in some northern and western European countries. More specifically, employment in health and social services ranged from 4 to 6% in Bulgaria, Estonia, Greece, Cyprus, Latvia, Poland and Romania to almost three times that level (about 12%) in Belgium, Denmark, Germany, Ireland, France, the Netherlands, Finland, Sweden and the UK.

Figure 4. **Changes in sectoral employment, EU-27, 2000-09 (index numbers 2000=100)**



Note: Starting from 2008, a new classification of economic activities (NACE REV 2) was introduced. Data up to 2007 refer to NACE Rev1.1, while data for 2008 and 2009 refer to NACE Rev 2.
Section N (Health and social work) of the NACE Rev 1.1 was substituted by section Q in NACE Rev 2 (Human health and social work activities).
The revised section now includes only human health activities. As a result veterinary activities have been removed from this section and put in section M (Professional, scientific and technical activities).

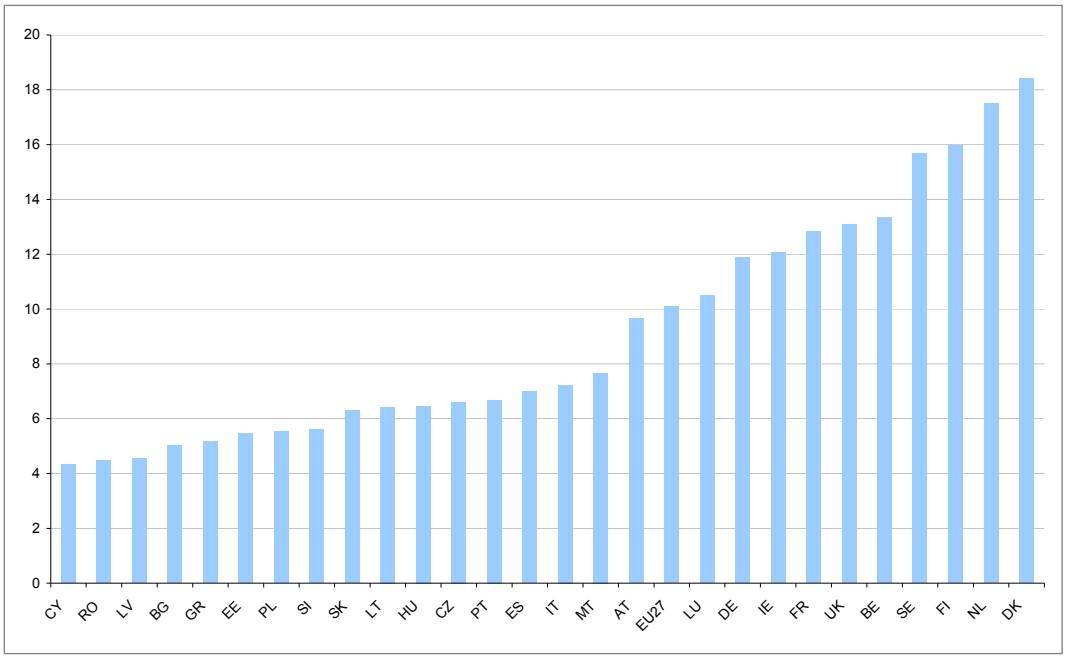
Source: Cedefop's calculations based on Eurostat, labour force survey [cited 15.7.2010].

The health and social care sector in Europe is a female-dominated sector, with only 21.5% male workers in 2009 (Cedefop's calculations above) ([18]).Workers in this sector have a relatively high educational level. In 2007 and 2008 around 40% of those working in the sector had higher education, a percentage considerable above the average in total employment, which is 27%. A very recent study by the OECD (2009) looks at growing demand for long-term care workers. The OECD has defined long-term support as a cross-cutting policy issue that brings together a range of services for persons dependent on help with basic activities of daily living over an extended period of time. Elements of long-term support include, medical treatment for long-term conditions, home nursing, social support, housing, employment and services such as transport and meals. Different professional groups are responsible for these various social and health interventions. The long-term care sector is a high labour-intensive sector.

([18]) The same trend was observed in Eurofound (2009a), based on its European working conditions survey of 2005.

Because of demographic and societal trends (the ageing population, less informal care givers, a declining working-age population), there will be a growing need for long-term care workers in the future. In terms of spending on long-term care the OECD forecasts that spending will reach between 2% and 4% of GDP by 2050 (OECD, 2009). However, long-term care jobs remain unattractive, because of unappealing working conditions. Long-term care workers typically earn lower wages than the average wage in the economy, even though their wage levels are often higher than the average wage of many low-skilled professions. Working hours are often long and irregular and labour contracts are precarious (part-time and short-term work). Domestic shortages of workers have resulted in more jobs being filled by migrant low-skilled workers, also as a consequence of enlargement of the EU.

Figure 5. **Employment in human health and social work activities, 2009 (% of total employment 15-64)**



Source: Cedefop's calculations based on Eurostat, labour force survey, 2009 [cited 15.7.2010].

2.4. Challenges for social services and the social care sector

Concluding this chapter, societal developments and trends described above cause new social risks and create new vulnerable groups, such as the elderly, minorities, people with mental disabilities, people living in rural areas, single mothers, and the low skilled. At the same time, policies towards social services are characterised by new public management, deinstitutionalisation of social care, the growing importance of scientific evidence and new technologies and a new vision based on human rights, empowerment and inclusion. The need for social services will increase, while they are confronted with a growing shortage of care workers. In addition, the public image of social care is rather low and working conditions are not sufficiently good to attract enough new workers. In other words, societal and policy changes increase pressure on social care workers but social services still have to convince new workers to enter the sector. VET becomes even more important. Especially in rendering existing and new social care workers and leaders familiar with new competences needed, such as empowerment, ability to work in the community, ability to use new information technologies, ability to transfer evidence-based knowledge into practice, promotion of human rights, new management skills and ability to work with other services to realise more tailor-made social care.

Thus, based on the literature review five generic competences can be identified:

- ability to work in the community,
- ability to use new information technologies,
- promotion of human rights,
- ability to work together with other services to realise more tailor-made social care,
- new management skills and leadership.

3. Generic competences in the social care sector

In this chapter important generic competences of both front-line staff and service leaders of community-based structures are defined based on literature review.

3.1. Definition of generic competences

Cedefop, Winterton et al. (2006) point to diverse use and interpretation of the concept ‘competence’. At EU level, competence is defined as the proven ability to use knowledge, skills and personal, social and methodological abilities in work or study situations and in professional and personal development. Knowledge is the body of facts, principles, theories and practices related to a field of work. Skills are the ability to apply knowledge and use know-how to complete tasks and solve problems. In this study, competences are defined as the ability to use and integrate knowledge, skills and attitudes to realise specific goals. By using the term attitude, we make explicit that care work has an important ethical component.

Generic competences can be defined as shared knowledge, skills and attitudes of different occupational groups of front-line social care staff and leaders. Generic competences have to be distinguished from key competences for lifelong learning. Key competences refer to competences which all individuals need for personal fulfilment and development, active citizenship, social inclusion and employment such as communication in the mother tongue, mathematical competence, digital competence, social and civic competences (European Commission, 2006a).

Generic competences refer to those competences needed by all front-line health and social care staff, independent from their professional background. Nowadays, specialised education is higher valued. Social care workers are under pressure to specialise in specific target groups and/or specific methods. For instance, there are more and more specialist VET programmes for nurses to specialise in elderly care, psychiatric care or addiction care. Consequently, specialist competences are considered more valuable. Generic competences ease cooperation between different professional groups, because they provide a common language. In addition, research shows that these generic competences

increase the effectiveness of social care interventions (Wampold et al., 1997). Description of competences in this chapter does not cover all competences needed by care workers in the health and social sector. The study focuses on generic competences, but it recognises the importance of specialist competences to work with specific target groups or in specific social services. However, specialist competences seem already better covered in existing VET standards and regulation of professions.

We focus on the competences of professionals because the purpose of this study is to bridge the current gap between skill demands of the health and social care sector and available knowledge, skills and attitudes of staff working in it. We pay attention to the competences of those who stand in the front-line and have direct responsibility for delivery of support in face-to-face contacts and to those who manage the changes in the sector and in the organisation. We are aware of the important role informal caregivers and volunteers play in supporting target groups but this is beyond the scope of the present study.

We describe the generic competences needed to support care providers working with difficult target groups. Their problems are related to physical, psychological or mental health, vulnerability to stress, lack of basic coping skills, limited transfer of learning experiences, addiction problems, behavioural difficulties, etc. They are excluded from social rights or from social life and their situation is precarious (at risk of isolation, exclusion and stigma, restrictive living conditions or homelessness). It concerns persons with ongoing (or even lifelong) needs for support in different key domains of life or long-term care as defined by OECD and the EU. OECD has defined long-term support as a cross-cutting policy issue that brings together a range of services for persons dependent on help with basic activities of daily living over an extended period of time. Elements of long-term support include, medical treatment for long-term conditions, home nursing, social support, housing, employment and services such as transport or meals. Different professional groups are responsible for these various social and health interventions. This study focuses on front-line social care workers and their common generic competences.

There is evidence of divergence in the quality of care offered between generic and specialist health or social care settings. Specialist services are perceived to be of higher quality, probably because generic care settings have less staff, time and resources available (Innes et al., 2006). These complex target groups do not fit into one or other specialist service but ‘fall between the cracks’. It is hard to deal with such ‘complex cases’ in regular education systems. The common characteristic of working with this target group is that each individual with

complex needs has a unique share of different care needs which vary in depth (intensity of services needed) and/or in breadth (range of services).

3.2. Literature review of generic competences of front-line staff

In this section we look more closely into recent literature on generic competences needed for front-line staff to offer long-term care to people with multiple needs. As the review shows, there is quite some diversity in approaches. This is typical for the social care sector, in which a common language is often missing. In addition, the social care sector itself is very diverse since it focuses on different target groups such as the elderly, the disabled, children, the poor with various and sometimes contradictory needs and expectations. We can observe some overlap between the different approaches presented in this overview of recent evidence on generic competences. First we present these various approaches. The last part focuses on new trends for groups with complex and multiple needs which were mainly developed in mental health care.

3.2.1. Community-based services

The shift from residential support to support in small-scale institutions and offering support in the community has an impact on needed competences. Deinstitutionalisation was described as one of the main developments concerning social services of general interest. Aubry et al. (2005) make a relevant distinction between competences needed before starting the job and competences to be learned on the job. In their opinion, community support workers should acquire some values, attitudes, personal characteristics and work practice skills before starting the job, but most values and attitudes, knowledge and skills are to be learned on the job (see Table 3). The wide range of competences reflects the complexity of contemporary community support.

Research with 18 consumers and 16 staff members from different fields (developmental disabilities and mental health) resulted in a list of 68 competences for community support workers. Next, 34 consumers and 34 staff members rated 59 of these competences as either absolutely necessary or desirable (marked in italics in Table 3).

Table 3. **Competences for community support workers**

Competences needed before starting the job	Competences to be learned on the job
A. Personal attributes	**A. Personal attributes**
1. Values and attitudes	1. Values and attitudes
• sensitivity to and respect for individual differences • positive attitude towards people with disabilities • commitment to work • belief in individual rights to a certain standard of living/quality of life • caring and supportive attitude towards persons receiving services	• sensitivity and understanding of personal difficulties • approach guided by service recipient needs and desires
2. Personal characteristics	2. Personal characteristics
• sincere and genuine in interaction with others • independent, takes initiative • common sense and good judgment • does what promises to do • positive and optimistic view of others • friendly, kind and warm manner with others • *adjusts well to change* • *sense of humour* • *creativity and intelligence*	• *manages stress well*
B. Knowledge	**B. Knowledge**
	1. General knowledge
	• ethic standards • social problems • physical health issues • family issues • disciplines relevant to community support provision
	2. Specific knowledge about the target group
	• effects of problems on functioning • crisis prevention and intervention • strategies to achieve a minimum quality of life • *multiple disorders* • *medication (treatment use and side effects)* • *legislation* • *first aid* • *counselling theory and practice*

	3. Knowledge on community and health resources
	• health-care services in the region • community resources related to housing, recreation, finances, transportation
C. Skills	C. Skills
1. Work practices	1. Brokerage skills
• able to work in team • professional approach to work • confidentiality of information regarding persons receiving support	• assists persons receiving services to identify, access and benefit from relevant community and health resources • assists persons in receiving services to develop natural supports such as friends and family in the community
	2. Individual assessment and planning skills
	• assists persons receiving services to identify needs and aspirations on the key domains of life • sets objectives and plans actions • puts plans in place • monitors and follows up plan realisation
	3. Relationship and counselling skills
	• relates to the person with complex and multiple needs • assists to manage changes • provides emotional support when needed and wanted • counselling skills specific to specific problems • assists persons to follow up medication • crisis planning and intervention skills
	4. Work practices
	• time management • able to work without supervision • keeps in contact with persons • *record keeping and correspondence skills related to support provision*
	5. Supporting community living roles
	• helps involve persons in community activities, mediates conflict between persons and local community, provides role model

Source: Aubry et al., 2005.

Although this model of Aubry describes the generic competences for community support providers working with people with psychiatric disabilities, most of the identified competences are generic for all community support workers in the health and social sector.

3.2.2. Comprehensive and coordinated support: brokerage skills

Front-line workers can play an important role in integrating and coordinating services in different life domains (Thornicroft and Tansella, 2009; Aubry et al., 2005). Shepherd et al. (1994) defined 11 key domains of life in which support should be considered. These are: professional support, treatment, monitoring, physical health, counselling, information but also housing, finance, day-care social support at home and social networks outside the home. Front-line workers need to be skilled to keep individuals with complex and multiple needs in contact with the agency. In other words, we need multidisciplinary teams composed of multiskilled professionals. This relates to horizontal continuity (among various services) as well as longitudinal continuity (across the continuum of time) across a range of mental, physical, social and psychological problems. Good staff get new roles as case managers. They function as 'spiders in the web of support' (the spider keeps contact with individuals and with their different support providers, and the intensity and specific content of the contact varies through time).

In other words, brokerage skills are necessary to coordinate the care provided by different organisations and services. Aubry et al. (2005) define these as:

- assist persons receiving services to identify, access and benefit from relevant community and health resources;
- assist persons in receiving services to develop natural supports such as friends and family in the community.

3.2.3. Person-centred care

Recent policy developments have highlighted the importance of a 'person-centred approach'. Front-line workers have a crucial role to play in limiting, easing or delivering these policy imperatives (Ines et al., 2006). Brooker (2004) proposes four elements that must be included to produce person-centred care:

- valuing people and those who care for them;
- treating people as individuals;
- looking at the world from the perspective of the person;
- a positive social environment to enable the person with dementia to experience relative wellbeing.

According to McCormack (2004), person-centred nursing has four aspects:

- being in relation (social relationships),
- being in a social world (biography and relationships),
- being in place (environmental conditions),
- being with self (individual values).

In a person-centred approach the support provider is 'a facilitator of an individual's personhood'. Competences and attitudes to realise person-centred care are: communication, treating people as individuals, organise support starting with knowledge of the life history, focus on what is important for the person in different key domains of life, cooperate with other support providers to put the needs of the individual at the centre of the care giving, treat individuals as you would wish to be treated. In other words, working with these groups asks for specific attitudes or social competences.

3.2.4. Participation, empowerment and human rights

In Chapter 2, a new vision of care based on participation, empowerment and human rights was presented. Participation refers to involvement and engagement of users of care services in decision-making and in a range of activities (planning, evaluation, treatment, research, training, recruitment, etc.). Participation may be both at individual or collective levels (Beresford and Croft, 2001). Policy innovations pay more and more attention to participation of service users. They are no longer seen as 'recipients of services' but as experts by experience. Their beliefs on cure and care are known to be the most important determinant on alliance. Their views and situations enable caregivers to find a solution that will lead to a successful outcome. The patient should be seen and treated as 'autonomous, resourceful and involved' (Shaw and Baker, 2004). For staff, this means a paradigm shift from someone who is seen as remote, in a position of expertise and authority, to someone who behaves more like a personal trainer or coach, offering their professional skills and knowledge, while learning from and valuing the patient.

The human rights perspective on disability views people as subjects and not as objects and as holders of rights instead of problems. The disability rights approach is not about granting specific rights, but about ensuring equal enjoyment of all human rights without discrimination. Empowerment fits in with this perspective. Social service users are more and more 'empowered' to express their own opinions, to make choices and to control their life situations (Saleeby, 2005; Quinn and Degener, 2002).

Translating these trends into competences, social care workers are challenged to empower service users. This implies:

- recognising and respecting individual rights and human dignity;

- viewing people as subjects and holders of rights and not as objects;
- focusing on strengths instead of problems;
- improving and stimulating self-realisation, self-determination and personal mastery over their own lives;
- ensure equal enjoyment of all human rights without discrimination;
- involving service users in decision-making.

3.2.5. To work with the (local) community

Because of deinstitutionalisation of social care, a more open and inclusive community is needed. An inclusive community resists stigma and discrimination. Those with complex needs are at risk of discrimination. The term stigma refers to problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination). Most research in this area has been based on attitude surveys, media representations of mental illness and violence. There is scientific evidence which shows that interventions to improve public knowledge about mental illness can be effective in reducing the stigmatising experiences of persons with (mental) disabilities. The main challenge is to identify which interventions will produce behaviour change to reduce discrimination (Thornicroft and Tansella, 1999; Thornicroft, 2006; Thornicroft and Tansella, 2009). Professionals can play a central role in the fight against discrimination if they treat service users as persons instead of ‘patients’ or ‘clients’.

Research shows that when neighbours, shop-keepers, bus drivers and the like actually meet service users their views often change dramatically. They stop seeing ‘mental patients’ and start seeing them as persons. People with disabilities want to lead a life in the community that is as normal as possible. This also demands changes in society. Tolerance towards the ‘deviant’ and positive appreciation of difference are currently important points of attention.

Care workers have to promote a social climate in which more possibilities are created for persons with disabilities who are often confronted with exclusion. Social care workers are challenged not only to build protected environments and offer good quality services, but also to create and support a hospitable reception of persons with all kinds of disabilities in the community. In other words, two worlds have to be connected: the world of the so-called ‘ordinary citizens’ and the world of the vulnerable persons who often are excluded or just do not fit in.

3.2.6. Working in a multicultural environment

First, the concept of ‘multicultural environment’ needs to be clarified. In the literature, two meanings can be distinguished. A multicultural environment can refer to an environment with people from different ethnic backgrounds, class,

Table 4. **Conceptual framework for cross-cultural counselling competences**

I. Awareness of one's own assumptions, values and biases	II. Understanding the worldview of the culturally different colleague or service user	III. Developing appropriate intervention strategies and techniques
• aware and sensitive of their own cultural heritage and valuing and respecting differences; • comfortable with differences in terms of race, ethnicity, culture and beliefs.	• aware of their negative emotional reactions toward other racial and ethnic groups; • willing to contrast their own beliefs and attitudes with those of culturally different others in a non-judgmental fashion.	• respect others' religious or spiritual beliefs and values about physical and mental functioning; • respect indigenous helping practices and minority community intrinsic help-giving networks; • value bilingualism and do not view another language as an impediment to support giving.
• knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions and biases of (ab)normality; • knowledge about how discrimination and stereotyping affect them personally and professionally.	• knowledge about the particular group that they are working with (their life experiences, cultural heritage, historical background); • understanding how race, culture, ethnicity may affect personality formation, vocational choices, manifestation of psychological disorders, help seeking behaviour, and the (in)appropriateness of support approaches.	• knowledge about the generic characteristics of front-line support work (often culture bound, class bound, monolingual) and how they may clash with the cultural values of various minority groups; • aware of institutional barriers that prevent minorities from using the support services; • knowledge of the potential bias in assessments instruments; • knowledge of minority family structures, hierarchies, values and beliefs (knowledge about the characteristics/resources in the community as well as in the family); • aware of relevant discriminatory practices at the social and community level that may be affecting the welfare of the service users.

• seek out training experiences to enrich their understanding and effectiveness in working with culturally different persons; • are seeking to understand themselves as racial and cultural beings and are actively seeking a non-racist identity.	• familiarise themselves with research regarding frequent problems and disabilities of various ethnic and racial groups; • become actively involved with minority individuals outside the job context (community events, friendships, celebrations, neighbourhood groups, etc.) so that their perspective of minorities is more than an academic or helping exercise.	• able to send and receive verbal and non-verbal messages accurately and appropriately, they recognise that helping support styles and approaches may be culture bound, when they sense that their support approach is potentially inappropriate, they can anticipate and improve its negative impact; • can help service users determine whether a 'problem' stems from racism or bias in others so that service users do not inappropriately blame themselves; • are not averse to seeking consultation with traditional healers or religious/spiritual practitioners in the support of culturally different service users when appropriate; • interact in the language requested by the service user, seek a translator or refer; • work to eliminate biases, prejudices and discriminatory practices.

Source: Sue et al., 1992.

sexual orientation, religion, sex or age (inclusive definition). On the other hand, the definition can be limited to 'visible racial and ethnic minority groups' (exclusive definition). The inclusive and exclusive definitions are not necessarily contradictory. Both offer issues and views that can enrich understanding of multicultural competences.

Front-line workers should acquire 'cultural competences'. This refers to the ability to interact effectively with people of different cultures. Sue et al. (1992) propose a conceptual framework for cross-cultural counselling competences. According to them, cultural competence comprises three characteristics, each having three dimensions: beliefs and attitudes, knowledge and skills.

Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures. Elliott et al. (1999), who developed a multicultural toolkit, underline that is seems not to be the degree of difference between cultural groups that causes harm. Rather, it is the lack of skills in identifying breaches of trust based on ethnic differences and lack of skills in restoring trust once it is broken.

3.2.7. To build partnerships with informal support providers

A partnership with informal carers implies shared responsibility. The first step is to trace and reach available and potential informal support providers. After entering into a partnership, the next challenge is to maintain the partnership, especially in cases of persons with enduring and complex problems. Partnerships in which professionals clarify roles, work as a team, use educational approaches, involve families in planning and system monitoring, learn to respond to intense (negative) feelings, meet local support groups, recognise diverse beliefs and needs, point out family strengths and one's own limitations are very important (Spaniol et al., 1992). Essential in partnerships in care is that both parties are willing to trust and learn from each other, make an effort and negotiate about the most desirable approach (Robison et al., 2007).

3.2.8. Transdisciplinary teamwork

Traditionally, different professional groups are employed in social services, such as social workers, nurses, psychologists, doctors and occupational therapists. Cooperation between these various professional groups does not always run without a hitch. Other team models are necessary, such as transdisciplinary teams. Members of such teams share roles systematically across discipline boundaries. The primary purpose is to pool and integrate the expertise of team members to provide more efficient and comprehensive assessment and intervention services. The communication style in this type of team involves

continuous give-and-take between all members on a regular, planned basis. Professionals from different disciplines teach, learn, and work together to accomplish a common set of intervention goals. The role differentiation between disciplines is defined by the needs of the situation rather than by discipline-specific characteristics. Assessment, intervention, and evaluation are carried out jointly by members of the team. Table 5 shows the differences between three types of teamwork in which different professional groups participate.

Table 5. **Three types of interprofessional working**

	Multidisciplinary	Interdisciplinary	Transdisciplinary
Assessment	Separate assessments by team members	Separate assessments with consultation	Team members conduct comprehensive assessment together
User participation	Consumers meet with individual team members	Consumers meet with team or team representative	Consumers are active and participating team members
Service plan development	Team members develop separate plans for disciplines	Team members share separate plans with one another	Team members and consumers develop plans together
Service plan implementation	Team members implement part of the plan related to their discipline	Team members implement their section of the plan and incorporate other sections where possible	The team is jointly responsible for implementing and monitoring the plan
Lines of communication	Informal lines	Periodic, case-specific team meetings	Regular team meetings with ongoing transfers of information, knowledge and skills shared among team members
Guiding philosophy	Team member recognises the importance of contributions from other disciplines	Team members are willing and able to develop, share and be responsible for providing services that are part of the total service plan	Team members make a commitment to teach, learn and work together across disciplinary boundaries in all aspects to implement unified service plans
Staff development	Independent within each discipline	Independent within, as well as outside own discipline	An integral component of working across disciplines and team building

Source: Center for Mental Health Services and The Robert Wood Johnson Foundation (2002).

As part of a large Canadian study on interprofessional education and collaborative practice, Suter et al. (2009) focused on the core competences for collaborative practice of professionals in the front line. Based on interviews of 60 professionals working in the front line, the authors identified two core competences: professional role understanding/appreciation and effective

communication. Front-line workers are crucial in prevention, offering stepped-care support, easing relations and support and making adequate referrals. However, this will only work if their role is clearly perceived as valuable and if they feel appreciated.

3.2.9. Competences linked with new trends in support for persons with multiple and complex problems

After this overview, this last part of the literature review presents some new models and trends in care for persons with multiple and complex problems. These were mainly developed in mental health care, but are transferable to other social care sectors in which persons with complex needs are involved.

3.2.9.1. *Recovery-oriented approach and harm reduction*

Onken et al. (2002) wrote a research report on 'what helps and hinders mental health care recovery'. A team of consumer and non-consumer researchers and a consortium of State mental health authorities defined a set of mental health system performance indicators based on experiences of persons with psychiatric disabilities. The central question was to identify what promotes and what obstructs the recovery process. The consortium identified predictors for recovery/relapse related to the environment/organisation, the person and the relationship. Mainly the last category is relevant for competences of social care workers. Some characteristics of the relationship between support givers and persons with problems or disabilities are linked to chronicity, while others are linked to recovery.

Table 6. **Chronicity versus recovery**

CHRONICITY	RECOVERY
Diagnostic category	Individualising
Pessimism	Hope, realistic optimism
Dysfunctions	Strengths, resilience
Fragmented model	Bio-psycho-social model
Paternalism	User-oriented
Professional support	Self-care, experiential expertise
Power and coercion	Empowerment, choice
Artificial environment	Natural support, peers
Stabilisation	Growth, calculated risks
Helplessness	Emancipation

Source: Onken et al., 2002.

'Harm reduction' arose in the 1980s when HIV became an epidemic among injecting drug users. It is a new form of health promotion that refers to a pragmatic approach in which the security and health of the person and of society are a priority. Research (WHO, 2005) shows that harm-reduction programmes are effective: they reduce risky behaviour (unsafe sex, alcohol use, drug use) and the associated risks of health problems. Instead of judging undesirable behaviour (such as using drugs), this approach offers services (such as syringe exchange, provision of methadone) 'in the field'. The services are not imposed. It is important these health promoting initiatives do not interfere with other efforts of treating the problems more fundamentally. Harm reduction challenges support providers to find persons at risk to offer their services. This approach tries to recognise and accept problems (such as use of drugs) as an existing and essential part of contemporary society. Therefore, it is necessary to address the consequences rather than ignore them.

3.2.9.2. *Assertive community treatment (ACT)*

ACT is the most widespread and durable model of clinical case management for treating and rehabilitating people with severe and enduring mental health problems. It is the dominant model of specialist assertive outreach for this target group. It was developed by pioneering psychiatrists in the USA with the explicit aim of helping patients struggling to stay out of hospital and to live more successfully in the community. It achieved this by providing more intensive support in obtaining the material necessities of life and by placing a greater emphasis on social functioning and quality of life rather than on symptoms and disease. It has been repeatedly shown to have significant advantages over routine care, and it is increasingly being adopted in the UK and mainland Europe. Key elements of the ACT model (Kent and Burns, 2005) are:

- a core services team is responsible for helping individual patients meet all of their needs and provides the bulk of clinical care;
- improved patient functioning (in employment, social relations and activities of daily living) is a primary goal;
- patients are directly assisted in symptom management;
- the ratio of trained staff to patients should be small (no greater than 1:15);
- each patient is assigned a key worker responsible for ensuring comprehensive assessment, care and review by themselves or by the whole team;
- treatment plans are individual for each patient and may change over time;
- patients are engaged and followed up in an assertive manner.

Treatment is provided in community settings because skills learned in the community can be better applied in the community. Care is continuous both over

time and across functional areas. What does ACT teach us about needed competences for front-line workers? One guiding principle is that the team should provide as much direct care as possible and avoid referring externally. Therefore, the range of skills in an ACT team is even more important than in traditional community mental health teams. Although ACT requires a lot of specialist competences (for example, skills in cognitive–behavioural therapy, compliance counselling and motivational interviewing), it also stresses the importance of generic competences. ACT challenges staff not only to develop new skills, but also to adopt new ways of working. ACT demands a lot of individual case managers, whatever their professional background, as they are continuously expected to work beyond traditional professional boundaries and develop at least a minimal competence across a range of areas.

3.2.9.3. *Presence theory*

Persons with multiple and complex problems often have the feeling that front-line workers want to offer support to solve their problems, but do not really care about them. In the 1990s, Baart (2001, 2003) developed the ‘presence theory’ in the Netherlands. This theory is mainly based on qualitative research evidence. According to Baart, to be present is the only possible answer to problems of the most vulnerable people in society. Care and support for the target group should be more than interventions and treatment. It has a lot to do with philanthropy and human dignity. People with multiple and complex needs should not be abandoned but instead be offered authentic human proximity. The central characteristics of the presence theory are: being there for the other, respect for human dignity, acceptance of the other person, reciprocity, being unhurried, alignment to the other’s perception and experiences, a cautious and slow approach. The most radical change is that attention, involvement, support and care are not offered under the condition that the person shows motivation to change or respects service rules and agreements. Front-line workers present themselves as a companion and help the person to tell their own life story. The hierarchy between the professional and the service user disappears: the front-line worker regards and treats the person as equal. The competence of being present is ‘being able to really meet the person’, to exchange human thoughts and experiences, to deter from intervening with professional methods and tools. Other characteristics of the ‘presence worker’ are: easily approachable, accessible, adaptable to the other’s rhythm, with an open agenda (instead of fixed goals), warm and informal.

3.2.9.4. *Long-term care and expressed emotion*

Long-term care and support relations between care workers and service users are in every way emotional. These social care workers will often play different roles in their lives. Long-term support can/will lead to emotional involvement. Expressed emotion (EE) is a well documented and interesting concept in the relationship between support givers (family or professional caregivers) and persons with mental illness. Expressed emotion is a qualitative assessment of the amount and the way of emotion displayed. Based on the expressed emotion concept, a core competence for front-line workers is to express their emotions in a helping way. Low EE-relations are characterised by: comprehension of the disability, tolerance for challenging behaviour; good balance between under- and overstimulation; constructive criticism; clear limits (involvement but not over concern); warm attitude towards the user; positive and motivating; attention and interest for the life project of the user; openness and flexibility; stimulation of the user to express their feelings (Van Humbeeck and Van Audenhove, 2003). Other important competences are to: have a reflective attitude, get in touch with one's own emotions, recognise one's own part in the evolution of the other's behaviour and know when to adapt one's expectations and intensity of support.

3.3. Leadership competences

Leaders must be visionary, able to design a mission, communicate transparently about long-term goals and decisions, support a culture of innovation, encourage diversity inside the organisation (appreciating different perspectives on issues), elicit and take care of involvement of staff, involve private or voluntary bodies, work on positive image building and destigmatisation of users (Fauth and Mahdon, 2007). Anthony and Huckshorn (2008) state that good leaders in community-based services should be able to:

- communicate a shared vision;
- centralise by mission and decentralise by operations;
- create an organisational culture that identifies and tries to live by key values;
- create an organisational structure and culture that empower their employees and themselves;
- ensure that staff are trained in human technology (teaching employees how to be leaders, how to set their own goals and learn new skills, and how to relate to clients) that can translate vision into reality;
- relate constructively to employees;

- access and use information to make change a constant ingredient of their organisation;
- build their organisation around exemplary performers.

3.4. Conclusions

In Chapter 2, deinstitutionalisation was described as one of the main developments concerning social services of general interest. Deinstitutionalisation brings about new trends and methods (such as empowerment, person-centred care) which require new generic competences of front-line staff. In this chapter, we presented a broad range of research evidence on generic competences needed by front-line workers to work with people with complex and enduring needs. Since we can observe some overlap between these different approaches, we regroup them into five generic competences to:

(a) **integrate and coordinate services in different life domains**
People with multiple and complex needs are confronted with various services which focus on different life domains. Consequently, actions of these different care workers need to be coordinated. These coordination skills are necessary to realise more person-centred care. Coordination relates to horizontal continuity (among various services) as well as longitudinal continuity (across time) across a range of mental, physical, social and psychological problems;

(b) **create an inclusive community and to fight stigma and discrimination**
Research shows that when neighbours, shop-keepers, bus drivers and the like actually meet service users their views often change dramatically. They stop seeing 'mental patients' and start seeing the individual as a person. People with disabilities want to lead a life in the community that is as normal as possible. This also demands changes in society. Tolerance towards the deviant and a positive appreciation of difference are currently important points of attention. How can we fight stigma and discrimination and at the same time make sure that people with limitations can take full part in labour, education and recreation? For people with disabilities, this trend is strongly captured with the concept of inclusion, which states that all people together create society, including people with disabilities. People with disabilities do not have to be integrated; they are already part of society;

(c) **empower service users based on a human rights perspective and realise their participation**

The human rights perspective on disability means viewing people as subjects and not as objects and as holders of rights instead of problems. The disability rights approach means also ensuring the equal enjoyment of all human rights without discrimination. Empowerment is a fundamental part of this perspective and refers to reinforcing individuals, groups and communities to control their own lives by focusing on strengths instead of problems and by helping them make their own choices (Saleeby, 2005; Quinn and Degener, 2002). Participation refers to involvement and active engagement in decision-making at individual and collective levels (Beresford and Croft, 2001);

(d) **build a relationship of trust with service users characterised by 'low expressed emotion' and a recovery-oriented approach**

These relationships are characterised by: comprehension of the disability, tolerance for problem behaviour; good balance between under- and overstimulation; constructive criticism; clear limits (involvement but not overconcern); warm attitude towards the user; positive and motivating; attention and interest for the life project of the user; openness and flexibility, stimulation of the user to express their feelings (Van Humbeeck and Van Audenhove, 2003);

(e) **build partnerships with informal support givers**

Informal carers are an essential part of the client's network and formal care workers consider them as partners with their own expertise.

At organisational level, we distinguish between innovative team models and leadership competences. Innovative team models are transdisciplinary. Traditionally, different professional groups are employed in social services, such as social workers, nurses, psychologists, doctors and occupational therapists. Cooperation between these various professional groups does not always run without a hitch, because these different disciplines focus on their own specialities. Members of such transdisciplinary teams share their knowledge and skills across discipline boundaries. The primary purpose is to pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided. Their relations are based on equality.

Innovative leadership stresses the importance of the following competences: to be visionary, to communicate transparently about long-term goals and decisions, to support a culture of innovation, to encourage diversity inside the organisation, to strengthen involvement of staff, to pay attention to lifelong learning of staff and to work towards positive image-building of users.

4. Generic competences: focus groups in five Member States

Country-specific material collected by the five national focus groups ([19]) is described and compared, to define similarities and differences with particular focus on the competences needed to meet them. Six generic competences have been defined as the most important ones for front-line staff and service managers to cope with current challenges in care provision.

4.1. Method

As already mentioned in Chapter 1, focus groups were organised in Germany, Poland, Portugal, Sweden and the UK, by local research partners. These focus groups had three main objectives. First, results of the literature review were validated. Second, the focus groups helped to explore new ideas which were not covered by the review. Third, discussions were meant to bring into focus country-specific information.

Three topics were covered by the focus groups. The first ws the main societal and policy challenges and their effects on the social care sector in the countries under investigation. Particular attention was paid to what extent current social services meet the nine quality criteria of good services, formulated by Thornicroft and Tansella (1999). The second covered the needed generic competences of front-line staff. In particular, they were asked to describe the ideal front-line worker. The third concerned the qualities of good leadership.

Table 7 shows essential information on the focus groups: recruitment, number and characteristics of participants, the moderator and the duration. In Germany, participants were mainly from the elderly care sector. The UK mainly focused on services for the homeless. Poland, Portugal and Sweden mainly discussed care for the disabled.

([19]) More information on the Member States selected and their health and social services systems can be found at the following websites: for health services: http://www.euro.who.int/countryinformation and for social services: http://ec.europa.eu/social/main.jsp?catId=815&langId=en [both cited 27.4.2010].

Table 7. **Focus groups in five Member States**

	Germany	UK	Poland	Sweden	Portugal
Recruitment	During AWO training	Invitation to known experts and front-line/client representatives	Invitation to staff of the Integracja Centre – information and advisory support for people with disabilities	Invitation to trainers for staff working with vulnerable persons	Invitation to staff of the social care sector, clients and client representatives
Number	14	9	8	10	9
Characteristics	Services for the elderly 12 elderly care nurses 1 manager (home care service) 1 director of training centre	Homeless services 1 ex-service user 2 training managers 1 HR manager 1 clinical psychologist 1 social worker 1 nurse 1 psychiatric worker 1 front-line support worker	Services for the disabled Leaders Front-line staff Professional advisors	People involved in planning and realising education for staff in social field	Rehabilitation services 3 service users 2 directors of social solidarity cooperative 1 training director 1 counsellor 1 case manager 1 training counsellor
Moderator	Project manager AWO (head training centre)	Mike Seal (trainer and lecturer)	Tomasz Krasoń (researcher, cooperating with Millward Brown)	Project leader Maarit Aalto	Project member from CRPG (Raky Wane)
Duration	3h15	2h45	2h	2x 3h	3h

4.2. Outcomes

Diverse focus groups and the various topics handled led to a rich overview of country-specific challenges and competences needed. We start this section by giving a brief summary of results of the focus groups in each Member State. Subsequently, we analyse the main differences and commonalities between countries. An essential part of this analysis is the comparison between focus group data and the literature review on generic competences.

4.2.1. Germany

As mentioned above, the focus group in Germany concentrated more on the situation of elderly people. First, social and policy changes concerning this specific target group were discussed. Demographical developments caused by rising life expectancy together with a growing number of people with dementia will have a huge effect on care for the elderly. For instance, Eurostat estimates that old-age dependency in Germany will increase from 27% in 2005 to 55% in 2050. As the number of people in need of assistance will increase enormously, there will be a huge need to recruit more professionals. Participants also pointed to growing ethnic diversity. This challenge reveals itself in both demand and supply sides of social services. This means the elderly themselves become more diverse, and recruitment of ethnic minorities as care workers is still underdeveloped. Another topic concerns the consequences of deinstitutionalisation of social care services for the elderly and their effects on their living conditions. The current ambulatory care service, semi-residential and residential services for elderly people were also analysed. The current trend of deinstitutionalisation is forcing the social care sector and policy-makers to develop new forms of living concepts such as small living groups, joint apartments, service apartments, etc. These new kinds of living opportunities fit better the needs and expectations of the elderly.

On the characteristics of ideal front-line staff, the German focus group mentioned attitudes such as reliability, motivation, politeness and social skills. A new skill was added, namely readiness for shift work. Front-line workers have to be more inclined to change their routines.

On competences of managers, the German group insisted on the need for business training. As a consequence of applying market principles to social care, care managers are forced to have more economic and commercial competences. Ideally, leaders should also have a qualification as home managers and knowledge of standard and job-specific software. They should also possess practical care knowledge and knowledge of personnel management.

4.2.2. The United Kingdom

The focus group in the UK concentrated mainly on services for homeless people. They analysed statutory and non-statutory measures given to this target group and reviewed recent initiatives and projects. Projects included assertive outreach teams, health promotion, homeless initiatives and day centres providing basic food and health opportunities for young homeless people. Assertive outreach teams have already been discussed in Chapter 3. Homeless Link, the British

umbrella organisation of services for the homeless, developed guidelines for health promotion of the homeless ([20]).

Unfortunately these different projects have led to a pot-pourri of systems and funding streams which makes long-term planning and commitment to individual clients and schemes very difficult and constitutes a source of considerable frustration and disappointment in the sector. Three challenges were highlighted by the focus group: accessible low-threshold services, opportunity for true client participation and coordinated multiagency/multidisciplinary support.

The front-line staff competences encompassed the ability of the worker to undertake reflective practice. Schön (1983) suggested that the capacity to reflect on action to engage in a process of continuous learning was one of the fundamental characteristics of professional practice. Reflective practice involves thoughtfully considering one's own experiences in applying knowledge to practice while being coached by professionals in the discipline.

It was noted that workers should also be able to listen effectively, interview motivationally and assess client needs effectively. Motivational interviewing is a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence. Compared to non-directive counselling, it is more focused and goal-directed. Examination and resolution of ambivalence is its central purpose, and the counsellor is intentionally directive in pursuing this goal. Motivational interviewing has become an evidence-based approach to overcome the ambivalence that keeps many people from making desired changes to their lives (Miller and Rollnick, 2002). These three skills are considered quite important in this sector because often homeless people have multiple and complex needs difficult to be assessed. In addition, these people are often reluctant to change.

A good leader should dispose of personal attitudes like being able to take criticism constructively and having a strong sense of purpose and commitment. A real leader also needs to model good practice and recognise the need for the organisation to change its daily routines and functioning.

4.2.3. Poland

The Polish focus group concentrated on promoting social and labour market integration of people with disabilities. Although many actions were taken during the past couple of years for people with disabilities, employers still need to be activated to hire them. A second obstacle is lack of information on specific needs of people with disabilities. Consequently, planning in social policy is less effective. Third, current social policies are not based on a common and

([20]) For more information, see: www.homeless.org.uk [cited 5.5.2010].

coordinated vision of working with people with disabilities. Fourth, lack of coordination between actions carried out by State and NGOs can be observed. This sometimes causes malpractice because beneficiaries use this misunderstanding to get parallel support from different organisations at the same time. In addition, an often forgotten task is 'activating' people with disabilities instead of 'tolerating' them. Better procedures that make clear how and how long people with disabilities can be supported are needed.

According to participants, front-line staff should have the following interpersonal competences: patience, assertiveness, physical strength and the ability to maintain a relationship with the service user. They must also know how to access and process information and be creative in solving problems and managing stress. As was noticed in the focus group:

> There is no space for routine. Sometimes beneficiaries may show anger as some situations make them nervous. A front-line worker must handle this kind of situation and must do it quickly.

Participants also mentioned it would be useful in everyday work to learn how to keep a safe distance from people with disabilities and understand the symptoms of their disease.

The group concluded that the main leadership competences are: appropriate behaviour, objectivity in care and dialogue in the team. Leaders should give equal treatment to all staff and this regardless of their status, as sometimes personal advisors, lawyers and psychologists are treated better than front-line staff. In addition, leaders should be decisive, skilful and have experience in working with a particular target group. Towards staff, leaders should proceed with an optimal evaluation to be able to define their problems together and support them in crisis situations such as burn-out.

4.2.4. Sweden

The Swedish focus group reviewed the situation of disabled persons in their country. They started by explaining the LSS law of 1993: the Swedish Act on support and service for persons with certain functional impairments. This act defines 10 types of services (advice and personal support, personal assistance, escort services, contact person, daily activities, housing arrangements, companion service, etc.). Swedish municipalities are responsible for implementing this act. The national government makes grants available to municipalities. As such, the act fits into the broader philosophy of the Swedish welfare State, in which responsibility for social welfare services (such as care for the elderly, social assistance and child care) rests primarily with municipalities.

This LSS law instigated the transition from large institutions to small-scale and community-based services. It also represents a turning point in changing attitudes towards empowerment, inclusion of personal rights, participation and personal support.

Current challenges are to guarantee the same quality of service during the financial crisis. This crisis will lead to cuts in social benefits. A second challenge is to increase the effectiveness of services in favour of service 'users'.

The Swedish focus group underlined the importance of personal competences such as flexibility, and following a value-based approach for front-line staff. To improve client interaction, front-line staff need good communication skills. They have to be able to work with an inclusion-oriented approach which starts with users' opinions and helps them find a solution. Other relevant competences relate to case management. Case management is coordination of different community services by allocating a professional responsible for assessing needs, implementing care plans and coordinating activities of various social and health services. Case management is usually most appropriate for people who, as a result of complex problems have ongoing support needs in areas such as housing, employment, social relationships and community participation.

4.2.5. Portugal

On social policy, the focus group underlined the constraints and challenges people with disabilities have to face. The greatest constraint is rigidity of social policies which does not allow real client participation. An additional problem is lack of coordination of different policies. A third challenge is the need to improve dissemination of information on social services, since users do not know which support is given by different service providers. Fourth, they underscore the importance of prevention. Too many policy interventions only happen after problems arise. The focus group also mentioned the growing figures of domiciliary care, although many services are still concentrated in institutions.

This focus group considered the role of front-line staff to be 'change agents'. Staff should be able to identify problems and ground the needs for change. New roles such as creators and facilitators of networks and partnerships are also important. Accordingly, some competences for front-line staff relate to these roles: identifying new needs and new services and being able to communicate with community agencies. Alongside these brokerage skills, flexibility, versatility and adaptability should also be included in competences for front-line staff. Staff should also be motivated for lifelong learning.

The Portuguese focus group agreed that 'communicate a shared vision' is the most important competence for a service leader. Next to communication and implementation of vision, competence to improve management was added, which includes service efficiency and ability to think long term to ensure financial sustainability and identify both new services and alternative funding sources.

4.2.6. Comparison between countries

We now compare country-specific information to explore commonalities and differences in relation to societal and policy changes and the competences needed by front-line workers and good leaders.

4.2.6.1. *Societal and policy changes*

As mentioned earlier, focus groups were characterised by a large diversity of participants (front-line staff, managers and VET managers) from various social services: services for the elderly, the disabled and the homeless (Table 8). Consequently, results are less comparable between countries. As this study is mainly explorative, diversity also leads to a broader and richer overview of the challenges in different social care sectors.

Focus groups did not identify any new societal changes. In other words, the literature review covered all relevant societal and policy evolutions. While the literature review described societal changes in more general and academic terms, focus groups discussed their consequences for front-line workers and managers dealing with specific target groups. As viewed in Table 8, the German and Portuguese focus groups discussed current societal changes from a more general point of view. The three other countries mainly focused on the challenges of their own specific social care sector.

Two main conclusions can be made on policy changes. First, different levels of development of social services can be distinguished. This was also covered by the literature review in which attention was paid to various welfare State models. At the moment, more actions are needed to increase acceptance of persons with disabilities by the community in general and by employers more specifically. Second, policy changes are linked to the sectors in which participants are employed. Despite large diversity of the sector, five common challenges can be identified: (a) shortage and recruitment of workers; (b) growing multicultural diversity; (c) deinstitutionalisation; (d) lack of a shared vision and coordination between policy measures; (e) empowerment instead of paternalism.

Characteristics of the social care workforce have already been described in Chapter 2. The social care sector is highly labour-intensive. Due to demographic and societal trends, there will be a growing need for social care workers in future.

Although spending on social care will increase considerably in the next 40 years and unemployment is rising, social care jobs remain unattractive, because of unappealing working conditions. Domestic shortages of workers have resulted in more jobs being filled by migrant low-skilled workers, also due to enlargement of the EU. The Swedish focus group points to the specific need of the social care sector to recruit well-educated workers. This is an example of large differences in priorities between Member States. While in Poland, the focus group was in favour of more action for persons with disabilities, in Sweden the focus group was particularly concerned about preserving the current quality of social services.

Growing multicultural diversity discussed in Chapter 2 was confirmed by the German and Portuguese focus groups. Especially in the German care sector for the elderly, the search for new migrant workers to fill current needs is a hot issue. Demand and supply in different social care sectors differ, although some common trends can be observed. The British focus group provided some examples of the deinstitutionalisation process in the homeless sector. Although large institutions are decreasing, new community services are not always well coordinated and able to meet complex needs because of insufficient means at their disposal. Since homeless people have complex needs, alternative support services are required. The British focus group described different examples such as self-help groups for people with dual diagnosis, community mental health teams in every area consisting of psychiatrists, social workers and nurses, crisis resolution teams, assertive outreach teams and the homeless mentally ill initiative (HMII).

A next challenge is lack of a shared vision on the future of social care sectors. This impacts negatively on coordinating the various policy measures adopted. More coordination between existing policy measures is needed. Lack of coordination can be situated at different levels. The first is at the level of individual users and their social/family surroundings. At organisational level, cooperation between different service providers is needed particularly because clients with complex needs are nowadays increasingly involved with more and more service providers. More cooperation and coordination between these groups through case management could be relevant. Despite a few good practices, focus groups pointed out that coordination is less developed, since funding is increasingly based on performance. Consequently, social services develop strategies focusing on quantity instead of quality. Vulnerable groups with multiple and complex needs, are treated less, because they consume more time and need more support. In other words, coordination takes time but front-line workers are under pressure to show quantitative results. At policy level there is a need for coordination between State and NGO action and a shared vision and

coordination between policy measures. Focus groups also defined the qualities of a more innovative vision for social care dialogue and the sector. They point to a vision based on empowerment, human rights and more person-focused support instead of paternalism.

Table 8. **Conclusions on societal and policy changes**

	Germany	UK	Poland	Sweden	Portugal
Main focus	Elderly	Homeless people	Persons with disabilities	Persons with disabilities	Persons with disabilities
Societal changes	• Ageing society • Shortage of workers • Ethnic minorities				• Ageing of the population • Migratory movements and ethnic minorities
Policy changes	Deinstitution-alisation Differences between urban and rural areas	Various innovative services and policy innovations, but: • complexity of systems and funding streams • lack of coordination	No common and coordinated vision on people with disabilities More actions concerning people with disabilities needed Employers need to be educated Lack of coordination between actions of State and NGOs Actions mainly focus on cities Need of rendering people active instead of paternalism	Innovative trends towards empowerment, human rights, participation and personal support Challenges: • retaining the same quality, especially in current financial crisis • recruitment of educated staff • sustainable development Effective care provision	Deinstitution-alisation Four main challenges: • client orientation • integrated services • accessibility • empower-ment

The Portuguese and Polish focus groups also pointed to differences between rural and urban areas. At present, less attention is paid to specific challenges of rural areas. This was also emphasised in a European study on social inequality and health. Huber et al. (2006) presented evidence of concentration of services in urban areas. The Portuguese focus group confirmed that this is also applicable to VET systems.

4.2.6.2. *Generic competences of front-line workers*

Members of the focus groups were asked to prioritise the generic competences derived from the literature review. They provided an even broader and richer view of generic competences of front-line workers. The results for each country are summarised in Table 9.

Table 9. **Generic competences for front-line carers based on focus group findings**

Germany	UK	Poland	Sweden	Portugal
• Professional work (based on knowledge) • Empowering the client • Reliability • Motivation • Dedication • Social competence, e.g. empathy • Ability to transfer knowledge into practice • Spirit of teamwork, competence of organisation • Flexibility • Planning, carrying out and reinforcement of care • Politeness • Appreciation of other people • Readiness to shift work	• Effective communication skills • Motivational interviewing • Ability to reflect and to undertake reflective practice • Giving and receiving feedback • Engage in self-care and support • Resilience • Psychological mindedness • Effective assessment of clients needs • Being able to balance need for validation with ability to work for change (no mollycoddling) • Understanding behavioural/ emotional disturbance through different models • Coping with challenging behaviour	• Patience • Assertiveness • Empathy • Ability to start and maintain relationship with client • Ability to quickly access and process information • Knowing how to solve conflicts • Managing stress • Avoiding discrimination in offering support • Individual approach to each client • Using the relationship with the client • Involving the client in the process of decision-making • Knowing the needs of clients in the local community • Ability to start and maintain cooperation with local institutions	• Relation-oriented education • Flexibility • Value-based • Case management • System knowledge (knowledge of authorities, the law, rules, services, etc.) • Interaction-based knowledge • Special knowledge of communication, active listening • Coordination and coaching • Consultative support • Creating a constructive work situation/ environment • Solution driven • Open-minded • Creativeness • Inclusion-directed	• Ability to identify new needs and new services • Greater flexibility and creativity • To create chances for user participation • Connector/ facilitator • Work with the local community • Partnership with informal carers

Based on the rich findings of the focus groups, Table 10 regroups the data into six categories of generic competences. The first refers to personal characteristics and attitudes, such as empathy, assertiveness, resilience,

patience. Second, as relational skills are the quality of the relationship between the care worker and the client, which strongly influences the effectiveness of the care provided, social care workers need to have the ability to build relationships based on trust and communicate effectively. The third group of skills relates to the ability to transfer knowledge into practice. Fourth, empowerment is strongly stressed in all focus groups. Fifth, brokerage skills are already described in the literature review and were confirmed by the focus groups. A last category of competence relates to the ability to work in a team. Giving and receiving feedback is necessary to improve continuously their performance. The capacity to reflect on action and engage in a process of continuous learning is one of the fundamental characteristics of professional practice. Reflective practice involves thoughtfully considering one's own experiences in applying knowledge to practice while being coached by other professionals.

Table 10. **An overview of the generic competences identified by focus groups**

Personal characteristics and attitudes	Relational skills	Empowerment and participation skills	Brokerage skills	Teamwork skills	Knowledge management skills
• Motivation • Flexibility • Professional attitude • Reflective • Spirit of teamwork • Self-care and stress management • Work/life balance • Empathy • Patience • Assertiveness • Appreciation of differences/ coping with challenging behaviour • Readiness to change • Resilience	• Ability to build relationship based on trust • Effective and active listening • Communi-cation skills • Motivational interviewing	• Avoiding discrimination and paternalism • Involving service user in decision-making	• Cooperation with local institutions • Inclusion: cooperation with the local community • Case management	• Giving and receiving feedback • Reflective practice • Consultative support	• To transfer knowledge into practice

4.2.6.3. *Knowledge management skills*

Knowledge management skills were not detected in the literature review. However, their importance was stressed by the focus groups, so this can be considered one of their most important contributions to this study. Indeed, one of the major challenges for social services is to master its knowledge management. Knowledge management is a key dimension of a learning organisation. Effective knowledge management is closely linked lo leadership competences and to problem-solving competences of all staff. Managers with effective knowledge management skills:

- establish some of the key conditions required to help knowledge management;
- show willingness to share information and knowledge freely and seek it from others in the organisation;
- convey the attitude that knowledge to solve organisational problems and improve the organisation's effectiveness can exist at any level of the organisation and not exclusively in the upper levels of the hierarchy (this attitude creates an environment of trust, and influences attitudes about information sharing and collaboration);
- function as role models (through their visible actions, leaders can encourage willingness in other employees to emulate them).

Goh (2002) proposes an integrative framework in which he suggests that effective knowledge management can be achieved only with a complex multilevered approach that does not ignore the important 'soft factors' in the process. Emphasis solely on information technology or structured organisational processes (the 'hard factors') to ease knowledge transfer will not succeed. The important 'soft factors' are hard to develop and require long-term focus and effort. Positive relationships and ease of communication have to be developed between all stakeholders of knowledge management.

According to Goh (2002), effective knowledge transfer is a complex process that requires a manager to consider issues on several levels. The organisational characteristics and managerial practices needed to ensure effective knowledge transfer are:

(a) high level of trust between levels, individuals, and work groups in the organisation. This is evidenced by widespread sharing of and ready access to information about the organisation. The behaviour of leaders also needs to be consistent with a philosophy of openness;
(b) strong and pervasive culture of cooperation and collaboration. It is developed through work practices that encourage and allow individuals and groups to work together on projects and problems. Teamwork is strongly

emphasised and cross-functional work teams are formed regularly in the organisation;

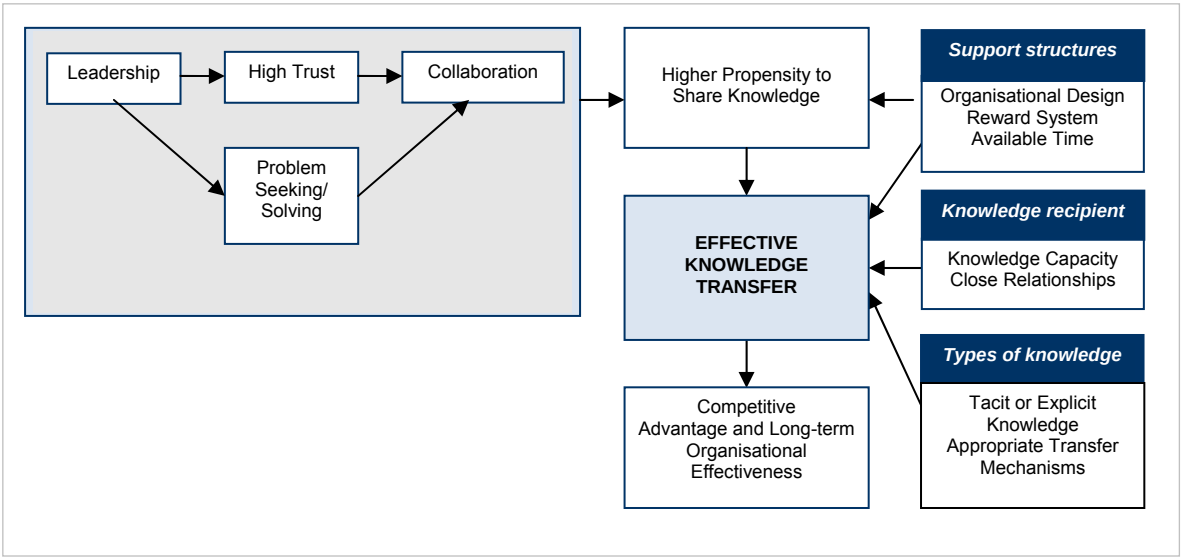
(c) strong culture of continuous improvement and learning, linked to problem-seeking and problem solving and focused on specific values (such as empowerment of service users). Employees are encouraged to gather relevant information – on, for example, customer dissatisfaction, or defects in support quality – and to use and share that information in problem-solving and implementing innovative solutions and practices;

(d) organisational design that encourages horizontal communication and has few hierarchical barriers to block communication flow. Information technology systems should ease the flow and accessibility of information;

(e) consistent level of skills and competences among employees. Employees are well trained and have both the knowledge and skills needed to accomplish their work and realise the desired values. Competence is not defined solely by level or by a particular set of tasks;

(f) balanced approach to encourage sharing and transfer of knowledge through structured processes such as sharing best practices and through less structured processes like mentoring, personal intranets/websites, group dialogue and reflection sessions;

Figure 6. **An integrative framework: factors influencing effective knowledge transfer**



Source: Goh, 2002.

(g) reward system not purely focused on financial results or outcomes based on competition between groups in the organisation. Rewards should be broadly based on other criteria such as successful knowledge sharing, cooperation, and teamwork.

From the above, ideally everyone in an organisation has or should have the skills to promote, create and share knowledge to a level corresponding to their function in the service. Therefore, both front-line workers and managers should dispose of knowledge management skills, albeit to a different degree.

4.2.6.4. *Good leadership*

On the competences of leaders, more commonalities between countries can be observed compared to front-line workers. Most participants stressed three competences which were also present in the literature review:

- centralise by vision;
- notice good performance and multiply good practices;
- relate constructively to employees.

Ability to centralise by vision is to develop an organisational culture based on a common vision shared by all members of the organisation. This means that good leaders are able to inspire others in a common vision by appealing to shared aspirations. They also identify good performance in their own organisations and try to establish basic conditions to promote multiplication of these good practices.

Next to these three competences, participants also named two new skills and two new attitudes. The new skills are ability to act as an interagency interface and ability to involve service users. As cooperation and coordination between social and health services is necessary, leaders must have the ability to build partnerships with other services. The ability to involve services is a direct consequence of the new vision on care based on empowerment, human rights and participation (Chapter 2). User involvement is an active process, giving users a voice to air their views on their own care trajectories, organisational policy and public policies more generally. Especially in the UK, there is a strong service user movement. On attitudes, leaders of social services should be able to take criticism constructively and be decisive. German experts added another competence: it is important for leaders to have gone through additional commercial or economic training. This can be partly explained by application of market principles in the social care sector in Germany.

Table 11**. Competences of leaders according to national focus groups**

Germany	UK	Poland	Portugal
• Additional commercial or economic training • Practical care knowledge • High commitment • Persistence • Organisational skills • Knowledge of software • Knowledge of human resources management	• Understand the clients for which service is provided • Strong sense of purpose and commitment • Can take criticism constructively • Recognise need for organisation to change • Model good practice • Manage interagency interface • Support and supervise staff effectively • Involve service users effectively	• Create clear organisational structure, clear scope of competence and decisions on specific levels • Build culture that strengthens and helps front-line staff in their work • Ability to converge all activities of staff to a common mission • Communicate the common vision comprehensively • Good relations with staff • Openness for positive and negative feedback on organisation • Notice outstanding performance • Make use of their skills	• Communicate a shared vision • Centralise by mission and decentralise by operations • Create an organisational culture based on key values • Improve management: greater concern with service efficiency, more management-based practices • Think long term • Ensure financial sustainability • Identify alternative funding sources • Identify new services

4.3. Definition of the six general competences

The steering group of the study chose to focus on the most fundamental and urgent needs for training in the social care sector in view of time constrains. Consequently, they compared and discussed the outcomes of the focus groups' work and the literature review. They identified six generic competences needed to face the current societal and policy changes and to make social services more effective for the most vulnerable groups in society. These six generic competences are well documented in the literature review (see Chapter 3) and were also broadly shared by the five focus groups. The competences are: empowerment skills, brokerage skills, working in a cross-disciplinary team, working in a multicultural environment, knowledge management skills and leadership. They can be further defined:

(a) **empowerment:**

- recognise and respect individual rights and human dignity;
- view people as subjects and holders of rights, and not as objects;

- focus on strengths instead of problems;
- improve and stimulate self-realisation, self-determination and personal mastery over one's own life;
- ensure equal enjoyment of all human rights without discrimination;
- involve service users in decision-making;

(b) **brokerage skills:**

- assist service users to identify, access and benefit from relevant community services in different life domains (social security, employment, housing, leisure activities, health services, etc.);
- assist service users to develop a natural support system consisting of friends and family;
- work with the local community to create an inclusive and accepting environment in which everyone can participate;

(c) **multicultural diversity:**

- respect different cultures and be sensitive to cultural differences;
- adapt interventions to different cultures and search for ethno-sensitive interventions;

(d) **transdisciplinary teamwork:**

- share roles systematically between team members and across discipline boundaries;
- pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services can be provided;
- promote continuous give-and-take between all members on a regular and planned basis;
- invite professionals from different disciplines to teach, learn, and work together to accomplish a common set of intervention goals;
- differentiate between disciplines according to needs of each case rather than by discipline-specific characteristics;
- carry out assessment, intervention, and evaluation by the members of the team jointly;

(e) **knowledge management skills:**

- transfer theoretical knowledge into practice;
- transfer knowledge to other social services and social care sectors;
- integrate new technological developments into social services;

(f) **leadership:**

- create an organisational culture based on a central vision and key values;
- entrepreneurship;
- manage change.

Innovative leadership consists of three competences. The first relates to the way social service leaders communicate, support and reinforce an organisational vision. The leader makes sure the vision is a shared vision and identifies its relevance for service users. The leader uses central values as anchors and guidelines for decisions. Second, a good leader should dispose of entrepreneurship. Because of new public management and new steering instruments such as tendering procedures and introduction of quasi-markets, social service leaders need more entrepreneurial skills to obtain public means and show the results of their actions. The third competence refers to managing change. Since society is changing fast, social services are constantly challenged both to analyse their functioning and search for better answers to evolving needs of changing vulnerable groups. Social service leaders are expected to smooth, monitor and evaluate organisational change.

4.4. Validation of results in a hearing group

Three general remarks can be made. First, multicultural diversity concerns, not only migrants but also ethnic minorities. Second, current knowledge-based economies may cause even greater inequalities among people, as also stressed in the literature review. Third, and this is a new element, the numbers of persons with disabilities are increasing, due to better medical and social care from birth onwards.

On the six core generic competences, participants stressed that the need for more specialists in all areas of the social care sector should not be overshadowed by the search for 'horizontal' competences. Eurofound (2009b) recently published a study on the social care sector in which it pleas for more specialisation. A second remark concerned the target group of this study: not to forget children's and young people's needs; in fact, they are complex and should not be denied. A third remark referred to lack of attention to prevention. Indeed, the present study does not refer explicitly to the prevention side of social services. Fourth, social care workers also have to work with informal care providers, as mentioned in Chapter 1. This and corresponding attitudes and skills should become the focus of further analysis of other training needs not covered by this study. Fifth, the gender dimension plays a double role: on the one hand poverty concerns many women and on the other, staff in the social care sector are also mainly composed of women. Specific skills are needed to tackle these women's needs, as equal treatment of women is still an important issue in the EU.

5. Innovative VET and quality assurance

Sixteen examples of practices in five Member States and two at European level are given in Annex 3.

This chapter describes gathering and analysis of innovative VET. These VET programmes are innovative because they are related to at least one of the six core generic competences: empowerment, brokerage skills, knowledge management skills, working in a transdisciplinary team, working in a multicultural environment and innovative leadership.

In this chapter, particular attention is paid to the growing importance of quality assurance in VET. The practices selected by national partners are also analysed based on the European quality assurance framework (EQARF) (see Annex 2) to define their quality-related dimensions and transferability potential. The major drivers of change in the sector described in Chapter 2 are analysed.

5.1. Definition of innovative practices

This section analyses 16 practices of VET in five selected Member States and focuses on the six identified generic competences. In addition, two European practices have been included because of their particular comprehensiveness; both are organised by the European Platform for Rehabilitation (EPR). The following characteristics are described: (a) main objectives of VET and their link with generic competences; (b) target group; (c) main content; (d) organising body; (e), financing; (f) price for learners; (g) didactical approach; (h) quality assurance system. On quality assurance, the roles of evaluation and stake-holders are described.

5.2. Analysis of good practices

The described practices give a broad overview of innovative VET programmes in the selected Member States. However, as this is mainly an explorative study, it is advisable to compare and focus on some transversal issues and draw up conclusions on the case studies presented.

5.2.1. Definition of VET and level of development of the social care sector

Based on the good practices gathered, large differences can be observed in duration and learning outcomes of VET-related projects, which can be partly explained by differences between countries, regions and various subsectors within the larger social care sector. Certainly, differences can also be attributed to differences between welfare-State regimes in the EU. A Eurofound study (2009b) redefines these different welfare-State regimes and relates them to VET.

Table 12. **Three types of VET models**

	A. Liberal	B. State-controlled	C. Corporatist
Decision-maker	Business (and individuals)	State	State and social partner organisations
Rationale	Liberalistic competitive	Centralistic State-centred	Corporative – social consensus
Programmes	Business and individual	Education and citizen	Occupation
Content	Needs of business and individual, utility-oriented, short-term and specific	Politically determined, general knowledge, course-oriented, academic	Determined by social partners, occupation centred, traditions
Labour markets VET relates to	Internal (business) labour markets	Occupational and internal labour markets	Occupational labour markets
Strengths	Flexible, cheap for the State, close to the needs of production	Strong linkage to the education system, no lack of training places	Broad vocational educations with status equal to general education
Weaknesses	Under-investment in training and education	Weak linkage to the labour market	Inertia in the institutions
Representatives	United Kingdom, Ireland	France	Germany, Austria, Denmark
Trends	Stronger State involvement in certification and quality	'Dual system' emerging and stronger orientation on business needs	Internal labour markets Marketing of VET

Source: Eurofound, 2009b.

Table 12 shows how these differences between countries can be explained. However, this remains a very generalised picture of VET. At the same time, attention must be paid to the level of development of the social care sector in the different countries. For instance, the Polish focus group pointed to the deficiencies in access to training. There is often no funding for training in organisations. In addition, it's difficult to convince managers of social services of the relevance and necessity of continuing education and training. Another example can be found in the homeless sector. Because this sector is less developed in the EU, VET programmes are less developed too. Consequently, more short-term programmes are offered to meet the most urgent training needs.

Thus, good practices are often a national, sectoral or regional answer to specific needs in a certain field. Innovation has not got a clear-cut definition either. A VET programme can be innovative, because of specific needs in one sector, country or region. In other words, special attention has to be paid to the national and sectoral contexts of the VET programme under consideration. At the same time, a more ambitious VET strategy is needed for these services, in which certification and accreditation are part. It should be noted that, certification and accreditation may not hinder innovations in VET; instead they may be the driving force for improving quality.

5.2.2. Innovative approaches

Despite no clear-cut definition of innovation, five recent trends can be highlighted as characteristics of innovation in the social care sector. A first innovative trend is participation of service users in VET. Service users can fulfil different roles in these training programmes. In the UK, user involvement is a prerequisite for social work education. The financial resources provided by the General Social Care Council (GSCC) which supports education and registration of social workers, has allowed for an increase in user involvement in social work programmes in England and Wales. Research (Taylor and Le Riche, 2006) shows that partnership with service users in social work education is generally, although not exclusively, regarded as ‘a good thing’. Students can develop greater empathy by recognising the skills and strengths of users. For users, involvement can lead to increased self-esteem and value. However, partnership is resource-intensive, requiring a delicate balance between token and genuine involvement. In other words, results are promising, but at the same time user involvement is not an easy solution.

A second innovative approach to be highlighted consists of VET programmes being organised at European level. In the present study, the EPR delivered two examples. These promote exchanges of social care workers and managers between countries. Since new approaches can be shared, such European VET programmes can serve as drivers for change in different Member States.

The third innovative characteristic is many good practices are the result of different types of cooperation with a university or university college. In these educational institutions new knowledge is developed or translated into practical guidelines and cooperation with them eases integration of new approaches and new knowledge into the VET programme. For instance, in Nordic countries, different networks exist consisting of 30 service units and university colleges (ISCED 5B) to develop and implement knowledge of severe and multiple disabled persons.

A fourth issue refers to EU financing. Some of these practices were developed through European grants. Therefore, the EU serves as a driver of change but it should be underlined that these grants for projects are only temporary. Serious problems of project sustainability may arise once EU financing is terminated.

Fifth, the Swedish focus group stressed that innovative training combines theoretical knowledge and practical experiences. Most practices reported here use this combination, although their concrete characteristics differ largely.

5.2.3. Quality assurance

This study focuses on two fundamental characteristics of quality assurance, namely involvement of stakeholders and evaluation of VET. For each practice, both characteristics are described. Most involve stakeholders and use different evaluation methods. To guarantee quality of VET, at least five conditions have to be fulfilled.

First, stakeholders such as employers and social care workers have to be involved in setting up the goals of VET. In this way, training is customised to the specific needs of these groups. Second, the examples show that cooperation with universities or other knowledge centres makes it possible to keep VET relevant. In other words, universities (ISCED 5A) or university colleges (ISCED 5B) can be considered as necessary stakeholders to assure quality in the long term. Third, as shown by both practices of EPR, a VET programme has to be flexible to enable a tailor-made approach. In other words, it has to be possible to adapt the VET programme to specific questions and needs of trainees.

Fourth, quality assurance also foresees procedures for trainees' feedback. Most good practices presented have feedback mechanisms based on the evaluation made by trainees. The most innovative VET also tries to assess its impact on the quality of services delivered by the social care sector. However, this remains a difficult task to achieve. Only the example of EPR on empowerment seeks to assess its effect by asking two years after completion of VET whether the organisation still uses its tools and to what extent these tools have an impact on its functioning. Overall, more cooperation between researchers and VET programmes is necessary to assess these effects more validly. Since VET programmes can have effects in the short and long term, little is known about the mechanisms which improve sustainability of learning outcomes. Another issue concerns the definition of effects. For instance, how can we assess the effects of the German VET programme 'qualification of migrants in care'? The VET provider assesses participation in training. Although this is a fundamental measure, more ambitious assessments could be developed, such

as measuring the effects of VET on the quality of care provided by social care workers on completion of training.

Fifth, service users are emerging as a new group of stakeholders. They can be involved in planning VET, but also during its implementation or even evaluation. During the implementation phase they can be trained as trainers. During evaluation, they can be asked to clarify the effects of VET on the quality of care received.

Thus, quality assurance in VET implies at least five measures:

(a) involving stakeholders in the different phases of the quality circle;
(b) flexible programmes which make a more tailor-made approach possible;
(c) assessing the effects of VET on trainees, the organisation and quality of care (goal attainment);
(d) cooperating with research institutions (universities, university colleges) to link VET with research and development;
(e) involving service users as stakeholders.

6. Policy recommendations

6.1. Societal and policy changes challenge social and health services

Health and social services are one of the largest growing economic sectors. At the same time, the sector is challenged by fundamental societal changes such as the ageing population, globalisation, growing cultural diversity which increase the needs for social services. Scientific evidence also shows the negative consequences of social inequality in terms of health, psychosocial problems, crime and less social cohesion. One specific new vulnerable group are people with mental health problems. In addition, health and social services are steered by new policy trends such as deinstitutionalisation of social care, new public management and evidence-based practice. Deinstitutionalisation is one of the main challenges for the social care sector. Instead of bringing vulnerable groups to institutions, social services have to be delivered in the community and more cooperation between different social services is needed. Deinstitutionalisation asks for new competences of front-line staff. In addition, the UN convention on human rights asks the social care sector to pay more attention to the human rights of vulnerable groups. These issues require major focus on workforce development in the social sector deriving from both the disability strategy 2011-20 and Europe 2020 strategy, which aim at increasing employability and flexibility and combating poverty and social exclusion.

Instruments such as public procurement should be revised as they proved to have negative consequences on the quality of training of front-line employees in the social sector. Public authorities boost competition through public procurement. They publish a call for tenders where the type of product or service need is defined. Any interested operator can thus submit an offer. This procedure is meant to guarantee equal treatment and transparency, but may nevertheless have a negative impact on quality of social or health services purchased because financial criteria often prevail over quality – content-related criteria. Accurate guidelines for public procurement are badly needed to prevent deleterious effects and promote the attractiveness of the social sector.

Relevant instruments such as the open method of coordination set up by the Social Protection Committee, should gain more attention than at present and serve as benchmarks for improving working conditions and promoting the sector

as a safer and more reliable workplace than it is now considered. The Social Protection Committee, which is composed of high-level officials and promotes cooperation between the European Commission and Members States to improve and modernise social protection systems, should be considered an important agent for improving the public image of the social sector. Prevailing working conditions are rather poor and do not attract new workers.

This becomes even more important because social services are an expanding economic sector, confronted with a growing shortage of care workers.

In other words, societal and policy changes increase pressure on social care workers on the one hand, and on the other, social services have to convince new workers to enter the sector. Recovery plans being developed as a buffer against the economic crisis should promote the social sector and give it a clear definition to make it more attractive and clarify its potential. The European Social Fund should pay more attention to the changing needs of the sector and channel its means better to match society's new needs.

As for the shortage of staff, mobility of care workers from 'newer' Member States or even from outside the EU is considered a solution. However, foreign workers often have language problems and no specific training. It is an enormous challenge to train these new workers up to a level guaranteeing the current quality of social care. At the same time, the current workforce also needs training on new technical as well societal evolutions, such as empowerment, human rights or participation. Training and retraining staff could help to 'unlock' the job-creation potential of the social sector, a high priority on the agenda of Europe 2020 strategy. As stated by Commissioner Spidla, responsible for Employment, Social Affairs and Equal Opportunities, in a meeting with the Social Platform, the actual workforce is 11% and growth potential of the sector is estimated at 3 to 4%. However, to overcome staff shortages without reducing the quality of care, there is an urgent need for defining national and European qualification frameworks (NQFs and EQF).

These fundamental changes demand new skills and competences from front-line workers and managers in the social and health services as well as innovative VET programmes. VET has to play an essential role in helping the sector to face current challenges. Investing in VET is needed to make the sector's potential a reality. The lifelong learning programme of the European Commission provides huge potential. It can promote development of the social sector by focusing on the needs for human resource management, also fulfilling the programme's objective, to stimulate learning opportunities across Europe. Specific objectives related to staff training needs should be further defined, and a platform with all stakeholders could be set up to define and support implementation of NQFs and

EQF. Implementation of such activities could also benefit from the debate on quality of services in the framework of the social services of general interest directive, which will soon be active again, with particular focus on Protocol 26 of the Lisbon Treaty. In parallel, the working time directive will also be tackled and the social sector should be an active party in this debate. Considering at present there is no 'social sector social dialogue committee' at EU level, special attention should be paid to raise this issue high on the agenda of the sector for trade unions, employers and governments.

6.2. More attention to generic competences of front-line workers and leaders is needed

At present, generic competences are less valued than specialist competences although they are essential to render the social care sector more effective. Focus on generic competences was chosen because specialist ones are already better covered in existing VET standards and regulations of corresponding professions. This study fully recognises the importance of specialist competences to work effectively with specific target groups or in specific social services.

Generic competences can be defined as shared knowledge, skills and attitudes of different occupational groups of front-line social care staff. In other words, these are competences needed to be a good front-line worker in the social care sector since they increase the effectiveness of social care interventions. In addition they serve as common language among different professional groups and help cooperation. This study highlights six generic competences for all front-line staff in the social care sector:

(a) **empowerment:**
- recognise and respect individual rights and human dignity;
- view people as subjects and as holders of rights and not as objects;
- focus on strengths instead of problems;
- improve and stimulate self-realisation, self-determination and personal mastery over one's own life;
- ensure equal enjoyment of all human rights without discrimination;
- involve service users in decision-making;

(b) **brokerage skills:**
- assist service users to identify, access and benefit from relevant community services in different life domains (social security, employment, housing, leisure activities, health services, etc.);

- assist service users to develop a natural support system consisting of friends and family;
- work with local community to create an inclusive and accepting environment in which everyone can participate;

(c) **multicultural diversity:**

- respect different cultures and be sensitive to cultural differences;
- adapt interventions to different cultures and search for ethno-sensitive interventions;

(d) **transdisciplinary teamwork:**

- share roles systematically with team members across discipline boundaries;
- pool and integrate the expertise of team members to provide more efficient and comprehensive assessment and intervention services;
- communicate with all members in a regular, planned and continuous give-and-take way;
- teach, learn, and work with professionals from different disciplines, to accomplish a common set of intervention goals;
- differentiate between disciplines based on the situation rather than on discipline-specific characteristics;
- carry out assessment, intervention, and evaluation jointly with team members;

(e) **knowledge management skills:**

- transfer theoretical knowledge into practice;
- transfer knowledge to other social services and social care sectors;
- integrate new technological developments into social services;

(f) **leadership:**

- create an organisational culture based on a central vision and key values;
- entrepreneurship;
- change management.

Since society is changing fundamentally, social care leaders are constantly under pressure to adapt their organisations to new needs and expectations. The study identifies three generic competences of innovative leadership to react proactively to these changes. The first competence relates to the way social service leaders communicate, support and reinforce the vision of the organisation they are leading. The leader makes sure the vision is shared and evaluates its relevance for service users. In addition, the leader uses the central values of the organisation as anchors and guidelines for decisions. The second competence relates to entrepreneurship. Due to new public management and new steering

instruments such as tendering procedures and introduction of quasi-markets in the sector, social service leaders need more entrepreneurial skills to obtain public means and to show results of their actions. The third competence refers to managing change. Social and health services are constantly challenged to analyse their functioning and to search for other and better answers to evolving needs of vulnerable groups which change often. Social service leaders should be able to smooth, monitor and evaluate organisational changes.

All the above generic competences are needed to make the social care sector more demand-oriented and effective. They can apply to different professional groups operating at the front line of social care organisations. These generic competences need more attention from policy-makers, social care workers, managers and VET providers. They also need further analysis of knowledge and attitudes. Cedefop could undertake this task by completing the present study which mainly defines the skills corresponding to these competences, in full line with its mission.

Quality standards across Europe are needed to know what people active in the sector really know and do. Validation of existing skills and competences should also be further encouraged. Cedefop could develop indicators; elaborate a proposal for certification or a portfolio for carers to testify the competences they have acquired and how they use them at work.

6.3. Innovative VET programmes should become sustainable

Analysis of VET programmes shows that the extent of coverage and content of VET programmes is directly related to the level of development of the social care sector. Good practices are often a national, sectoral or regional answer to specific needs of the sector. Innovation does not have a clear-cut definition. A VET programme can be innovative, in relation to specific needs in one sector, country or region. In other words, special attention has to be paid to the context in which VET programmes are implemented. A more comprehensive VET strategy is also needed to address certification and accreditation in the sector without hindering innovations in VET.

Based on the 18 practices in Annex 3, the study formulates six policy recommendations to render VET programmes more effective and innovative.

They refer to:

- involving service users in VET;
- transnational character of VET programmes organised at European level;
- strengthening cooperation with research institutions, high schools and other educational instances;
- importance of European grants as drivers for change;
- combining different learning methods;
- transdisciplinary learning between different professional groups.

Participation of service users in VET is highly recommended since they are increasingly becoming important stakeholders during the planning, implementation and evaluation phases of VET programmes. In other words, service users fulfil different roles in training. Not only do they bring new knowledge into VET programmes but they can also teach front-line workers to take the views of service users more into account.

A second innovative element refers to VET programmes organised at European level. They promote exchanges of social care workers and managers between countries. They serve as drivers for change in different Member States, because participants become familiar with care methods in other countries. At the moment, these kinds of VET programmes are little developed.

A third element refers to cooperation with universities or university colleges which greatly helps integration of new approaches and new knowledge into VET programmes. Thus, research institutions and other knowledge centres can act as drivers for change bringing new knowledge and scientific evidence to VET. In this way, they guarantee that the content of VET corresponds to recent research evidence. Partnerships between these different actors have to be supported and stimulated more strongly than at present.

A fourth innovative issue relates to EU financing. Innovative practices are often developed through European grants. It should be underlined that these grants are only temporary. Therefore, problems of project sustainability may arise once EU financing is over. Thus, it is important to investigate conditions that help these VET programmes to survive and guarantee their implementation on a large scale, probably through mainstreaming existing funding lines.

A fifth characteristic of innovative training refers to combining theoretical knowledge with practical experience. Experience-based learning is particularly important in this sector which deals with people in need and depends on human interaction. Most case studies reported make use of this combination, although their concrete characteristics differ largely. It should be noted that development of e-learning can help with other kinds of learning processes. It can provide online

courses offering extra techniques such as reflective diaries, online discussions and forums and e-mail-based tutor support.

The sixth innovative element relates to transdisciplinary learning: bringing together participants from different professional backgrounds allows them to get informed about skills and knowledge in other disciplines or organisations. In this way, carers can discover other generic competences which improve communication and stimulate exchange of ideas and practices. Since deinstitutionalisation of social care demands more cooperation between front-line workers from various organisations and professional groups, this kind of VET programme should be further promoted.

6.4. Quality of VET programmes should include trainee needs assessment

To guarantee the quality of VET offered, at least five quality assurance measures should be present:

(a) involvement of stakeholders in different phases of the quality circle of VET;
(b) existence of flexible programmes which make a more tailor-made approach possible;
(c) assessment of the effects of VET on trainees, the organisation and quality of care (goal attainment);
(d) cooperation with universities or other knowledge centres to link VET to research and development;
(e) assessment of trainees' satisfaction, learning processes and (objective) learning outcomes.

One of the biggest challenges is assessing the impact of VET on social care workers and on their organisations. To improve sustainability of VET programmes, more research on the effects of such programmes is needed. These effects can be distinguished based on their impact on learning outcomes of trainees; on the organisation and on the quality of care. However, VET providers should not only assess the effects mentioned, but also check the learning processes of trainees. More cooperation between researchers and VET programmes is necessary to assess these effects in a more substantiated way.

6.5. Exchange of good practices should be further promoted

Pushing exchange of good practices forward is crucial in EU-27. Results of this study show how many interesting approaches and good practices are already in motion in the sector. Sharing these good practices allows European policy-makers, sector organisations and VET providers to join forces to improve understanding, building common trust and cooperation for the benefit of those active in the sector and ultimately of those in need of care in our societies.

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ANNEX 1

The research consortium – European and national levels

European level

Organisation	Names
EASPD (European Association of Service Providers for Persons with Disabilities) http://www.easpd.eu/	Luk ZELDERLOO Sergio MICHELINI Sabrina FERRAINA
LUCAS (Centre for Research and Consultancy in Care KUL Leuven) www.researchportal.be/.../division-lucas-centre-for-research-and-consultancy-in-care	Chantal VAN AUDENHOVE Koen HERMANS Iris DECOSTER Evelien DEMAERSCHALK
WE (Workability Europe) http://www.workability-europe.org/	Bertie HUNT Henner SORG
FEANTSA (European Federation of National Organisations Working with the Homeless) http://www.feantsa.org/code/en/hp.asp	Freek SPINNEWIJN Stefania DEL ZOTTO
EPR (European Platform of Rehabilitation) http://www.epr.eu/	Nadège JIBASSIA
AWO Arbeiterwohlfahrt http://www.awo.de/	Peggy SASS

National level

Country	Organisation
Germany	AWO (Arbeiterwohlfahrt) http://www.awo.org/
United Kingdom	FEANTSA (European Federation of National Organisations Working with the Homeless) Angela Jones, Independent researcher for FEANTSA http://www.feantsa.org/code/en/hp.asp
Poland	SPI – Stowarzyszenie Przyjaciół Integracji (The Friends of Integration Association) http://www.niepelnosprawni.pl/ledge/x/12396 Workability member in Poland
Portugal	CRPG (Gaia Vocational Rehabilitation Centre) http://www.crpg.pt/Paginas/index_home.htm EPR member in Portugal
Sweden	Nordic Cooperation on Disability (NHS) http://www.norden.org/en/areas-of-cooperation/the-nordic-welfare-model EASPD member in Sweden

ANNEX 2

European policy on quality assurance in VET

In 2000, the Lisbon European Council called on Member States to modernise their education and training systems, to make Europe more competitive and to create 'more and better jobs and greater social cohesion'. VET was considered crucial for Europe to position itself in the global economy and to respond successfully to social challenges. In the following years, special attention was paid to quality assurance in VET as quality is at the heart of the process of increasing cooperation and common trust between VET systems in Europe and of rendering VET more attractive.

European process of quality assurance in VET

2000	Adoption of the Lisbon strategy Launch of the European forum on quality in VET
2002	Barcelona European Council *'To make European education and training systems a world quality reference by 2010.'*
	Copenhagen declaration *Call for enhanced cooperation in VET on 'promoting quality assurance.'*
2003	Establishment of the technical working group on quality in VET Definition of the common quality assurance framework (CQAF) for VET: common principles, guidelines and tools
2004	Endorsement of CQAF by the Spring Education Council
2005	Set up of the European network of quality assurance in VET (ENQA-VET)
2006	Helsinki communiqué *'Need to progress from the CQAF to a culture of quality improvement and to strengthen cooperation on quality improvement in VET'*
2009	Adoption of the European Parliament and Council of the recommendation on the establishment of a European quality assurance reference framework (EQARF) for VET: common criteria, indicative descriptors and indicators Political launching conference of EQARF by the Czech Presidency of the Council of the European Union and the European Commission Technical launching conference of EQARF by the European Commission and Cedefop
2010	EQARF is renamed EQAVET. The network is enlarged with new members. First annual forum

At EU level, the start of discussions on quality assurance in VET took off with launch of the European forum on quality in VET. The forum developed a two-year work programme for 2001-02 and was replaced by the technical working group on quality in VET, substituted in its turn by ENQA-VET at the end of 2005. All three were cooperation platforms of a voluntary nature, composed by representatives of Member States, social partners, EFTA-EEA countries, the European Commission and Cedefop. Great impetus for quality assurance was given by the Barcelona European Council (March 2002) which set the ambitious goal to make the European education and training systems a world quality reference by 2010. Subsequently, the Copenhagen declaration which called for 'enhanced European cooperation in VET' (Council of the European Union; European Commission, 2002) and the Council resolution of December 2002 (Council of the European Union (2002) defined the political priorities and process of cooperation on quality assurance in VET to achieve the VET-related Lisbon goals. Synergies have been encouraged between initiatives at European level, Member States, social partners and participating countries to achieve a coherent approach to quality in VET.

The common quality assurance framework

To ensure a common understanding of and to promote further quality in VET, the common quality assurance framework (CQAF) was defined by the technical working group (TWG) with the technical and scientific support of Cedefop while the European Training Foundation (ETF: http://www.etf.europa.eu/) assured its diffusion in candidate countries. This framework proposed common principles, guidelines and tools and served as a reference instrument to help Member States to promote and monitor continuous improvements of their VET systems, based on it, since it was considered making use of common European references would increase transparency and consistency between Member States while fully respecting their responsibility for developing their own VET systems.

The CQAF was endorsed by the Education Council in 2004 (Council of the European Union (2004)). Two years later, the Helsinki communiqué of 2006 (European Commission, 2006b) underscored the need to progress from the CQAF to a culture of quality improvement and to strengthen cooperation on quality improvement in VET.

The EQARF model

From experience gained by implementing several of its tools, the framework was revisited and updated. It was also renamed as European quality assurance reference framework, EQARF.

The recommendation of the European Parliament and of the Council on establishing a European quality assurance reference framework for VET (European Parliament and Council of the European Union, 2009) constitutes the European reference framework to ensure and develop quality in VET to which Member States are invited to relate their quality systems and to report on progress in this field by mid-2011. Building on the key principles of the most relevant quality assurance models, the framework may be considered as a cross-reading instrument that can help policy-makers and practitioners to get a better insight of how existing quality assurance (QA) models work, to identify areas of provision that need improvement, and take decisions on how to improve them based on common quantitative and qualitative references contained in Annexes I and II of the recommendation. The model also allows for capturing and classifying best practice within and across Member States.

Therefore, EU Member States are provided with a common model, methodology, monitoring system and measurement tool to promote and monitor continuous improvements of their VET systems.

EQARF can be applied at both system and VET-provider levels and can therefore be used to assess the effectiveness of VET. It emphasises improvement and assessment of 'outputs' and 'outcomes' of VET in terms of increasing employability, improving the match between demand and supply, and promoting better access to lifelong training, in particular for disadvantaged people.

The political launch of EQARF took place on 20 May 2009 under the Czech Presidency of the Council of the European Union in a conference dedicated to it and to the European credit system for VET (ECVET), both having been adopted in parallel. On 17 and 18 November 2009 EQARF was launched technically by the European Commission and Cedefop at a conference in Brussels to inform all stakeholders of what was at stake and what had been achieved so far, and to invite them to help shape the process of its instrumentation with their ideas and actions. With these two conferences, the cycle of adoption of the recommendation was closed.

In 2010, EQARF was renamed EQAVET to mark the analogy to ECVET, the other European initiative forming part of European VET tools.

The EQARF model includes the following interrelated elements:

(a) planning

Setting clear and measurable goals regarding policies, procedures, tasks and human resources involved;

(b) implementation

Expectations are transparent, procedural steps (time-spans and tasks) are clear and carried out;

(c) evaluation and assessment

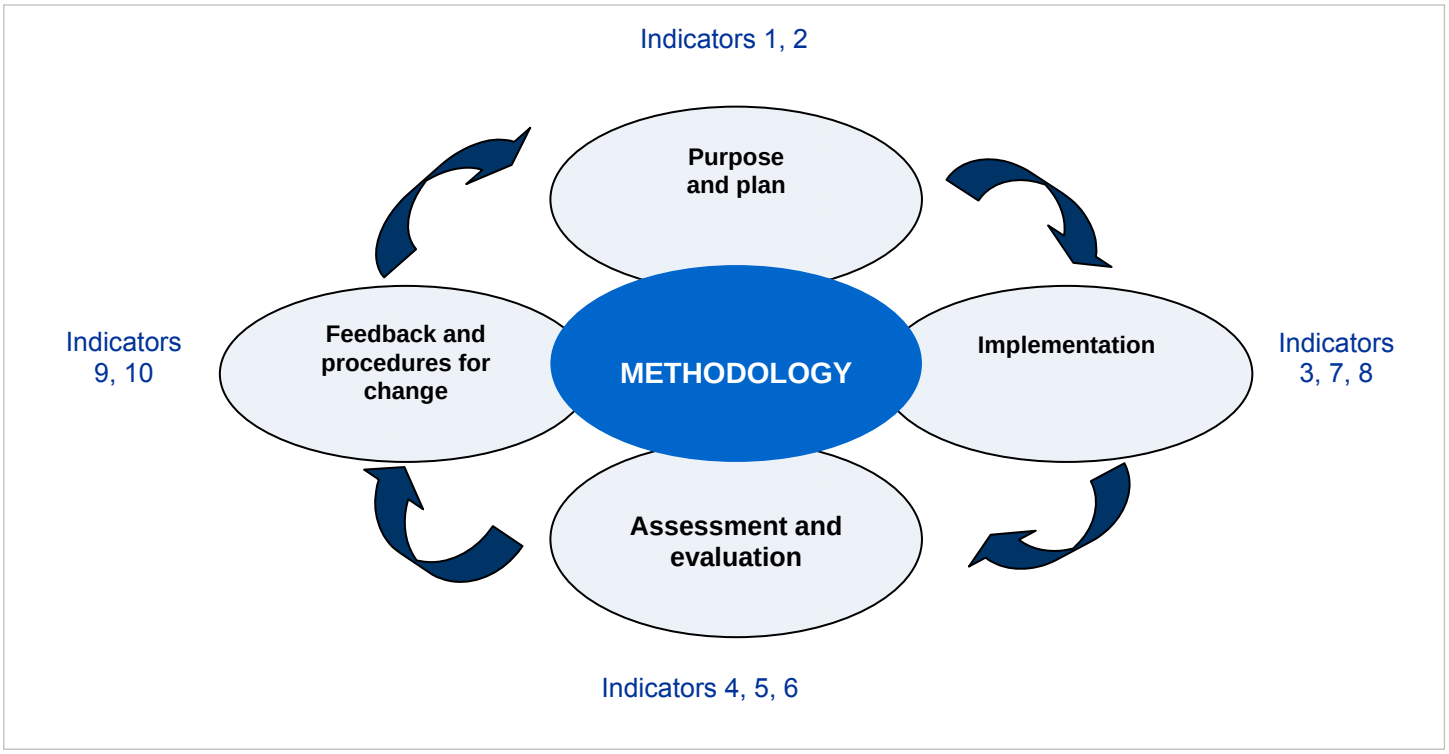
Evaluation of programme provision;

Assessment of achievement of outcomes at system and individual level;

(d) review

Feedback and procedures for change.

The EQARF model



Source: European Commission. The European quality assurance reference framework for VET. Available from Internet: http://ec.europa.eu/education/lifelong-learning-policy/doc1134_en.htm [cited 26.4.2010].

(a) Planning (purpose and plan)

This relates to setting up clear and measurable goals regarding policies, procedures, tasks, and human resources. It also relates to defining input and output standards linked with goals to support the design and implementation of quality assurance, as well as with providing reference points for certification of individuals or accreditation of VET institutions and/or programmes. Goals and objectives should be formulated in clearly understandable terms and as far as possible they should be combined with definitions of measurable indicators as this allows for checking achievement of planned objectives, at later stages.

(b) Implementation

It is essential to establish key principles that underpin implementation of planned actions to ensure effectiveness in achieving the goals and objectives which have been planned. These principles have to be coherent with the goals set. Such coherence can be achieved in many ways for example through regulations, funding incentives, provision of guidelines on how to proceed at local level, building capacity of key actors on quality issues through training, combination of internal quality systems at provider level with external inspections, etc. Whichever approach is chosen, it is essential that expectations are transparent and that the procedural steps, including time-spans and tasks to be fulfilled, are clear for all the actors involved. Developing ownership and personal motivation among staff, trainers and trainees, are important preconditions for achieving coherence between goals, objectives and implementation.

(c) Evaluation and assessment

This covers continuous evaluation – of programme provision by objectives including learner data; and assessment – of achievement of outcomes at system and individual levels. It implies designing evaluation mechanisms according to the context, defining the frequency and scope of evaluations, and providing evidence of the findings of the evaluation to those concerned, including strengths, areas for improvement and recommendations for action. In general, the assessment and evaluation phase consists of two parts, collection and processing of data and discussions on the results achieved. An important challenge is to avoid collecting useless data or using cumbersome methods of data collection. Effective assessment depends to a large extent on clear definition of the methodology and frequency of data collection. It also depends on the coherence between data collection and predefined indicators and the goals and objectives to be achieved. Relevant stakeholders, namely current and former

trainees, staff, employers and trade union representatives should be involved in discussions arising from evaluation results.

(d) Review (feedback and procedures for change)

Quality assurance and development is a continuous and systematic process. It can undergo constant review combining self-assessment with evaluation by an external body, processing feedback and organising procedures for change. In practice, this last phase of the cycle is quite often the weakest: revision of planning, fine-tuning of quality objectives and quality management activities. A key factor is to make available publicly results of the quality assessment procedure and to foster an open debate with relevant stakeholders on the factors which might have contributed to certain results. Further, organisation of benchmarking processes between comparable settings can strengthen common learning, especially when combined with incentives for good practices and further improvement.

EQARF quality criteria and indicative descriptors

Quality criteria	Indicative descriptors at VET-system level	Indicative descriptors at VET-provider level
Planning reflects a strategic vision shared by the relevant stakeholders and includes explicit goals/objectives, actions and indicators	Goals/objectives of VET are described for the medium and long terms, and linked to European goals The relevant stakeholders participate in setting VET goals and objectives at the different levels Targets are established and monitored through specific indicators (success criteria) Mechanisms and procedures have been established to identify training needs An information policy has been devised to ensure optimum disclosure of quality results/outcomes subject to national/regional data protection requirements Standards and guidelines for recognition, validation and certification of competences of individuals have been defined	European, national and regional VET policy goals/objectives are reflected in the local targets set by the VET providers Explicit goals/objectives and targets are set and monitored Ongoing consultation with relevant stakeholders takes place to identify specific local/individual needs Responsibilities in quality management and development have been explicitly allocated There is an early involvement of staff in planning, including with regard to quality development Providers plan cooperative initiatives with other VET providers The relevant stakeholders participate in the process of analysing local needs VET providers have an explicit and transparent quality assurance system in place
Implementation plans are devised in consultation with stakeholders and include explicit principles	Implementation plans are established in cooperation with social partners, VET providers and other relevant stakeholders at the different levels Implementation plans include consideration of the resources required, the capacity of the users and the tools and guidelines needed for support Guidelines and standards have been devised for implementation at different levels Implementation plans include specific support towards the training of teachers and trainers VET providers' responsibilities in the implementation process are explicitly described and made transparent A national and/or regional quality assurance framework has been devised and includes guidelines and quality standards at VET-provider level to promote continuous improvement and self-regulation	Resources are appropriately internally aligned/assigned with a view to achieving the targets set in the implementation plans Relevant and inclusive partnerships are explicitly supported to implement the actions planned The strategic plan for staff competence development specifies the need for training for teachers and trainers Staff undertake regular training and develop cooperation with relevant external stakeholders to support capacity building and quality improvement, and to improve performance

Quality criteria	Indicative descriptors at VET-system level	Indicative descriptors at VET-provider level
Evaluation of outcomes and processes is regularly carried out and supported by measurement	A methodology for evaluation has been devised, covering internal and external evaluation Stakeholder involvement in the monitoring and evaluation process is agreed and clearly described The national/regional standards and processes for improving and assuring quality are relevant and proportionate to the needs of the sector Systems are subject to self-evaluation, internal and external review, as appropriate Early warning systems are implemented Performance indicators are applied Relevant, regular and coherent data collection takes place, in order to measure success and identify areas for improvement. Appropriate data collection methodologies have been devised, e.g. questionnaires and indicators/metrics	Self-assessment/self-evaluation is periodically carried out under national and regional regulations/frameworks or at the initiative of VET providers Evaluation and review covers processes and results/outcomes of education including the assessment of learner satisfaction as well as staff performance and satisfaction Evaluation and review includes adequate and effective mechanisms to involve internal and external stakeholders Early warning systems are implemented
Review	Procedures, mechanisms and instruments for undertaking reviews are defined at all levels Processes are regularly reviewed and action plans for change devised. Systems are adjusted accordingly Information on the outcomes of evaluation is made publicly available	Learners' feedback is gathered on their individual learning experience and on the learning and teaching environment. Together with teachers' feedback this is used to inform further actions Information on the outcomes of the review is widely and publicly available Procedures on feedback and review are part of a strategic learning process in the organisation Results/outcomes of the evaluation process are discussed with relevant stakeholders and appropriate action plans are put in place

Source: European Parliament and Council of the European Union, 2009.

Quality indicators

A comprehensive set of 10 quality indicators has been defined to support evaluation and quality improvement of VET systems and/or VET providers. The set includes overarching indicators for quality assurance, indicators supporting specific quality objectives for VET and indicators on context information. All 10 indicators can be used both at initial and continuing vocational training levels.

A reference set of quality indicators for VET

Indicator	Type of indicator	Purpose of the policy
Overarching indicators for quality assurance		
No 1 Relevance of quality assurance systems for VET providers: (a) share of VET providers applying internal quality assurance systems defined by law/at own initiative; (b) share of accredited VET providers.	Context/input indicator	Promote a quality improvement culture at VET-provider level. Increase the transparency of quality of training. Improve common trust on training provision.
No 2 Investment in training of teachers and trainers: (a) share of teachers and trainers participating in further training; (b) funds invested.	Input/process indicator	Promote ownership of teachers and trainers in the process of quality development in VET. Improve the responsiveness of VET to changing demands of labour market. Increase individual learning capacity building. Improve learners' achievement.
Indicators supporting quality objectives for VET policies		
No 3 Participation rate in VET programmes: number of participants in VET programmes, according to the type of programme and the individual criteria.	Input/process/output indicator	Obtain basic information at VET-system and VET-provider levels on the attractiveness of VET. Target support to increase access to VET, including for disadvantaged groups.
No 4 Completion rate in VET programmes: number of persons having successfully completed/abandoned VET programmes, according to the type of programme and the individual criteria.	Process/output/outcome indicator	Obtain basic information on educational achievements and the quality of training processes. Calculate drop-out rates compared to participation rate. Support successful completion as one of the main objectives for quality in VET. Support adapted training provision, including for disadvantaged groups.

Indicator	Type of indicator	Purpose of the policy
No 5 Placement rate in VET programmes: (a) destination of VET learners at a designated point in time after completion of training, according to the type of programme and the individual criteria; (b) employed learners at a designated point in time after completion of training, according to the type of programme and the individual criteria.	Outcome indicator	Support employability. Improve responsiveness of VET to the changing demands in the labour market. Support adapted training provision, including for disadvantaged groups.
No 6 Utilisation of acquired skills at the workplace: (a) information on occupation obtained by individuals after completion of training, according to type of training and individual criteria; (b) satisfaction rate of individuals and employers with acquired skills/competences.	Outcome indicator (mix of qualitative and quantitative data)	Increase employability. Improve responsiveness of VET to changing demands in the labour market. Support adapted training provision, including for disadvantaged groups.
Context information		
No 7 Unemployment rate: According to individual criteria.	Context indicator	Background information for policy decision-making at VET-system level.
No 8 Prevalence of vulnerable groups: (a) percentage of participants in VET classified as disadvantaged groups (in a defined region or catchment area) according to age and gender; (b) success rate of disadvantaged groups according to age and gender.	Context indicator	Background information for policy decision-making at VET-system level. Support access to VET for disadvantaged groups. Support adapted training provision for disadvantaged groups.
No 9 Mechanisms to identify training needs in the labour market: (a) information on mechanisms set up to identify changing demands at different levels; (b) evidence of their effectiveness.	Context/input indicator (qualitative information)	Improve responsiveness of VET to changing demands in the labour market. Support employability.
No 10 Schemes used to promote better access to VET: (a) information on existing schemes at different levels; (b) evidence of their effectiveness.	Process indicator (qualitative information)	Promote access to VET, including for disadvantaged groups. Support adapted training provision.

Source: European Parliament and Council of the European Union, 2009.

The above 10 indicators are related to the following European policy goals:

- improve quality and quality assurance of VET (Indicators 1 and 2);
- improve employability (Indicators 5 and 6);
- adapt VET to changing demands on the labour market (Indicator 9);
- make VET more accessible to vulnerable groups as well (Indicators 3, 4, 8 and 10).

The quality approach described above is based on the quality cycle present throughout the model. It includes decisions about participation mechanisms, measurement and indicators, design of assessment and evaluation tools, procedures for planning, implementation and feedback in an integrated way, combining all elements to create a unified system.

ANNEX 3

Examples of practices in five Member States and at European level

- Model of a stepped and modularised qualification for care of the elderly
- Qualification of migrants in care
- Presence worker for people with dementia
- Creating local partnerships
- Change management
- Empowerment – principles, values and practical application in contemporary communities
- Advanced training in identity and leadership in third sector organisations
- Training programme for social economy organisations
- Qualified education focused on housing pedagogy
- Teaching intellectually disabled pupils
- Children and youth at risk
- Postgraduate certificate in provision of health care for people experiencing homelessness
- Home, homelessness and community
- Advanced professional certificate in working with homeless people
- The Homelessness Training Unit
- St Mungo's learning and development programme
- Interdisciplinary and interdepartmental strategies to ensure a continuum of services
- Measuring and improving empowerment through the Vrijbaan and Request methods

Model of a stepped and modularised qualification for care of the elderly

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Focus

Key words/competences

Transdisciplinary teamwork, innovative leadership

Project description

Goal
To develop a permeable qualification system to improve and ensure high level quality in care by demand-oriented and organisation-oriented qualifications.

Content

Part 1 Theoretical part

- Apply the European qualification framework (EQF) and the German qualification framework to transfer the usual VET in care for the elderly into stepped and modularised VET.
- Identify different graduations of training and further training in care up to university level.
- Describe all qualification levels distinctively.
- Allow people with a lower educational level to better approach the care professions since the different qualifications are based on one another, offering a lifelong learning opportunity.

Part 2 Pilot test

- The stepped and modularised training models will be developed and tested within the project until December 2011, by the federal state of North Rhine Westphalia (NRW):
  - ✓ training programmes for care helpers/assistants, for the elderly;
  - ✓ three-year training programme for care nurses for the elderly;
  - ✓ extended training for experts in care for the elderly.

Quality

Innovative/good practice

- It is the first test to relate care qualifications to EQF and the German qualifications framework.
- It offers: a good chance to integrate care qualifications into the different levels and to compare qualifications in care Europe-wide.
- It is a good basic recruitment tool for the future, e.g. possibilities to be used in Sweden.

Quality improvement

- Involvement of funding organisations, stakeholders, project partners.
- Involvement of Federal Ministry of Families, Seniors, Women and Youth.
- Involvement of Federal Ministry of Social Affairs and Health in NRW.
- Use of formative evaluation of all implementing phases.
- Regular feedback of results to all involved partners.

Practical aspects

Participants

40 elderly care assistants
70 elderly care nurses
40 care unit managers

Duration

Theoretical part: May 2008 – June 2009
Pilot test: October 2008 – May 2011

Funding

Federal Ministry of Family, Seniors, Women and Youth
The Ministry of Labour, Health and Social Affairs of North Rhine Westphalia

Certification/accreditation

Courses themselves are not certified.

The University of Bielefeld is accredited by AHPGS (accreditation agency for degree programmes in health and social work) and by AQUAS (Agency for Quality Assurance by accreditation of degree programmes).

Qualification of migrants in care

Contact

Bremer Heimstiftung
Fedelhören 78
DE - 28203 Bremen

Fachschule Altenpflege

Mrs Heidi Wohltmann

heidi.wohltmann@bremer-heimstiftung.de

Focus

Key words/competences

Working in a multicultural environment

Project description

Goal
To provide the qualification requirements in elderly care to migrants for the first time on the labour market.

Content

Part 1 Theory

- German language as foreign language (encourage the general language development and professional terminology).
- Cultural learning (imagination of personhood, being healthy and being sick).
- Self- and social-competences (everyday working life and individual art of living age/gerontology (ageing and age-related life).
- Introduction to the profession (social security, care institutions, care as a profession).

Part 2 Practice

- 11-week placement in a residential care home and home care service.
- With mentorship.
- With individual practical visits by school teachers to support participants and practical teachers.
- Exercise tasks.

After this pre-vocational training, students can continue with:
- a selection process (assessment) to get the entrance qualification to the one-year care assistant training programme;
- care training as elderly care nurse.

Quality

Innovative/good practice

- This is a unique possibility for migrants in Germany to get access to a preparatory course in care, which very often represents for them the only possibility to work.
- Fight against unemployment: the unemployment rate among migrants is very high.
- Good results: approximately 70% of the migrants having attended this course, start vocational training in care.

Quality improvement

- Involvement of Senate of the Free Hanseatic City of Bremen, the Social Services Department, Employment Office, Senate for Education – regular meetings between all these stakeholders.
- Integration into labour market and/or vocational training is promoted.
- Evaluation of participants' satisfaction and a list of their future dispositions are made, Regular meetings with stakeholders are organised.

Practical aspects

Participants

13 migrants

Duration

Three months

Funding

Senate of the Free Hanseatic City of Bremen
Special fund from the senate to support participants without income to pay for course attendance
Subsistence allowance to participants paid by the Social Services Department or Employment Office

Certification/accreditation

Certified by BAG Zert

Presence worker for people with dementia

Contact

AWO Bildungszentrum Preetz
Hinter dem Kirchhof 10
DE - 24211 Preetz

Irmgard Stremlau

Focus

Key words/competences

Empowerment

Project description

Goal
To teach participants how to become a presence worker in attendance and care for people with dementia to sustain the domestic normality of people with dementia.
This helps to contribute to the current development of new forms of attendance and care as well as of alternative living concepts for people with Alzheimer's disease.

Part 1 Three months theory on 'Alzheimer's disease'

- Theoretical background
- Practical skills in care
- Communication
- Biography work
- Organising everyday life
- Self-monitoring and practice-reflection of the trainee
- Organisation of the course
  (Assessment of participants and organisation of the course, taking into account the specific needs and skills of participants)

Part 2 One to three months practice

Placement in a service organisation for the elderly, e.g. home care service or retirement home.

Quality

Innovative/good practice

- The first qualification offered which connects domestic economy and care.
- This is a qualification with special orientation to people with dementia aiming at rendering activities as qualitative as possible.
- This training is organised jointly by different vocational schools.

Quality improvement

- Adequate and specific services for people with dementia.
- There is legal frame (care insurance law) around this field of work that describes the guidelines regarding to the qualification of presence workers.
- Experts and care providers are involved in the course content to provide information and to share good practices.
- Self-assessment of participants.
- Employers and care providers give feedback during and after the course.

Practical aspects

Participants

73 unqualified or low-qualified people

Duration

Three months theory and one and a half months practical training (depending on the organising body)

Funding

For participants already working in care: self financing or by employer.
For unemployed participants: financing by public authorities (e.g. Employment Office).

Certification/accreditation

Unemployed participants receive a certificate from the Employment Office.

Creating local partnerships

Contact

BORIS Biuro Obsługi Ruchu Inicjatyw Społecznych
(The Support Office for the Movement of Social Initiatives)
PL - 00-876 Warszawa, Ogrodowa 50 lok.1

Lucasz Wachowski lukaszw@boris.org.pl

Focus

Key words/competences

Transdisciplinary teamwork

Project description

Goal

To build coalitions and partnerships between public authorities, NGOs and the business sector around a certain problem in the community for example families with a problem of violence/alcohol abuse.
At first, BORIS is contacted and then it invites valuable community organisations to work in a partnership to face the problem together.

Content

Step 1 One-day seminar
Presentation of the identified problem and proposal for cooperation to the heads of the organisations.

Step 2 Two-day workshop
Outdoor teambuilding.

Step 3 One-day workshop
Definition of the problem and activity plan.

Step 4 Two-day study visit
Visit to an already established partnership in another town to learn about their cooperation.

Step 5 One-day workshop

- Working on a part of the identified problem.
- Learning how to fill in forms to ask for financing for example, through, EU funding.

Step 6 Closing seminar
Presentation of results and plans for the future.

Quality

Innovative/good practice

- The training brings various institutions together to work on a common problem.
- Participants learn the sphere of other organisations so they know what to expect from one another and how to use one another's resources.
- The study visit shows participants how the model works and its benefits.
- The model also helps in creating leaders in the community.
- Learning by doing: the workshop approach is considered the most effective method to learn.

Quality improvement

- The current model has been used and adapted since 1993.
- Evaluation form upon completion of the training with a part on suggestions on how to improve it.

Practical aspects

Participants

20-30 participants per group coming from: police, social workers field, teachers, representatives of municipalities, etc.

Duration

During six months: one-day seminar – Two-day workshop – one-day workshop – two-day study visit – one-day workshop – closing seminar

Funding

Financed by the City of Warsaw, the European Social Fund and the Polish government jointly.

Certification/accreditation

No certification

Change management

Contact

DOOR Poland SA
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PL - 02-384 Warszawa

Malgorzata Jarmoc Malgorzata.jarmoc@door.com.pl

Focus

Key words/competences

Innovative leadership, knowledge transfer skills

Project description

Goal

Make participants familiar with the process of introducing changes in their organisation and help them develop the relevant skills.

Content

Part 1 **One-day training**

Model and steps of how to introduce change in an organisation:
- prepare the employees for change, show them the need for change;
- show them possible solutions/ amelioration of the current situation;
- plan together with employees how the change will be introduced: what/who/how;
- implement change initiative;
- freeze the change: inform about/celebrate the reached effects of the change.

Part 2 **One-day training**

Development of skills needed when implementing change:
- how to motivate people to participate;
- how to convince people reluctant to participate;
- how to keep involvement during the implementation phase;
- how to behave towards people during the change process.

Quality

Innovative/good practice

- The subject of the training responds to the needs of every organisation.
- Experiential learning: learning through role plays, group and individual exercises, discussions.
- Quality of the trainers: solid experience and knowledge both in training and in social networking.

Quality improvement

- Pre- and post-test with the same questions to assess the knowledge acquisition of participants.
- Satisfaction questionnaire distributed at the end of the training.
- Content of training adjustable to specific needs of participants.
- Assessment of needs of both the organisation and participants before training.
- Participating organisations receive a report after training with the trainer's observations.

Practical aspects

Participants

Four participants from social care sector, rest from private sector

Duration

Two days

Funding

Organisations pay themselves.
Public organisations might get funding from the European Union.

Certification/accreditation

Certified training.
DOOR has a licence from the Ministry of Education.

Empowerment – principles, values and practical application in contemporary communities

Contact

Reale Europeia Anti Pobreza (REAPN)
European Anti Poverty Network (EAPN)
Av. Dom João II, No 14- R/C Dir.
PT - 2910-548 Setúbal

Ana Vizinho setubal@reapn.org

Focus

Key words/competences

Empowerment

Project description

Goal

To improve theoretical and practical competences of social intervention agents for the empowerment of their target public. Participants are expected to get knowledge and better understanding of the empowerment concept, so they are able to apply it to their target public.

Content

Part 1 General contextualisation of the idea of empowerment – One day
- Definitions
- Levels, processes and outcomes of empowerment
- Exercises

Part 2 Empowerment and community participation – One day
- General principles
- Implication of the empowerment philosophy application
- Exercises

Part 3 Community partnerships and empowerment – One day
- Conceptualisation
- Efficacy criteria and partnerships promoting empowerment
- Examples of empowerment community partnerships

Part 4 Evaluation of empowerment-based programmes – One day
- Principles
- Participative methodologies
- Empowerment processes and outcomes in the context of evaluation
- Exercises

Quality

Innovative/good practice

- Discussion of various strategies regarding the implementation of the concept in daily practices.
- Discussion and passing on of good practices.
- Eight-hour session for discussion of empowerment strategies implementation (main difficulties, impact of training on daily practices).

Quality improvement

- Measuring participants satisfaction at the end of the course (questionnaire).
- Involvement of members of social organisations.
- Involvement of professionals of the social sector.
- Involvement of volunteers.
- Involvement of REAPN staff.

Practical aspects

Participants

Eight administrators and six counsellors of social sector organisations that intervene in the regional district of Setúbal.

Duration

Four days

Funding

Costs shared by Social Security and Rede Europeia Anti Pobreza (REAPN)

Certification/accreditation

The VET provider is certified as training body by the DGERT – *Direrção Geral do Emprego e das Relações de Trabalho* (Directorate General for Employment and Industrial Relations).

Advanced training in identity and leadership in third sector organisations

Contact

Faculty of Human Sciences (FCH) of the Portuguese Catholic University (UCP)
Palma de Cima
PT - 1649-023 Lisboa

Patricia Ferreira pferreira@fch.ucp.pt

Focus

Key words/competences

Innovative leadership

Project description

Goal

Development of leadership competences of administrators of social sector organisations to prepare them for new management models, bearing in mind tradition and the original mission of organisations. Competences enabling them to innovate and adjust available resources to their community needs should be developed.

Content

Part 1 Theory: one day per topic

- Critical perspective on third sector: the third sector in its current context; types of organisations of the third sector; principles and philosophy.
- Organisational identity: fundamental identity issues; strategy and identity interaction; construction of the organisation's purpose; identity process management.
- Charisma and leadership: problems of leadership; the purpose of leadership in the organisation's success; leadership in complex systems.
- Leadership styles: lead versus manage.
- Reputation and image of the organisation: operative concepts; integrated building of relations; multiplicity of stakeholders; management issues.
- Integrated communication: communication strategies; internal communication; external communication; targets, contents and channels; communication and new technologies.
- Fundraising in the third sector: management of stakeholders; social marketing; fundraising.

Part 2 One-day study visit

Part 3 Two-day workshop

Quality

Innovative/good practice

- Content defined by scientific in the social care sector and in sociology.
- Multidisciplinary teaching team (social services, organisational management and psychology).

Quality improvement

- Service organisations are asked to identify main obstacles in their daily activities.
- University and public organisations promote development of competences: publish studies and research in the field.
- Participant satisfaction measured at the end of each module (questionnaire).

Practical aspects

Participants

18 administrators, technical directors and managers of social sector organisations

Duration

10 days

Funding

Supported by the National Association of Families for the Integration of Disabled People (AFID)

Certification/accreditation

UCP is recognised by the *Ministério da Ciência, Tecnologia e Ensino Superior* (Ministry of Science, Technology and Higher Education). This training course confers six units of credit (European credit transfer system – ECTS).

Training programme for social economy organisations

Contact

Professional management and improvement, in the framework of the 'operational programme of human potential' (POPH)
Avenida Infante Santo n.º 2, 2º Andar
PT - 1350 – 346 Lisboa

Sónia Pereira sonia.pereira@poph.qren.pt

Focus

Key words/competences

Innovative leadership, knowledge transfer skills

Project description

Goal

Providing standard and individualised training to social economy organisations. Professional management and improvement in the framework of POPH.

Content

Part 1 Standard training (up to six months)

- According to characteristics and needs common to the professional subsector of the same and of similar in size organisation.
- Based on the diagnosis of needs and strategic plans at sector level.
- Examples:
  - ✓ Project Q3: development of competences of staff organisations of the third sector improving the quality of their performance and management effectiveness thus contributing to their competitiveness and sustainability;
  - ✓ Qual Is: empowering and supporting social institutions at the level of the development of organisational qualification;
  - ✓ solidarity action training FAS: develop the capacity of social economy organisations' to improve service delivery to their target public.

Part 2 Individualised training (up to 12 months)

- According to the recipients' specific needs.
- Based on the diagnosis of their individual needs.
- Define strategic plan of intervention responding to these needs. Administrators and staff can attend training under the coordination of a trainer-consultant.

Quality

Innovative/good practice

- Combination of training and consultancy.
- Organisations are free to delineate specific objectives.

Quality improvement

- Involvement of managing body (POPH).
- Involvement of beneficiary organisations.
- Involvement of training recipients.
- Evaluation at the end of each module (satisfaction, assessment of knowledge).
- Project monitoring and evaluation sessions.

Practical aspects

Participants

701 staff members from social economy organisations

Duration

The project might last up to 24 months.

Funding

Supported by the programme manager POPH.

Certification/accreditation

The VET providers are certified as a training body by the *Direcção-Geral do Emprego e das Relações de Trabalho* (Directorate-General for Employment and Industrial Relations – DGERT) and trainers must have the certificate of pedagogical aptitude (CAP).

Qualified education focused on housing pedagogy

Contact

NVC Bräcke Diakoni
Box 21062
S - 41804 Gothenburg

Else Marie Hjert elsemarie.hjert@brackediakoni.se

Focus

Key words/competences

Empowerment

Project description

Goal

To promote pedagogical development work, acquired knowledge of relevant laws, social medicine and social pedagogy, to respect valued attitudes, ethics, relationship processes and partnership and get insights into working in other homes promoting independence and integrity.

Content

To develop the ability to carry on pedagogical development work on:

- method development;
- documentation and evaluation;
- influence processes;
- network activities;
- thorough knowledge of current laws and their implementation;
- thorough knowledge of different disabilities and their consequences on personal, group and society levels;
- thorough knowledge of social medicine and social pedagogy;
- definition of approach integrating ethical values, relation created processes, participation and meet the person skills;
- how to work in an other's home and respect of the persons' integrity and autonomy.

Method

- Working with real cases.
- Reflection group every second week.
- Four mentor discussions every year.

Quality

Innovative/good practice

- Connecting theory to practice.
- Making use of socio-pedagogical methods to provide a deeper knowledge of work development.
- Covering various real situations and individuals. This is also reflected in the possibility for students/participants to deepen in the topics of their choice.
- Focusing on learning outcomes.
- Inclusion of self-critical part.
- Involvement of service users in teamwork.

Quality improvement

- Using research and evidence-based changes.
- Collecting student assessments systematically.
- Students' evaluation is presented and discussed in the leader group.
- Evaluation of goals, guiding principles and plans.
- Cyclic evaluation activities.

Practical aspects

Participants

20 participants: staff working in the field of disability or other vocational fields

Duration

Four school terms – education in two-week periods, where a total of four days dedicated to practice

Funding

Students get a study loan via Central Study Board (CNS)
Contribution from the Authority for Vocational High Schools

Certification/accreditation

Yes

Teaching intellectually disabled pupils

Contact

Karlstad University
Estetisk-filosofiska fakulteten (special education)
S-65188 Karlstad

Karin Bengtsson karin.bengtsson@kau.se

Focus

Key words/competences

Knowledge transfer skills

Project description

Goal
To get inside knowledge of special schools for intellectual disability, their pupils, goals and organisation. To learn how to promote participation and an environment encouraging learning and interaction with pupils.

Content

Part 1 Special schools: pupils, goals and organisation

- Learning plans: rules/laws/systems.
- Ethics and the teacher.
- Preparing for pupils with disabilities.
- Participation.
- Safety, respect and responsibility.
- 'Salamanca declaration'.
- Special schools as a possibility or limitation: user perspectives on participation and integration.
- Consider difference as a resource.

Part 2 Learning and learning environments

- Complicated school situations: pupils/teachers.
- The future teacher.
- Augmentative and alternative communication (AAC).
- Motivation and working with motivation.
- Special pedagogical viewpoints.
- Sociocultural perspectives: to learn in practice.

Quality

Innovative/good practice

- Little training focused on intellectually-disabled pupils at school is available.
- Training is forming 'the future teacher' for intellectually-disabled persons, which means teachers who can work under various sociocultural perspectives considering differences as challenges for enrichment.
- Course on Internet platform and six meetings.
- Heterogeneous student groups with people with different experiences.

Quality improvement

- Involvement of the Faculty for Special Education, teachers, specialised teachers and educators.
- In the examination personal and group descriptions both verbal and written are used. In the evaluation a three-score scale is used: (U), (G) and (VG) = failed, passed and excellent. Constant follow-up of the learning conditions and goal-fulfilment takes place both during and upon completion of the studies to ensure continuous improvement.

Practical aspects

Participants

25 teachers for pupils in special or inclusive schools

Duration

One year

Funding

Karlstad University

Certification/accreditation

Accredited university course (ECTS credits) at the Estetisk-filosofiska fakulteten (special education) of Karlstad University

Children and youth at risk

Contact

Stockholm University, Institute for Special Education
Rålambsvägen 34B HUS H
S - 10691 Stockholm

Dr. Bozena Hautaniemi Bozena.hautaniemi@specped.su.se

Focus

Key words/competences

Brokerage skills, transdisciplinary teamwork

Project description

Goal

To understand the importance of the environment, intervention and prevention. To provide participants with the skills to explain and describe different aspects of child development, discuss aspects of normalisation, divergency and problematic behaviour.

Content

- Cooperation between individuals and their environment: development of natural support systems.
- Inclusion, acceptance by the 'milieu' one lives in.
- Possibilities for intervention and preventive measures.
- A holistic perspective on long-term and coordinated support in which different authorities, activities and services are involved.
- Different problems in a multicultural environment.
- Different aspects of child development.

Quality

Innovative/good practice

- Focus on teaching the professionals how to be a broker in the care for children.
- Working towards inclusion.
- Focus on a target group at risk.
- Divers composition of the participant group.
- The cooperation between the different environments a child or youth lives in.
- To make personal experiences visible and find solutions for children and youth at risk.

Quality improvement

- Being aware of the participants' needs, earlier experiences and viewpoints.
- Inclusion of expertise from the practical field and from different research and development projects.
- On completion of the studies, participants assess the course literature, quality of education and course content.
- Design of the next course is based on students' opinions.
- Reflecting on the role of professionals in this field in a changing society.

Practical aspects

Participants

20 professionals from various services for children: psychologists, social workers, opticians, local government officers, eye nurses, pedagogues.

Duration

One year

Funding

Stockholm University

Certification/accreditation

The course is part of the master programme in special education at the special Pedagogical Institution of Stockholm University.

Postgraduate certificate in provision of health care for people experiencing homelessness

Contact

Continuing Professional Development Centre
University of Oxford, Department for Continuing Education
Rewley House
UK-1 Wellington Square, OX1 2JA Oxford

cpdmail@conted.ox.ac.uk

Focus

Key words/competences

Brokerage skills, transdisciplinary teamwork, knowledge transfer skills

Project description

Goal

For professionals from all relevant disciplines, both clinical and non-clinical, to learn together in an interdisciplinary environment, thus breaking down professional barriers and improving transdisciplinary teamwork. To have an understanding of the full range of the person's complexity and to be able to communicate this to the full range of professionals needed to address the person's needs. Learning to read and evaluate research papers and documents, to become more discerning and able to apply knowledge appropriately to practice.

Content

Part 1 Three months online module
Module 1: Key concepts in provision of health care to people experiencing homelessness.
Key concepts: definitions of homelessness, causes and consequences, engagement, interagency working, values based practice, harm minimisation, and risk management.

Part 2 Nine months face-to face modules
Module 2: Homelessness: exclusion from health care and from society

Module 3: Health care needs of people experiencing homelessness

Module 4: Organising health care for people experiencing homelessness

Module 5: Working with people with complex and multiple needs

Module 6: Seminar and conference presentations

Quality

Innovative/good practice

- This course is unusual in the extent to which clinical and non-clinical disciplines are integrated. It is also addressed to an international audience.
- The course aims to be as inclusive as possible by supporting experienced workers who have not obtained previously a university degree, to study at postgraduate level.
- The course uses work-based assignments to ground the academic work in the reality of the workplace and to provide useful outputs for the student's locality.
- Partially online course which employs a range of techniques including reflective diaries, online discussions, forums and e-mail-based tutor support.
- Students are encouraged to form a mutually-supportive learning community through the initial online course, which extends into the rest of the year's work. Online contact and tutorials are utilised during Part 2 to link students between face-to-face sessions.
- The course was developed using input from a stakeholder group.

Quality improvement

- Evaluative feedback is encouraged in real time during the online module.
- Structured written feedback taken after the face-to-face sessions and a free text summary of feedback is encouraged at the end of the course.
- Quality assurance is controlled by the Board of Studies of the University, to which the course director reports every year. Course evaluations and results of assignments are presented and scrutinised to ensure quality.

Practical aspects

Participants

20-50 on online course, 12-20 on face-to-face modules
Students from all disciplines that work with homeless people

Duration

Three months online module – Nine months face-to-face modules

Funding

Financing through individual student fees.

Certification/accreditation

Postgraduate certificate of the University of Oxford

Home, homelessness and community

Contact

SAM Training and Consultancy Ltd
123 Fountain Road
UK-London SW17 0HH

Christopher Scanlon c.scanlon@btinternet.com
John Adlam john.adlam1@btinternet.com

Focus

Key words/competences

Transdisciplinary teamwork

Project description

Goal

To present in detail the difficulties of working with hard-to-reach homeless persons whose place in society is defined by their marginalisation, whether voluntary or otherwise.
To address the psychosocial causes of social exclusion and the structural (societal), objective violence that provides the context for or is the cause of the individual, subjective violence towards self or others.

Content

Part 1

- Objective: elaborating on the difficulties of working with hard-to-reach homeless persons.
- Content delivered from practitioners, service users and representatives of diverse communities.

Part 2

- Objective: discussion and exploration of the meaning, and our experience, of community, and of its potential contribution to personal, social and spiritual health, as well as a consideration of the pain caused when communities become corrupted, divided, damaged or fail.
- Method: groups and experiential exercises.

Quality

Innovative/good practice

- Use of the paradigm of the 'temporary learning community' as an experiential trigger to discussions about working with homeless or marginalised people.
- Use of a psychoanalytical and psychosocial approach to homelessness marginalisation to encourage deeper knowledge and understanding of the homelessness experience.
- Deeply considered approach to service-user involvement.

Quality improvement

- Constant evaluation and development of the model from workshop to workshop, varying lecture content, refining experiential exercises and adapting process work.
- During the workshops themselves, teaching/facilitating staff meet after each section of the day to compare notes and where appropriate to adapt to the tone of the day and the particular needs of delegates.
- Assessment methods during training ascertain achievement of individual objectives.
- Feedback evaluation form which is analysed to assess effectiveness and quality: trainer performance, pitched at appropriate level.
- Stakeholder evaluation from commissioning agency: staff performance and service-user outcomes.
- Written evaluation forms at the end of the day.
- Some delegates have entered into extensive e-mail correspondence with providers, after attending the workshop.
- A detailed report is drawn up for the commissioning organisation and a debrief/ evaluation meeting.

Practical aspects

Participants

35-50 participants (twice a year): services users, care workers and policy-makers

Duration

One-day workshop, with plans to develop as two-day workshop

Funding

Financed from advance sales of places on the workshop or bespoke commissioning of the workshop by a particular organisation

Certification/accreditation

Continuing professional development (CPD) certificates of attendance provided.

No external accreditation. In the UK, most professional CPD is organised according to professionals' personal development plans and certificate of attendance alongside reflections about training attended are presented by individuals in their annual appraisals.

Advanced professional certificate in working with homeless people

Contact

YMCA George Williams College
199 Freemasons Rd
UK-London, E16 3PY

Lesley Buckland/ Mike Seal l.buckland@ymca.ac.uk

Focus

Key words/competences

Empowerment

Project description

Goal

To obtain an understanding of homelessness and its impact on people, groups and communities. to synthesise and evaluate information/evidence and the significance of theory and research, to develop the ability to work to a professional standard with homeless people and agencies engaging with them and to make use of reflective practice around ethics and values.

Content

Part 1 Definitions and concepts
- Historical legacies: the construction of homelessness and housing.
- The ethos and practice of working in housing and homelessness.

Part 2 Developing working relationships
- Examining the client-worker relationship.
- Networking, advocacy and interagency contexts.
- The management and support of workers.

Part 3 Structuring work
- Working contracts and caseloads (trade-off between time available and level of support).
- Assessment, recording Information and support planning.
- The importance of risk assessment and health and safety.

Part 4 Developing our skills as workers: working with the process of change
- The 14-stage model of resettlement revisited.
- Prochaska and Diclemente's theory of change.
- Cognitive work: cognitive interventions in a housing context.
- Emotional work: transitional theory and the exploration of change.

Part 5 Reflecting in and on practice
- Development in supervision and the exploration of professional practice.
- The place of self-assessment.

Quality

Innovative/good practice

- Emphasis on professionalism.
- Underpinning of practice through understanding of evaluation of research and evidence.
- Emphasis on values, ethics.
- Reflection in and on action (Schön): thinking while acting and thinking back on your actions.
- Use of the educational paradigm as a model for interaction with clients.

Quality improvement

- There is a programme committee which advises on development of the programme.
- Employers, past participants and service users sit on the programme committee.
- The evaluation method is based on open discussion, rather than on closed criteria.
- Open discussion with students occurs at the end of each study-day plus a final formative discussion at the end of the course, facilitated by teaching staff.
- A final anonymous evaluation written by students takes place at the end of the course.
- Evaluation is also undertaken with employers.

Practical aspects

Participants

20-30 experienced front-line workers in the homelessness field

Duration

This course takes one academic year, from September to July

Funding

Funded through employers mostly state-aided

Certification/accreditation

This is a HE level 5 course (second year of a degree) accredited by Canterbury Christ Church University. It is also recognised by the National Youth Agency, the accrediting body for youth and community work.

The Homelessness Training Unit

Contact

The Homelessness Training Unit
88 Camberwell Road
UK-London SE5 OEG

John O'Neil John.ONeil@slam.nhs.uk

Focus

Key words/competences

Empowerment, knowledge transfer

Project description

Goal
To educate and train in mental health and associated areas, staff working in the homelessness sector.

Content

Objectives
- Empowerment of staff: to improve the skills levels and knowledge base of staff who work with vulnerable single homeless adults.
- Empowerment of service users by improving the effectiveness of the therapeutic relationship, thus maximising positive outcomes for service users.
- Empowerment of third sector: to support and improve working relationships between the voluntary and statutory sector.

Modules
- Homelessness
- Assessment skills
- Mental health awareness and boundaries
- Working with depression/schizophrenia/personality disorder/complex needs
- Cultural awareness
- Risk assessment and management
- Motivational interviewing
- Training the trainer

Key components
- The use of user/carer consultants in the delivery of the training.
- The use of local mental health practitioners as cotrainers to deliver the training.

Quality

Innovative/good practice

- Using the paradigm of mental health as an opportunity to improve the generic skills of front-line staff working with people with complex and multiple needs.
- Using the joint training experience to increase knowledge of the field more generally and to empower all staff and improve their interdisciplinary work.
- Specific inclusion and targeting of voluntary sector staff for joint training, with the potential to improve communication between sectors and thus better outcomes for clients.
- The training represents a local response to gaps in available vocational education, expressed and identified at local level, and as such demonstrates innovative practice, in areas which are not provided by any national VET.

Quality improvement

- Goals are set primarily by agencies requesting training and by members of the training unit, including associated clinicians
- Homelessness agencies are contacted after training is delivered for feedback on outcomes
- The unit is open to suggestions from agencies on new aspects/topics of training required
- Involved service users are debriefed and offer feedback in real time, plans for further involvement in course development
- Real time feedback and instant responses to requests for covering additional topics in training sessions
- Assessment methods during training ascertain achievement of individual objectives
- Feedback evaluation form which is analysed to assess effectiveness and quality: trainer performance, pitched at appropriate level
- Stakeholder evaluation from commissioning agency: staff performance and service-user outcomes

Practical aspects

Participants

300-400 staff working in the homeless field (hostels, day centres, outreach, etc.)

Duration

Modules range from one to four days

Funding

Funded by employers

Certification/accreditation

Courses are not linked to any accrediting body. However, the content has, in some cases been mapped across to the national occupational standards for drugs and alcohol, and for mental health. This enables participants to ensure that the learning fits with their personal development plans.

St Mungo's learning and development programme

Contact

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Focus

Key words/competences

Empowerment, brokerage skills, innovative leadership

Project description

Goal

All staff members should attain a level of qualification appropriate to their job by 2010 and most a recognised qualification by that date. Train its front-line workers in a wide range of skills to equip them with sufficient knowledge and skills to manage clients with complex and multiple needs.

Content

Part 1 Introduction programme
- Core skills for staff: behaviour and communication, safeguarding and protecting.
- Core skills for managers: supervision, recruitment and selection.

Part 2 Continuous development
Continuous development pathway depending on their job role in one or more of seven areas:
- working with our clients: recovery approach, person-centred planning;
- legislation and procedures: domestic violence awareness, housing benefits;
- mental health: mood disorder, self-harm;
- personal development: assertive manager, time management;
- health and safety: first aid, moving and handling;
- communication: conflict resolution, handling complaints;
- substance use: women and substance abuse, overdose;
- CPD for managers: stepping up, coaching skills.

Quality

Innovative/good practice

- The organisation ensures that staff have the opportunity to improve their skills and obtain recognised qualifications.
- A very organised and comprehensive approach to its staff training aims to produce staff with a range of competences, suitable for working with clients with complex and multiple needs. In particular, training staff around mental health and substance misuse problems, which are prevalent in the target client group.
- The organisation provides accredited training in leadership and management for its front-line managers.

Quality improvement

- Ongoing rolling evaluation by means of written and verbal feedback from individual modules, plus focus groups of staff, managers and clients regarding the quality of staff (and directly or indirectly, therefore, of the training and the impact of the training they receive).
- Module content and delivery is constantly reviewed and adjustments are made.

Practical aspects

Participants

1000 mainly front-line support workers and managers in the homelessness charity, St Mungo's , receive training and development. Over 100 volunteers can access courses online to update skills and also attend staff training. Clients also access training either as part of an innovative apprenticeship scheme or as mentors and facilitators within projects.

Duration

Most courses are offered as one or two day workshops. Management modules form part of a Continuous Development Programme for all managers within the organisation. All courses designed and delivered are in line with the organisation competency framework.

Funding

Training by an in-house training team financed through the organisation of St Mungo's which is an NGO and housing association which receives a combination of State and charitable aid.

Certification/accreditation

Staff may obtain the following formal qualifications:
national vocational qualifications in health and social care Levels 2, 3 and 4, with potential DANOS accreditation (drug and alcohol national occupational standards). Also offered are vocational qualification in other health care fields and a teaching award. In 2009 over 200 staff completed accredited courses in addition to attending other training.

Interdisciplinary and interdepartmental strategies to ensure a continuum of services

Contact

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Focus

Key words/competences

Transdisciplinary teamwork

Project description

Goal
To help participants in developing strategies for strengthening the continuum of services for clients in their respective organisations.

Content

Part 1 One-and-a-half-day seminar
- Lectures and discussions regarding client-centered services, the continuum of services, change-based strategies for organisational change, and organisational and professional challenges for organisational collaboration.
- Outcome: the identification of two to three potential change initiatives, related to their organisation's strategic plan.

Part 2 Implementation of change initiative
- Development of a change initiative plan and written approval from the centre director (within 45 days).
- Implementation of the change initiative through a five- to six-month period with monthly communication between the seminar faculty and each group.
- Submission of the change initiative outcome(s) to the seminar faculty 30 days before the culminating seminar.

Part 3 One-and-a-half-day seminar
- Reporting out of the change initiative including an analysis by the Centre Director. The Centre Directors are invited to the presentations.
- Analysing of the change initiatives and articulating the specific organisational changes essential to insure a sustained focus on the client for the continuum of services.

Quality

Innovative/good practice

- Format specifically designed for sustainability of the skills and practices acquired.
- Learning among peers, participation of the directors.
- Individual follow-up and tailor-made project development.
- Multidimensional approach to cross-departmental cooperation.

Quality improvement

- Involvement of universities in the design of training.
- Involvement of representatives of service-user organisations.
- Gathering feedback from service users.
- Evaluation of the course by collecting quantitative and qualitative data.
- Participants give written anonymous feedback.
- Annual evaluation meeting with EPR members.

Practical aspects

Participants

Five professionals dealing with people with disabilities

Duration

One-and-a-half-day seminar + six months implementation + one-and-a-half-day seminar

Funding

Training is financed by the annual membership of the EPR centres

Certification/accreditation

Not certified

Measuring and improving empowerment through the Vrijbaan and Request methods

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Focus

Key words/competences

Empowerment, transdisciplinary teamwork, Vrijbaan, Request

Project description

Goal

To learn how to use tools to define, measure and strengthen empowerment of:
- the individual service-user (VrijBaan);
- the service provider (Request).

Part 1 Three learning group meetings
- Get an in-depth understanding of the six components of the empowerment concept which are used as a touching stone to assess the 'empowerment profile' of the service user and the empowering capacity of the organisation.
- Train participants as Vrijbaan trainers in their own national settings:
  - ✓ learn how to use the VrijBaan questionnaire;
  - ✓ ability to compose and deliver tailor-made training modules to strengthen empowerment.

The participants receive the material, software and license to use the VrijBaan method.
In between the three meetings, participants adapt and test the Vrijbaan tool in their respective centres.

Part 2 Three-day in-house training
- Trainers visit participating centres.
- Identification of gaps and weaknesses among service users, staff and organisational environment to increase the empowering capacity of clients and organisations.
- Recommendations and improvement plan.

At the end of the training, organisations will be able to use Vrijbaan and Request as part of their operations.

Quality

Innovative/good practice

- A double-sided approach to empowerment.
- Measurement of empowerment.
- Participants from an international context.
- A training format focused on concrete implementation of the acquired tools and skills.

Quality improvement

- Involvement of universities in design of the training.
- Involvement of representatives of service-user organisations.
- Gathering feedback from service users.
- Evaluation of the course by collecting quantitative and qualitative data.
- Participants give written anonymous feedback.
- Annual evaluation meeting with EPR members.

Practical aspects

Participants

Five to eight professionals dealing with people with disabilities

Duration

Three meetings, adaptation and test in own organisation + three days in-house training

Funding

Training is financed through the annual membership fee of EPR centres.

Certification/accreditation

Not certified

European Centre for the Development of Vocational Training

Quality assurance in the social care sector

The role of training

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Quality assurance in the social care sector

The role of training

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Full participation in society is a fundamental human right and an ultimate goal of the European Union.
It is a right applying to all European citizens, irrespective of their physical, mental, economic, social or ethnic background, so everyone can maximise their own potential and also be of benefit to society and the economy.
With rising unemployment, highly demanding jobs and population ageing, the social care sector is called upon to alleviate the negative impacts these trends have on people's lives and on those who become increasingly vulnerable and threatened by poverty and social exclusion.
In parallel, as the health and social care sector in Europe is facing its own difficulties mainly due to budget restrictions, it is crucial to deliver quality care efficiently.
It is against this background that Cedefop carried out the present study on the competences required for front-line staff and leaders of 'new' community-based services, confronted with people with multiple, complex and enduring needs.
Literature review, focus group discussions in five Member States representing a different social model tradition, namely Germany, Poland, Portugal, Sweden and the UK, served to point out the latest changes in our European societies and define the generic competences required for responding to them adequately.
These competences have been further analysed by studying 18 innovative training and lifelong learning cases focusing on their quality and transferability aspects..

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