

# **Educational Multimedia Taskforce**



## **SCHEMA**

# Training Needs of Health, Education and Welfare Workers in Marginal Areas

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**More information about the Schema project can be found under  
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## **Executive Summary**

One of the aims of SCHEMA is to deliver continuing professional courses to health, education and welfare workers in marginal areas. In order to identify CPD needs the partners in the SCHEMA consortium have undertaken a training needs review. A considerable degree of consensus exists in the needs identified, with particular emphasis being placed on training relating to the care of elderly people, joint planning and problems of substance abuse. The particular requirements of workers in remote areas were also stressed. On the basis of the analysis a number of training modules have been defined for mounting in the 1999-2000 academic session.



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## 1. Introduction

One of the aims of SCHEMA (Social Cohesion through Higher Education in Marginal Areas) is the development of Continuing Professional Development (CPD) modules for delivery over the Internet to health and welfare workers in remote communities. The modules are intended to demonstrate the ability of the SCHEMA infrastructure, described in previous Reports (Booth, 1998; Rousselle & Pärkkä, 1998; Pulkinnen & Ruotsalainen, 1998) to support a collaborative, problem-solving approach to learning and, in the process, to meet identified needs of workers who are remote from training centers and often have more generalised roles than their colleagues in more central and more densely populated areas.

As part of the process of designing the training modules, members of the SCHEMA consortium in Finland (Universities of Lapland and Oulu), Sweden (Universities of Örebro and Karlskrona-Rönneby), Germany (IAT, Stuttgart) and Scotland (Universities of Stirling and Edinburgh) have examined current training needs of community-based health and welfare workers in their respective areas. On the basis of this review a number of training modules have been identified for implementation in the 1999-2000 academic session. Both the review and the course design have been conducted within the theoretical perspective adopted by SCHEMA, which emphasises the social constructive nature of professional learning and locates health and welfare provision firmly within a community context.



## 2. Rationale

Three work packages within SCHEMA are specifically concerned with the development of training modules:

- Work package three is devoted to the development of a module on applied social research methods (see Timms and Booth, 1998)
- Work package four is concerned with the use of computer-based communications, within a Web-based environment, for the collaborative production of community portraits (see Timms, 1999) and
- Work package eight is intended to lead to the production of a number of training modules based on the expressed needs of health and community workers in the areas served by the SCHEMA consortium.

The approach adopted by SCHEMA is based on the assumption that professional learning is essentially a social activity and that it should reflect the nature of professional practice. The social constructivist approach to learning emphasises the role of interaction and collaboration in the mastery of new skills and knowledge (Vygotsky, 1978). A further development of the approach, especially relevant to professional training, emphasises the development of shared cognitions, based on collaborative learning within contexts in which the newly-acquired knowledge and skills are directly applicable (Brown, *et al.*, 1988; Lave & Wenger, 1991). McMahon (1997) notes that developments in the use of the Web as a communications medium provide a good foundation for social interactivity and for the adoption of a social constructivist approach to online learning:

“The goal of this type of approach is the achievement of ‘virtual communities’ of learners on the Internet working in small collaborative groups to achieve a common goal”

Dillenbourgh and Schneider (1995) in a wide-ranging review of the implications of the Internet for collaborative learning, propose the development of 'socially shared cognition'.

“This theory views a group as a single cognitive system distributed over individuals. It does not focus on individual contributions, but on the shared representation built by the group. Within this perspective, the main reason why collaborative learning is efficient is that members learn to think interactively: thinking is not only manipulating mental objects, but also interactions with others and with the environment.”

The courses to be developed within SCHEMA are intended to reflect these principles and to encourage the formation of socially shared cognitions within a learning community.

### **The Community as a Context for Welfare Practice**

One of the basic tenets of SCHEMA is the importance of community in human welfare. This may seem so obvious as to be not worth stating, but, despite the wealth of evidence in the social sciences concerning the importance of context for human

welfare, the significance of community is often overlooked in the day-to-day practice of the health and welfare professions.

The literature of social work has always recognised the professional relevance of the social context of clients' problems. At the same time, the casework origins of much social work practice in the UK and Scandinavia and its reliance on theories of individual development have emphasised practice that is focused on the client and his or her problems. Within the UK this orientation has been given added force by Government policies which focus on case management and the adoption of a quasi-market approach. The adoption of this model carries with it a danger of neglecting the role of the community in the development, labeling and potential resolution of social problems.

Hadley and Leidy (1996) point out that an alternative perspective can be used in which the role of the social networks, which form the personal community of clients, is brought to the fore. This approach can trace its recent ancestry in the UK back to the Barclay Report on the role and task of social works, published in 1982 (Barclay, 1982).

The Barclay Working Part presented a case for community-orientated social work, based on a definition of community in terms of "local networks of relationships with their capacity to mobilise individual and collective responses to adversity" (Barclay, 1982: xiii). Through direct interaction with the community:

"Social workers, as the spearhead of the personal social services, may find ways of developing partnerships between informal carers (including self-help groups), statutory services and voluntary agencies (Ibid.: 202).

Timms (1983: 405-15) suggested that:

"Social workers at a local level will need to obtain a grasp of community life – cultural patterns and the meanings these hold for members of the community. ... Clearly what is needed is a service that works in partnership with the community as a whole, supporting existing support systems, promoting new support systems when appropriate and mobilising appropriate specialist help only when that is the most precisely suitable action. In working *with* the community the emphasis would be on supporting and extending the caring systems that already exist – neither taking them over nor supplanting them."

The case for the adoption of a community-orientated approach to social work has been presented in the UK by Smale and his colleagues in *the National Institute of Social Work* (Smale & Bennett, 1989; Darvill & Smale, 1990; Hearn, 1995).

Green (1989: 120) provides a case study illustrating the development of a community-orientated approach to the delivery of services in a Scottish social work setting. He is at pains to point out that the adoption of a community-orientated perspective does not imply the neglect of the individual client and his or her problems:

"Individual casework remains very important to the team and is vital to sensitive assessment of service required by clients and to intervention in personal problems. We do not live in isolation from the community and we have tried to capitalise on all available resources in that community to improve upon and take over some of our tasks. By mobilising the abilities of others we can find some time to practice our own skills more effectively."

The work of the U.K. Government “social exclusion unit” has a clear orientation towards a community networking approach and there have been recent signs in discussions taking place within the British Association of Social Workers, as reported in *Community Care* (3-9 June, 1999) and *Professional Social Work* (August, 1999), suggesting a rekindling of interest in the preventative possibilities of adopting a community-based approach. It nonetheless remains the case that the dominant mode of social work practice in both Britain and the Nordic countries remains focussed on individualistic pathology.

Lamenting the lack of attention paid to community social work in Britain during the 1990s, Hadley and Leidy (1996: 826) note that just as the approach seems to have been relegated to the fringe of practice in the U.K., several projects in North America are adopting it. They point to the irony that:

“there are some in America who are looking to Community Social Work as a way out of the dilemmas created by the very system the British are adopting.”

An American perspective, based on the needs of practice in small towns, is provided by Martinez-Brawley (1990: 216-7):

“Community-oriented social work depends on an attitude of mind that sees community as a potentially nourishing and important source of support and identity to its members. The notion that community nourishes its members is not commonplace. It is probably not an idea that is in the forefront of consciousness when social workers help clients make decisions.”

The comment by Martinez-Brawley applies with even greater strength to much thinking and practice in other professions concerned with health and welfare. The dominant bio-medical models in most of the professions specifically focussing on the treatment of illness remain focused on the problems of the individual patient and therapeutic endeavours concentrate on the treatment and management of disease processes within the individual. The role of social factors receives greater attention in the theory and practice of community and public health, but this remains a relatively minor aspect of the training of most primary health practitioners. Adams and Nelson (1997) point out that adoption of a community perspective provides a firm foundation for service integration:

“Working as part of a community-negotiating and building partnerships with families, social networks, and organisations to change problematic patterns and mobilise resources - requires not only collaboration among administrators, but teamwork among front line staff. Team members need to share work, knowledge, and resources, while building collaborative relationships with their counterparts in other organisations, service users, and other residents”

Community can, of course, be a negative factor as well as a positive feature in the life of its members. The literature on the effects of residential segregation in Western cities (e.g. Peach, 1975) is replete with examples of the ways in which characteristics of local communities can help to determine the life chances of their inhabitants, being implicated in such phenomena as delinquency, substance abuse, school attainment and a host of other problematic behaviours. Suttles (1972) has described how the social identity of neighbourhoods helps to set the scene for the personal identity of their residents and the problems of disorganised communities have received

considerable attention in both the popular press and in official reports. Health and welfare workers ignore the community at their peril.

### **Social Cohesion, Community and Communications and Information Technology**

The SCHEMA acronym gives pride of place to the concept of social cohesion. Before investigating how the use of the Internet for the delivery of open and distance learning can contribute to social cohesion in marginal areas it is necessary to attempt some definitions.

Social cohesion has become one of the catch phrases of social policy, but there is little consensus about its exact meaning. The term is often used informally, usually in reference to situations in which individuals feel themselves bound to one another by common social and cultural commitments. Social cohesion is represented by individual commitments to common norms and values, shared interests and identification with the group (Mitchell, 1968: 165). Putnam (1995) uses the term “social capital” to refer to a very similar concept. A high degree of social capital is represented by:

“features of social organisation such as networks, norms, and social trust that facilitate co-ordination and co-operation for mutual benefit”

There is a close relationship between the concept of social cohesion and that of community. The Australian Local Government Association (1998) explicitly links the two concepts, describing social cohesion as

“the process of looking after the community, establishing support mechanisms and networks, and living and working in an environment of trust.”

The term community is even more loosely defined than is social cohesion. At the same time, especially in English language cultures, it is a frequent component of politician’s speeches and both lay and professional articles on the characteristics of modern society. The search for community is part of the “Third Way” espoused by Governments in the US and the UK and represented in the philosophy of communitarianism (Etzioni, 1998). The basis of community is a sense of belonging, of having ties in common.

Wellman and his colleagues (Wellman *et al.*, 1988, 1997) have described community as a “network of networks”, the intermeshing of individual’s personal sets of relations.

“We look for the social essence of community . . . in the ways in which networks of informal relations fit persons and households into social structures. Our approach focuses attention on the characteristics of ‘community ties’ – informal links of companionship and aid between individuals – and on the patterns formed by these links.” (*Ibid.*, 1997: 131)

Personal ties may be formed and maintained on the basis of single interests or activities; for them to provide the basis for community the links between the members need to become multi-stranded, extending beyond the original tasks which may have brought them together. In this sense community can be conceived as the complex mesh of personal social networks, forming what Fischer *et al.* (1977: 17) describe as an intricate latticework.

The convergence of communications and information technologies in the Internet has provided a potent new medium for the development of personal communities. Bikson and Panis (1997: 410) point out that electronic “networks are not just information technologies but also serve as social technologies (or technologies for affiliation) ...” As Wellman (1997: 179) points out “When a computer network connects people, it is a social network”. The transformation of electronic networks into social networks provides the infrastructure for the development of on-line (or virtual) communities.

People who interact with each other across the Internet provide the basis for the development of a virtual or on-line community. A definition is provided by Rheingold (1993: 5):

“Virtual communities are social aggregations that emerge from the Net when enough people carry on ... public discussions long enough, with sufficient human feeling, to form webs of personal relationships in cyberspace”.

The development of such a community requires more than the act of communication itself.

“It seems that the key to a virtual community is the human interaction that computers, and the computer space allotted to the group, foster.” (Lapachet, 1995)

An on-line community, like one grounded off-line, is held together by the feelings of togetherness and connectedness that confer a sense of belonging (Foster, 1997). Such feelings do not ‘just happen’. As Rheingold (1999) points out in a speech delivered as part of the BBC Online Community Day (17 June 1999):

“In order to succeed, a virtual community has to have an affinity – the answer to the question ‘what would draw these people together?’”

Within SCHEMA, the intention is that people in diverse geographical locations, with diverse professional backgrounds, will be drawn together through an affinity for collaborative exploration of a number of issues concerned with the provision of health and welfare service in marginal areas.

Kollock (1998), while noting that “There is no algorithm for community”, suggests a number of guidelines for the development of on-line communities which are derived from work on interpersonal cooperation and social dilemmas. Among the points mentioned are the importance of individuals sharing information about each other, ensuring continuity of interaction, allowing sufficient time for people to express themselves, sharing interests and having self-administered rules and sanctions. Perhaps more controversially, he also suggests that the presence of some risk may be useful:

“without risk online communities will be dull and will not provide the possibility for the development of high levels of trust”

Within a learning community risks and crises can arise both from internal disagreements and from such external factors as assessment. The temptation to ensure harmony at all costs is to be avoided. Learning involves confrontation between alternative perspectives and experiences and space has to be allowed for participants to discover these and work through differences. Similar principles apply to the design of the learning environment itself. Kollock (Ibid) points out

“People are working hard to make online systems that are instant, seamless, and fully interconnected, but there are also social benefits to lags, seams, and islands”

It seems unlikely that bugs in software provide many benefits to the user, but there may be advantages in designing learning environments that encourage and support diversity and avoid the temptation of forcing homogeneity and premature closure.

Learning is a social process. The learning communities to be developed in SCHEMA are intended to bring together groups of people with different professional backgrounds and working in different national and regional contexts. “Lags, seams, and islands” may be there in plenty, but, rather than the differences being seen as a potential problem, the possibilities they offer for collaborative learning and for the development of a community of practice are there to be seized.

In the context of health and welfare provision in the community there are a number of examples of the potentially enriching effect of sharing a common learning environment:

- Dialogue between community nurses and social workers about best practice in the care of elderly people.
- Discussion of policies for controlling substance abuse between police officers, youth workers and schoolteachers.
- Consultation between housing officers, social workers and health professionals relating to the provision of housing and other facilities for people with a variety of special needs.

One of the aims of SCHEMA is to set up learning environments that will specifically require professional workers with different disciplinary backgrounds and experiences to collaborate together in learning environments which mirror ‘real-life’ contexts.

### **Collaboration as a Method for Learning and Working**

Collaboration is a common feature of statements about welfare practice. The desirability of workers from different backgrounds, with different skills, collaborating with each other to tackle multidimensional problems is commonly assumed to be self-evident. Addressing a conference of British social work educators in early summer 1999, John Hutton, the (English) Health Minister, asserted that a partnership approach to the delivery of social care in the community was the way forward and that this implied multi-professional training, with social workers working and learning alongside nurses, occupational therapists and other professionals (reported in *Professional Social Work*, August 1999: 1-3).

Despite the encouraging rhetoric, several studies (e.g. as reported in *Administration in Social Work*, 1997) have suggested that the reality of collaboration is frequently less than policy makers and commentators suggest is desirable. There is a good deal of literature on ways in which workers may establish and maintain effective working relationships with clients, but much less has been published on inter-professional relationships. Relatively little overt attention appears to be given to the nature of inter-professional collaboration in the initial training of health and welfare workers. The topic of collaboration across the various professions involved in the health and

welfare services is a prime candidate for inclusion in post-qualifying training programmes. The approach adopted in SCHEMA is to use a collaborative approach to learning as an overt stimulus to the development of collaborative forms of practice across the confines of individual disciplines, converting learning communities into practice communities.

Hartley (1999: 4) notes that a commonly-accepted advantage of collaborative learning is its encouragement of “active learning and more thoughtful participation from teachers and students.” Noting the evidence that students who self-question and self-explain show greater understanding and more readily acquire new knowledge, he goes on:

“How much better therefore if such questions and explanations are addressed not only to oneself but to others, so that queries seeking clarification, challenges requiring justification, inconsistencies needing resolution, qualifying implications and differing views can become part of the argumentation and discourse processes of the group.”

Face-to-face collaborative learning has long been part of qualifying training in both nursing and social work. Stress is laid on work in groups and on students learning from each other, rather than relying on the instructor. The “Enquiry-Action-Learning” method (Burgess, 1992), used in many social work courses, makes formal and substantial demands on students to contribute to each others’ learning tasks. What appears to be generally lacking, is any extension of this approach to cover the needs of inter-professional working.

### **The Internet and Collaborative Learning**

The existence of on-line courses designed to encourage collaboration between students does not guarantee success. A number of hurdles have to be cleared before fruitful collaboration can take place.

If an on-line community is to be a forum for cohesion all members must be able to participate. Even amongst the professional workers who are the initial target of SCHEMA there exist many differences in access to the Internet and ability to make use of the resources available. Some employers, notably local authority social work departments in the U.K. appear to have an almost pathological fear of the Internet, viewing it as a potential source of a breakdown in confidentiality, as a time waster, or, in the extreme, as being a haven for misfits, pedophiles and pornographers. There is some evidence that a negative view of the Internet is commonly shared amongst many social work professionals. For whatever the reason, social work departments in the U.K. appear to be relative laggards in getting their employees on-line. There appears to be less reluctance to use C&IT among social workers in the Nordic countries or amongst health professionals throughout the area covered by SCHEMA.

There remains a danger that the relative lack of access to the Internet characteristic of many British social workers will disadvantage them in the developing Information Society.

Writing about the population at large Bikson and Panis (1997: 407) note that:

“The gap between the information haves ...and information have-nots has actually increased in the last few years even as computers and online services have become less expensive.”

The more important the Internet becomes as a source, not just of information, but also of professional development and community cohesion, the more important it is that access should be available to all.

In addition to physical access, having a networked computer available, there are a number of other hurdles which have to be overcome before the Internet can become a generally effective means for delivering open and distance education and for developing on-line communities. Chief among the obstacles are usability and cost.

Usability considerations relate to technical aspects of both the computing and the communications infrastructures. Most computers used to communicate on the 'Net are general-purpose desk machines, mainly running under one or other version of Windows. Not only are the machines considerably over-powered and over-complicated for the great majority of the tasks for which they are used, but operating systems are also prone to "fall-over:" with disturbing frequency. Within a campus or large office environment technical expertise is (usually) on-hand to deal with system crashes and bugs; elsewhere the situation may be very different. Despite the seductive advertisements about the ease of using a desktop computer and a modem to connect to the "information superhighway", the experience of the lone user is often far from satisfactory. As a report by the National Working Party on Social Inclusion, set up by IBM to examine the implications of C&IT for social inclusion in the information society (INSINC, 1997: para. 4.41), put it:

"It seems mysteriously easy for those with privileged access to overlook [the fact] that the existing technology is extremely cumbersome and off-putting to the naive user."

They go on (Ibid: para. 4.43) to hope that

"computer and online technology will soon have outgrown its phase as a domain for specialists, a priesthood with protected knowledge."

The mystique that accompanied the early days of the Internet is not an adequate foundation for its exploitation as the delivery and support mechanism for universal membership in on-line communities.

"Our concern is that new users may quickly be discouraged and so opt out of the Information Society. Experienced users come to treat as acceptable a situation in which both system software and content may well be flawed or incomplete. At this point what concerns us is not so much that things don't work properly, as the fact that they're not necessarily expected to" (INSINC, 1997: para. 4.48)

If C&IT is to be used as the basis for widespread participation it must be as transparent and as reliable as possible, preferably no more difficult to use than say a phone or TV.

Access must also be cheap. In the case of continuing professional development costs may be shared between individual worker and employer, but both sides are more likely to be enthusiastic if the cost of access can be kept low. Use of the public service telephone network in Europe is generally cheaper in the evenings and at weekends, but this may result in employers requiring their staff to study out of official working hours and, possibly, to bear the costs themselves. Free access, as in so much of the U.S., would revolutionise the use of the Internet.

There is a temptation to develop on-line teaching resources to exploit the latest bits of technical wizardry, such as video clips and other multi-media materials. When used within a campus environment, connected by high bandwidth cable, the use of such materials may seem unremarkable. For a remote learner, connecting by modem across the public service telephone network, the result may be infuriatingly slow downloads and high telephone bills. Many of the on-line communities described in the literature (*e.g.* Baym, 1997; Curtis, 1997; Moursund, 1997; Rheingold, 1993) have developed on the basis of relatively simple forms of presentation, often little more than text. The use of more complex media needs to be justified in terms of its effectiveness.



### 3. The Target Group :Health and Welfare Workers in Remote Communities

The end users identified by SCHEMA are professional health and welfare workers in remote or otherwise marginalised areas. As a consequence of their geographical location the workers concerned are likely to experience relatively few chances of obtaining professional development. They are physically remote from training centres and often work in small teams, making it difficult for them to obtain cover for periods of absence. At the same time, many workers in these locations find themselves having to cover wider areas of knowledge and practice than their colleagues in more populous, central areas who can call on the services of specialists. Even in central areas, however, the rapidity of change in demographic and socio-cultural circumstances and the ever-changing nature of professional and administrative responses, has led to an increasing demand for 'just-in-time', flexible forms of continuing education. It is in this connection that the use of C&IT comes into its own.

A host of professions is involved in the provision of health and welfare services in the community. Among those consulted by SCHEMA in the course of developing a profile of training needs were workers with such titles as social worker, social secretary, care supervisor, youth and community worker, housing officer, social pedagogue, child supervisor, community nurse, geriatric nurse, social planner, teacher, nurse tutor and manager (of specialised units for people with drug and alcohol dependence problems, dementia sufferers and frail elderly people). The direct translation of titles into English fails to do justice to the full range of differences present in the organization and delivery of health and welfare services in the countries represented within the SCHEMA consortium. Some professions, such as social pedagogy, which are common in some countries (*e.g.* Germany and Sweden) are effectively unrecognised in others (*e.g.* the UK). Some client groups, *e.g.* elderly people with dementia, are served by different professions in different countries. The nature and length of initial training varies widely both between professions and between countries. The differences in professional background and work histories make the sharing of experience all the more important if the problems of marginal areas are to be tackled on a trans-European basis.

There are also clear national differences in the extent to which community-based health and welfare workers have access to the Internet. Among the areas and countries represented in SCHEMA, Lapland, South-eastern and Western Sweden and the Highlands and Islands of Scotland have the most pervasive network and the most well-developed policies for providing access and relevant training in the use of C&IT; Central Scotland and northern Germany have less well-developed resources and many users are likely to be dependent on provision at work rather than having their own machines and connections. And there are clear differences in the readiness of employers to allow access. Anecdotal reports from a number of social workers from both the U.K and Nordic countries suggest a widespread suspicion about the Internet on the part of many social work agencies. Publicity which has been given to the use of the Internet by paedophiles and other pornographers, combined with concerns about the confidentiality of information on the Internet, has resulted in a policy in which some social work authorities do not allow their employees to have online access and in which the use of C&IT at work is effectively kept to a minimum.



#### 4. Training Needs Reviewed

A rigorous training needs analysis, involving a survey of the welfare needs of remote communities and the requirements of the agencies and professional workers involved in attempting to meet them, would demand far more resources than were available. Instead reliance was placed on the knowledge of the SCHEMA participants, links with professional bodies and consideration of a number of reports already existing that detail training needs among particular groups (e.g. Connelly & Stubbs, 1997; NISW, 1998). The task given to the members of the SCHEMA Consortium was to determine ways in which the approach adopted by the Project could be used in an attempt to meet some of the more general gaps in training provision.

Each partner in the Consortium was charged with producing a report on the training needs of health and welfare workers in their own area. A common set of guidelines was used, reflecting the theoretical stance of SCHEMA and the social objectives of the EC:

- Any training defined should be capable of delivery across the Internet, making use of the learning environments specified.
- Wherever possible, preference should be given to meeting needs identified in more than one area and country, reflecting the trans-national, European dimension of the Project.
- Rather than addressing organisational requirements, *per se*, the emphasis should be on developing professional standards of practice.
- Reflecting the general social aims of the EC, the training provided should be address issues concerned with the social exclusion of people in marginal areas.
- The “European” dimension should be stressed.

Detailed responses from the SCHEMA partners are given in the Appendices.

Some of the identified training needs, e.g. the requirement in Scotland for an extension of training opportunities for those involved in the management of ‘social housing’, are largely specific to particular contexts, but the majority of the needs identified appear to be common across all, or at least several, of the sites.

Some comments were made about the access of staff to the Internet (notably in Scotland), but in general this was not seen as a major constraint. It was noted that even when staff did not have open access to the Internet, many had their own PCs at home. It remains the case, however, that full exploitation of the power of the Internet to provide continuing professional development at work will require a more positive attitude on the part of managers than is always apparent at present.

There was a general welcome among those consulted for the opportunities made available within *ProTo* and *TELSipro* for collaborative, problem-solving activities. There was general agreement that effective continuing professional development required extensive discussion between peers as well as guidance from “experts”.

Following receipt of the individual reviews, a series of meetings was held in early summer 1999 to consider the implications for courses to be delivered in 1999-2000. The following priorities for training were identified (in no particular order):

- The general characteristics of health and welfare in remote communities
- Care for elderly people, especially for those exhibiting symptoms of dementia
- Quality standards for the delivery of social services
- The problems of substance abuse in the community
- Joint planning of health and welfare services in remote communities
- The implications of new technologies for teaching and learning
- Housing (especially housing renewal) as a social issue

Running throughout the consultations was the perception that members of the different professions involved need to learn to work together and that this should (and could) be reflected in the design of CPD courses. This emphasis on collaboration was seen as reflecting both a common trend to joint practice and a growing realisation that people's problems cannot be put into disciplinary pigeon-holes.

Partners agreed that the continuing professional development of health and welfare workers in remote areas faced particular constraints of time and distance which the use of telematics could help address. At the same time it was stressed that varying levels of familiarity and confidence with the use of C&IT meant that the technical infrastructure would have to be as "transparent" as possible. In this regard it was regretted that the original intention in SCHEMA to make use of NCs had had to be abandoned (at least for the time being).

## 5. Training Modules

As specified in the Project Proposal, a number of courses are in the process of development based on the review of training needs. Each of the priorities identified forms the substance for one or more training modules. The courses are scheduled to be delivered during the 1999-2000 academic session and responsibility for their development and trial delivery has been allocated as follows:

- **Health and Welfare in Remote Communities**  
Stirling (Edinburgh) and Lapland (based on the existing *Community Portraits* module)
- **Care for Elderly People , especially for those exhibiting Dementia**  
Örebro (plus Stirling)
- **Quality Management in the Social Services**  
Stuttgart (plus Bremen) and Stirling
- **Substance Abuse**  
Stirling
- **Joint Planning of Care Services**  
Lapland, Oulu and Örebro
- **New Technologies in Teaching and Learning**  
Oulu
- **Social Aspects of Housing**  
Stirling and Örebro

In addition, work will continue on a revision of the module on *Applied Social Research Methods* piloted in 1998/9.

It is intended that the *Community Portraits* module, piloted in spring 1999, should be opened to teams containing lay members of marginalised communities as well as professional health and welfare workers. This is in line with the general objective of SCHEMA to investigate the extent to which the use of the Internet can not only improve inter-professional collaboration but can also contribute to social cohesion.

### Techniques of Delivery

Pedagogic approach

In line with the general SCHEMA philosophy all the units will emphasise the importance of group work. In some units, *e.g.* *Community Portraits* and the joint planning exercise on “*Maloa*”, collaboration in problem-solving will form the central activity of the work; in other units, *e.g.* the course on dementia care for nurses or the unit on drug abuse, collaboration will take a more traditional form, analogous to group seminar discussions. Although the trial runs of each unit may, for convenience, be conducted with single-discipline groups, the intention is to open all of them to multi-disciplinary study.

## Learning Environments

All the courses will be designed for delivery across the Web, making use of either *TELSIpro*, developed by the Continuing Education Centre in the University of Oulu, or *ProTo*, developed in the Faculty of Education of the University of Oulu. Details of each package are given in previous SCHEMA Reports (*Deliverables 5.1, 5.2, 7.1 and 7.2*). Both packages can be classified as group ware, supporting a collaborative problem-solving approach to learning and providing a well-defined framework for cooperation between learners and instructors.

*ProTo* is likely to be used as the primary platform for the modules on applied social research methods, the assessment and management of drug and alcohol problems and quality standards in residential care.

*TELSIpro*, which was originally developed in the context of language learning, has particular strengths in terms of support for role playing or “small-world” simulations, which will form a major plank in the module on the joint planning of health and welfare services in small populations. Its facility for supporting collaboration within and between sub-groups will also be exploited in the unit exploring the health and welfare conditions of remote communities, a development of the *Community Portraits* module piloted in spring, 1999.

Decisions have yet to be made concerning the choice of learning environment for the remaining courses.

## Hardware

The SCHEMA team remain convinced that the effective extension of open and distance learning into people's homes would be best served by simple-to-operate Network Computers or set-top-boxes, which require little setting up apart from connection to a phone line, mains electricity, a TV or monitor and a printer and greatly simplify the management task of the system supervisor. Users would log on by inserting a smart card, which would automatically connect them to the appropriate folders and files on a server. As explained elsewhere, notably SCHEMA deliverable 2.2 and its appendix, the promise of the NC solution has yet to be realised. In its place three possible configurations are being explored:

1. Standard desk-top machines with *Internet Explorer* or *Netscape* browsers
2. Desk-top machines or Network Computers, running the Citrix ICA client and getting applications from a central server through the use of *Metaframe*
3. Small local networks of NCs, connected to a gateway PC, running Linux or NT (described in Deliverable D2.4).

The majority of students enrolling on the pilot courses being offered in 1999/2000 are likely to be working from offices, study centres or university computing facilities and are thus likely to make most use of the first option. In view of its mission to explore the use of a set top box/thin client solution, however, the attempt will be made to ensure that at least some of the students will make use of the second and third options. The aim is to make the interface as simple as possible.

### Length of Courses and Assessment Patterns

The problems of comparability between courses in different countries of the EU have long been recognised. The SCHEMA partners have agreed to adopt a system based on ECTS points, with six points being the equivalent of a notional 160 hours work, the equivalent of four weeks full-time study. Most units are likely to require 160 – 240 hours of study over a 15 – 20 week period, with perhaps 25% of that time being on-line. Successful completion of a module will lead to the award of appropriate credits.

Each course will contain a number of formative assessment tasks, but the main summative assessment, used for certification purposes, will involve the production of specialised papers as laid down by the relevant academic authorities in each institution (*e.g.* the Faculty of Human Sciences in the University of Stirling).

Given the pilot nature of the courses being offered in 1999/2000 it is anticipated that a degree of flexibility will be allowed.



## 6. Conclusion

Health and welfare workers in the peripheral areas of Scotland, Sweden, Finland and Germany share many of the training needs of their colleagues in more central and populated areas. Changes in demography, *e.g.* the increasing numbers of elderly people in the population, in social structures, *e.g.* the increasing number of marital disruptions, in life-styles, *e.g.* the increasing use of psychotropic drugs and in economic factors, *e.g.* changes in employment opportunities for young men, have combined to produce an ever-increasing burden on the ability of the social services to promote the welfare of the community. At the same time there has been a growth in the demand that all public services, especially those which have a direct impact on people's lives should be publicly accountable. The demand to adapt to these pressures is common throughout the health and welfare professions and is leading to an increasing requirement for continuing professional development and for flexible, "just-in-time" training.

Reflecting changes which are impacting on the whole of Europe, there is considerable consensus in the list of training needs uncovered by the SCHEMA consortium: concerns with the care of elderly people and the impact of alcohol and other drugs reflect common demographic and social changes; concerns with professional standards, quality management and joint planning reflect common changes in legislation and administrative practice. It is unlikely that a drastically different list would have been drawn up if the review had concentrated on the needs of workers in urban areas (although it is noticeable that none of the respondents mentioned problems relating to ethnic minorities, which might have assumed greater prominence in cities). Responding to the list, however, does require account to be taken of the time, distance and resource constraints characteristic of sparsely populated peripheral regions. Remoteness from population centres and the absence of cover means that workers in peripheral areas have greater difficulty in accessing CPD courses given in traditional training sites than do their more centrally-located colleagues. Developments in the use of communications and information technologies provide the potential for overcoming these problems.

The use of telematics for the provision of continuing professional development is unlikely to be a panacea. Given the right infrastructure, it does, however, enable workers to take part in training regardless of considerations of time and distance. These considerations weigh most heavily on workers in peripheral regions but time constraints on health and welfare workers even in central areas make the use of telematics an attractive option for the provision of flexible training. Perhaps more significant exploitation of the communication capabilities of the Internet opens up the possibility of collaboration between workers located in widely dispersed communities. There is always a tendency for local problems to be seen as unique; the adoption of an overtly comparative approach to professional training should enable workers to perceive local problems in a more general context and, hopefully, will contribute to the development of trans-national understanding. The courses to be mounted by the SCHEMA consortium during 1999-2000 will provide an opportunity for testing the extent to which this hope can be realised.



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## Appendix A Training Needs of Social Workers in Lapland

Based on material collected by Pirjo Helppinkangas,  
Department of Social Policy and Social Work, University of Lapland, Rovaniemi

### Background

The University of Lapland, in Rovaniemi, had responsibility for examining the training needs of social workers in the northern periphery. Interviews were conducted with 21 “leading” social workers in the municipalities of Lapland. In some cases other persons also participated in the interviews. The work title of respondents, translated into English, included: social worker, social secretary, child supervisor, leading social worker, leader of social and health services and social leader. In each case, the person was identified as being in some way the leading practitioner/planner of social work services in the municipality. The educational background of the interviewees was varied, including Master of Administrative Sciences, Diploma/Certificate in Social Care, Master of Social Sciences, Bachelor’s Degree in Social Care, Candidate in Political Sciences and Candidate in Philosophy. The age range was from 30 – 56, with most interviewees being in their forties and early fifties, reflecting their relative seniority. Eighty percent of the interviewees were female.

### Training Needs Identified

#### Priorities

The most urgent educational requirements for social workers in the field were identified as:

- How to deal with drinking and other forms of substance abuse, especially among unemployed, young men (a group frequently mentioned as being especially at risk in peripheral communities).
- Further consideration of the social worker’s profession.
- A very broad range of skills relating to work concerning the care of elderly people in the community.
- Health and welfare problems specific to peripheral regions with harsh environments.
- Family support measures, including child protection and the problems of young people.
- Legal matters relating to the social work task.

It was stressed that the demographic, environmental and economic characteristics of Lapland – a small, scattered population, living in a harsh climate, with few employment opportunities - required detailed knowledge of local circumstances before “standard” social welfare packages could be used. This is especially likely to be the case if planning is to extend to preventative measures, rather than reactive work. Although much relevant information is available from Census and other

statistical sources (*e.g.* age and gender distributions, economic activity and sources of livelihood, household structures, vital statistics and other health characteristics), the variety of cultures in different communities requires in-depth investigation, akin to ethnographic methods. The Sami people are an internationally-recognised subgroup, but there are also a number of other social, cultural and economic variations between settlements which need to be taken into account.

There is general enthusiasm for collaboration with other health and welfare workers in order to compare welfare theories and empirical reality and to learn how to negotiate with other professionals from different backgrounds. It is important that enthusiasm for the use of new technology does not overwhelm the need for workers to understand the nature and context of the social problems in their communities.

### Pedagogic Approach

The adoption of an overtly comparative approach was thought likely to be especially valuable, suggesting collaboration between social workers in Lapland and those in other marginal areas, such as northern Scandinavia and Scotland. Sharing of experience was likely to be particularly valuable in relation to the problems of young people, including their attitude and use of alcohol and drugs. It would also be useful to exchange information on approaches to the social integration of people suffering from disabilities, to child protection matters and, more generally, to preventative work with families.

### Post-qualifying or Initial Training?

Although SCHEMA is especially concerned with the provision of continuing professional development at the post-qualifying level, there was general agreement amongst the Lapland respondents that many of the matters discussed could profitably be incorporated into the initial training of social workers and other welfare professions.

### Length and Timing of CPD

There was a division of opinion between those who favoured short periods of intensive training and those who said they would prefer a more extended approach. Different training goals were thought likely to require different training approaches. There was a general belief that training should take place during the autumn and winter months rather than the summer.

### Use of the Internet

The basic infrastructure for the use of the Internet is already in place and only one of the municipalities currently lacks access. None of the respondents was hostile to the use of the Internet, but a quarter professed some ignorance. There was general interest in the possible use of a NC or set-top box which made as few demands on technical computing competence as possible and could be used at home.

In addition to using the Internet to obtain information, interviewees were especially keen to exploit communicative possibilities, including on-line chat. The ability of computer-mediated communications to overcome the barriers of time and space were seen as being especially relevant to peripheral communities and had the potential of enabling scattered communities to work together

### **Planned Courses**

Staff in the Department of Social Work and Social Policy in the University of Lapland are working on several proposals designed to meet some of the training needs identified above.

In collaboration with a social work lecturer in the University of Edinburgh, seconded to Stirling, staff in Rovaniemi are involved in further development of the Community Portraits module, trialled in spring 1999 (see Timms, 1999). An additional module, specifically concerned with the social characteristics and needs of peripheral communities in the Arctic and sub-Arctic regions is under consideration. This could draw on the expertise of the international Arctic Studies Programme in the University of Lapland.

In conjunction with SCHEMA colleagues in the Universities of Oulu and Örebro, staff in Rovaniemi are also writing scripts for a simulated planning exercise for the provision of services for elderly people in a fictional island community (Maloa). This unit is due to go online in autumn 1999. The development of the unit is described in SCHEMA Deliverable D7.2.

### **Educational Environments**

Both the *TELSIpro* and *ProTo* environments are under consideration. *ProTo* was used for the trial run of the Community Portraits module in Spring 1999 and *TELSIpro* has been used for the development of the Maloa simulation

Experience gained during the trial of the Community Portraits course will be taken into account in the design of the new units. Lessons learnt include the importance of ensuring that the technology is set up appropriately in advance of course delivery so that it as transparent as possible, that sufficient time is allowed to allow participants to get to know each other socially as well as in the context of course work and that clear tasks are introduced at appropriate intervals during the course. As much information as possible about course participants should be made available at the beginning of a course to facilitate the development of a learning community.

Few problems are anticipated with the use of English as the language of instruction and communication: the ability to improve competence in English is thought to be an added value of the SCHEMA programme.



## Appendix B: Training Needs Identified in Örebro

Based on material supplied by Karin Josefsson  
Department of Caring Sciences, University of Örebro.

### Background

The Örebro Department has taken primary responsibility for investigating training needs in nursing and allied health professions. Interviews were carried out with fellow lecturers in the Department of Caring Science and with nurses working in the community with responsibility for quality control, medical aspects of geriatric care and post-qualifying training. Following the identification of a need for training in relation to the support of dementia sufferers and their primary care-givers, further discussions took place with staff in the Dementia Services Development Centre in the University of Stirling, a multi-disciplinary unit concerned with studying and disseminating best practice in the care of sufferers from dementia.

### Training Priorities

There was general agreement that a wide range of training was required to meet the needs of the growing number of elderly people in Europe, both those in the community and those in specialised geriatric settings. Particular emphasis was placed on work with people exhibiting dementia. Reflecting the medical orientation of those consulted, there was emphasis on initial diagnosis and assessment, on pharmacology for the elderly, on rehabilitation and on palliative care. It was also considered important that consideration should be given to inter-professional issues, including team-work.

In order to develop the analysis “in-depth” interviews were conducted with two experienced nurses who have both clinical and educational responsibilities. Their responses are shown separately (as “A” and “B”).

#### • **What training courses related to work are required?**

- A. As a nurse at a geriatric clinic which has both investigation and residential departments, there is a general need for training in the care of dementia, one part of which would be of value even for nurses who are not directly working in investigative care. People with dementia live in residential care and knowledge about leads the right approach to help them is very important. Nurses should also have an understanding of the different kinds of dementia and their specific problems.
- B. Within the area of dementia, there is a need for knowledge of the different ways of assessing dementia, what that to and how the result affects continued treatment and care. Nurses also need to have knowledge about the attitudes which both lay people and professionals have in relation to dementia and what is the best way to tutor other personnel. Specific information is required about severe behavioural conditions such as aggressiveness, extreme anxiety, rapid deterioration of dementia illness, etc., which greatly affect the care needed.

- **If there is more than one requirement for training, is it possible to prioritise the courses (i.e. which are the most important/needed?)**
  - A. I have difficulty prioritising training needs, but one of the most important areas for our nurses is rehabilitation care of the elderly, then palliative care, and further pharmacology for the elderly.
  - B. Tutoring by nurses of other personnel is urgent. People have to be able to work together.
- **Are there any time constraints for a course on “dementia in nursing care”?**
  - A. There are few time constraints on the course, but I do not think that it is meaningful to have too long a time
  - B. Part-time study is to be preferred. It is difficult for practicing to get cover: they need to be able to work a certain amount of the time as well as studying.
- **At what level should the courses be (diploma, degree, post-qualification, etc)?**
  - A. I think the courses should be at post-qualification level (although there ought to be some attention to dementia in foundation training).
  - B. Post-qualification training for nurses is needed, but occupational therapists and support co-ordinators/home-help assistants also need knowledge about dementia care. The ideal would be to study some parts together. We work a lot for a common understanding and integration in community care and common training is desirable.
- **What would be an acceptable cost?**
  - A. Cost for courses is difficult to judge, I think they change over time. It is dependent, of course, upon whether there is a widespread need of training or if it is for one individual nurse.
  - C. I do not know, the only training we have carried out which had a course fee is “geriatric care”, which was delivered via the educational radio and the University College in Jönköping. The cost per course participant was 2,560 SEK plus VAT; course literature was included but not reference literature.
- **Are the proposed courses suitable for delivery over Internet?**
  - A. I think that the courses are suitable to be run through computers, but it is important that you meet to have a deeper discussion between course participants in order to enrich the exchange of knowledge and discussions which can easily become short over the ‘Net.
  - B. Yes, I am sure that is so.
- **About how many practitioners do you think have need of a course in dementia nursing care?**
  - A. I cannot judge precisely how many have need of such a course, but as there has not been a course nearby before, the need among our nurses is great. They require the theoretical knowledge which provides the basis for practice.
  - B. Really, all nurses in community care, about thirty-five in my community areas, could profitably take such a course. One problem with the course currently being proposed is language: many nurses do not have a basic competence in English.

- **What proportion of the likely users will already have access to "connected" PCs?**
  - A. I am a bit uncertain about who applied in the end, but of those who talked to me before they were going to apply for the course, all but one had access to a computer.
  - B. All
- **Could the proposed course have a "European Dimension" (e.g. could it be offered to health and welfare workers in all the other areas covered by SCHEMA)?**
  - A. I think that the course content will need to be different in different parts of Europe, not necessarily because of the pathology, but because of the different conditions there are for the care of people with dementia and the differences in the structure of the societies.
  - B I am sure it does.



## Appendix C: Training Needs of Health & Welfare Workers in Scotland

Duncan Timms (University of Stirling) and Liz Timms (University of Edinburgh)

### Background

Information was collected from lecturers in the health and welfare professions and from Scottish members of the main professional body in social work: the British Association of Social Workers. Discussion of training needs took place during a meeting of SCHEMA work package leaders in Stirling in late June, 1999. Further information was obtained from the *Highland Wellbeing Alliance*, an umbrella body representing the Highland Council, Highlands and Islands Enterprise, Highland Health Board, Scottish Homes and the Northern Constabulary. The Highland Wellbeing Alliance is funded by the Scottish Office under the Social Inclusion Partnership Programme and has as its remit: “to promote, sustain and develop the wellbeing of the communities of the Scottish Highlands.” The Alliance also has the support of the Orkney and Western Isles Councils and its area of operations stretches from rural Stirlingshire to the whole of the Highlands and Islands of Scotland. The experience of Stirling members of SCHEMA in previous projects concerned with the application of C&IT to teaching and learning at university level has also been taken into account (for details of these projects see <http://annick.stir.ac.uk/varsetile>).

Within the Scottish health and welfare professions there is a variety of attitudes towards continuing professional education. On the whole, continuing professional development appears to be a more central part of the professions in the health care area than in those concerned with social work. There is a requirement for nurses to undertake a number of hours of in-service training each year, mainly related to changes in medical practice. At present no such requirement is placed on social workers, whether they are employed by local authorities or by agencies in the voluntary and private sectors. The majority of those employed as nurses and other ancillary health workers have qualifications which are at sub-degree level and the recent move of nursing training into the university sector has created a perceived need for an increase in opportunities for “top-up” programmes which will enable nurses to convert their qualifications into degrees. It may be anticipated that moves towards the registration of workers in the social work and social care areas will lead to a similar increase in demand for top-up and conversion courses.

Until the mid-1990s, nursing education took place in specialised Colleges, associated with hospitals. Since 1997 responsibility has been transferred to higher education institutions; the University of Stirling has responsibility for the provision of training in the areas covered by the Forth Valley (Falkirk, Clackmannan, Stirling) and the Highland Health Board.

Social work training mainly takes place in the university sector. There are two main routes to qualification: a two-year postgraduate programme and a three (or four) year undergraduate course. Many workers in the social care sector, especially those employed in residential institutions, have lesser qualifications. A recent review of the social work workforce in Scotland (NISW, 1997) discovered that 30% of front-line field workers, 44% of managers and no less than 93% of residential workers lack professional qualifications in social work. Rather more than half the workforce had taken training not leading to a qualification, but 41% said that they were unable to

take the training they would have wished in the preceding 12 months. Common reasons advanced for this included lack of cover to get away to courses, lack of management support and the sheer difficulty of attending courses away from the home and workplace.

### **Training Needs Identified**

There is a general interest in the provision of opportunities for the conversion of pre-degree diplomas, either in nursing or social care, into degrees. One of the requirements for this is an introduction to research methods, generally as a precursor to a dissertation. Other training needs identified in discussions are of a more professional nature:

### **Priorities**

The most urgent educational requirements for social workers working in the peripheral areas of Scotland were identified as:

- Consideration of measures designed to address the particular disadvantages faced by young people in remote communities
- Consideration of professional standards, with particular reference to the need to collaborate with members of other professions;
- Skills relating to work concerning the care of elderly people in the community.
- Training in the recognition and management of mental health problems
- Training relating to the care of children, including but not only those who are “looked after” by care agencies
- Training relating to the handling of violent behaviour
- Training in the planning and management of “social housing” (including the implications of housing renewal projects)

In the health area, particular concerns are with providing services for elderly people, especially those showing signs of dementia, for community care for people with disabilities and with inter-agency working..

During discussion it was pointed out that many of the demographic, economic and cultural characteristics of the Highlands and Islands - small, scattered populations, living in a harsh climate, with few employment opportunities – were similar to those experienced in other “Northern Periphery” Areas, suggesting that collaboration and sharing of experiences was likely to be especially valuable.

### **Pedagogic Approach**

As in the case of the workers consulted in Lapland, those in Scotland were enthusiastic about the adoption of an overtly comparative approach, with an emphasis on the integration of academic knowledge with practical experience and with the possibilities for inter-professional collaboration.

## Use of the Internet

The basic infrastructure for the use of the Internet is already in place within the Health service. Within the social work area there has been greater resistance to the introduction of C&IT and there remain a number of issues concerning workers' access to the Internet which have still to be settled. The issues reflect concerns about privacy and the need to ensure the security of personal information.

In addition to using the Internet to obtain information, many workers in both the health and the welfare sectors express enthusiasm for exploiting the communicative possibilities of the Internet, including on-line chat. Again, as in Lapland, the ability of computer-mediated communications to overcome the barriers of time and space were seen as being especially relevant to peripheral communities.

## Courses to be Offered

Staff in the Department of Applied Social Science in the University of Stirling are working on several proposals designed to meet some of the training needs identified by SCHEMA, including modules in relationship to drug and alcohol misuse among young people, comparative housing studies, care services for elderly people and the development of quality standards for the provision of social services.

In conjunction with SCHEMA staff, a lecturer in sociology from the University of Stockholm is involved in developing a module on applied social research methods. The module was piloted in autumn 1998 (see SCHEMA deliverable 3.1) and will be run again in 1999-2000

A social work lecturer in the University of Edinburgh, seconded to a fixed-term appointment in Stirling, is involved in further development of the Community Portraits module, trialled in spring 1999. This unit too will be rerun in 1999-2000.

Both *TELSipro* and *ProTo* environments are being used. The applied social research methods module and the course on drug and alcohol misuse have been developed in *ProTo*; the *Community Portraits* module is in *TELSipro*.



## Appendix D: Training Needs of Health & Welfare Workers in South Sweden

Duncan Timms (University of Stirling) and Liz Timms (University of Edinburgh)

### Background

South-eastern Sweden shares many of the characteristics of other regions involved in SCHEMA, notably distance from metropolitan centres, the need to adapt to changing economic conditions which have resulted in relatively high rates of unemployment, a high proportion of elderly people and a tendency for young people to move out of the area. The basic infrastructure for the use of the Internet is already in place. Through a process of competitive tendering a cable backbone has been installed throughout the area and local authorities are enthusiastic supporters of the use of C&IT.

Recognition of the similarities between the region and other marginal areas involved in SCHEMA, and the possibility of extending the scope of the Project to other Baltic-rim areas, led to the involvement of a Karlskrona-based institution, the *Baltic International School of Public Health* (BIH) as an associate partner in the development of the SCHEMA proposal. During 1998 BIH ceased to exist as a separate institution, becoming part of the new "Regional University" of Karlskrona-Ronneby. Most of the staff concerned were incorporated into a new Department of Caring Sciences in the University. During the rather protracted merger between BIH and the University it was made clear that the Department remained interested in taking part in SCHEMA activities, but there was a hiatus in their active involvement between Spring 1998 and the early part of 1999. The Regional University shares responsibility for training in the health services in southern Sweden with the (new) University of Växjö and the Universities of Lund and Göteborg; social work education is concentrated in Lund and Göteborg.

Meetings held in Växjö, Karlskrona and Ronneby in spring 1999 were used to re-establish channels of communication and to discuss the general training needs of health and welfare workers in southern Sweden. Further meetings are scheduled during the summer in Växjö and Lund. A group of senior officers with responsibility for health and welfare services in four southern counties of Sweden (Blekinge, Halland, Kronoberg and Skåne), representatives from the Medical Faculty in the University of Lund and from the Health Region of South Sweden, is planning to visit Stirling in October for further discussions on the use of the Internet for the delivery of continuing professional development for health and welfare workers. The visit is to be funded by the Swedish National Board for Information Technology.

Changes in the location of nursing training in Sweden have paralleled developments in Scotland, with responsibility now being vested in universities rather than specialised Colleges. The changes in training provision should facilitate closer links between nursing, social work and social care, but there remain considerable hurdles to overcome before members of each profession can work together in a "seamless" fashion. Developments more generally in the area of social care include a new degree programme in "Community analysis and welfare development" (Programmet för samhällsanalys och välfärdsutveckling), to be offered by the University of Växjö, and the institution of Web-based courses for social workers by a consortium led by the University of Lund.

### **Training Needs Identified**

One of the consequences of the change in the nature and location of training for nursing and ancillary health professions is the growth in interest for continuing professional development and for opportunities to share experiences with other caring professions.

Among the training priorities identified are:

- Collaborative working in the community
- The care of elderly people, especially those exhibiting signs of dementia
- Professional standards
- The implications of new technology for training and practice, including the development of new research paradigms.

## Appendix E: Training Needs in Residential and Nursing Home Care in Germany

Barbara Klein, Barbara Schnücker and Lucy Bangali, IAT, Stuttgart

### Executive Summary

The following paper describes the training needs of professional care workers in residential and nursing home care in Germany with particular emphasis on issues relating to quality management and quality assurance.

The need for quality management and quality assurance in the care of elderly people is becoming increasingly obvious. Quality, quality assurance and quality control are terms that are discussed in nearly every article written about the subject in both the professional and lay literature and is a common topic for discussion in conferences and seminars. Many different systems for quality assurance in residential and nursing care homes are being brought onto the market and more and more German universities are in the process of installing a new subject called “care management”.

Legal changes in the last decade demand an increasing professionalisation in respect to residential and nursing care homes in Germany. . A major step towards professionalisation is the institution of quality management measures.

A number of different systems for quality assurance have been developed in the past few years and a variety of organizations are involved in training:

- The topics of “care management”, “public health” and “social management” have been introduced into the curricula of polytechnics (FHs) and universities.
- Consultants and other private training organisations offer a variety of courses on quality management.

The discussion of quality in relation to the provision of care for elderly people has also been influenced by the development of an increasingly competitive market in the area:

- Local authority homes are being turned into private homes, subject to standard market forces. As a result they have to work more economically and sustain if not increase quality standards.
- International care companies have entered the German market and advertise that they offer the combination of good quality and competitive prices.

### Background and Situation in Germany

Following publicity relating to a number of scandals involving poor standards in residential and nursing care homes the discussion of quality management and quality assurance came up in the 80s – but there were almost no consequences of this discussion for the care homes. However, with the introduction of the new care insurance in 1995 there was a real demand for support of quality assurance. Up to 1995 residential care in Germany was – in contrast for example to Great Britain – discussed almost wholly in terms of expense and cost effectiveness; the discovered scandals in the care homes did not change the situation. The reason for this can be seen in the principles underlying the work of Inspection Units in Germany.

In Germany the principle for Inspection Units is different to - for example - the one in Britain. According to Klein (1996) the work of Inspection Units in Britain is based on a “value-based” model, in which the quality of residents’ life is an important consideration. In contrast, the inspection of residential care facilities for elderly people in Germany is focused on a custodial model.

“In Germany, the “custodian” (ordnungspolitisches) model for the inspection of homes concentrates on building/technical aspects, storage of medication, hygiene and kitchen arrangements. Issues important to residents, such as care aspects and social care, do not receive the same attention as these others ... Thus, inspections seem to be a formal check and an administrative procedure to determine whether homes work according to the law or not....

The “Value-based” Model in Residential Homes in Britain: Only the inspection units of the Social Work/Services Departments consider the quality of the residents’ life. They rely on a value-based model established in two official documents: *Home Life* (1984) and *Homes are for Living In* (1989), ... “Home Life” was developed as a code of practice for inspection units, proprietors and managers of homes. It underlines principles of care based on dignity, the right of self-determination and individuality. “Home Life” already formulated the basic rights which were later taken up in “Homes are for Living In”. Here, a model was developed providing qualitative performance criteria for residential care.” (Klein, 1996: 143).

The model is based on six basic values:

- Privacy,
- Dignity,
- Independence,
- Choice,
- Rights
- Fulfilments.

In the past few years, a discussion about the quality of care has started to emerge in Germany and there have been a number of changes in the law, notably relating to the introduction of care insurance in 1995, and concerned with various budgetary issues.

On the basis of the care insurance legislation there is a statutory requirement for quality management and quality assurance. “Quality is the catchword of the 90s” (Cook, 1997: 16). Inspection units in Germany need to improve their style of work if they are to become more effective.

In addition to the statutory demands many care homes are getting aware that they have to compete with other establishments and that their inhabitants are their customers.

The demand for quality, quality management and quality systems is lead by politicians and officials and the discussion focuses on cost effectiveness, legal demands and how to keep quality. Definition or discussion about what quality is and what it means from the different perspectives of residents, other carers, staff *etc.* is generally lacking. It is important that this gap is filled in professional training.

Due to the lack of consideration given to the nature of quality in the provision of social services, there is insecurity about how to proceed in respect to the implementation of quality management and assurance. The situation can be characterized as one in which service providers are waiting for official government's or medical services' voices: what quality systems, what standards will they recommend (if any)? However, official voices want market principles in place.

### **Analysis the Nature of Quality Management and Assurance in Germany and Britain**

The situation in Germany is shown in sharp relief by making a comparison with the situation in Britain. Several surveys show the differences between Germany and Britain in the care home sector and give an idea of how quality management and quality assurance in care homes can and should be implemented

In 1993 the IAT carried out a survey for the Ministry of Social Welfare in Baden-Württemberg, in order to lay down a framework for the development of recommendations for the organization of work in care homes for elderly people. Shortly afterwards Dr. Barbara Klein (IAT) was able to undertake a survey in Britain focusing on quality assurance in care homes. The survey was funded by the EU "Human Capital and Mobility" programme, based in the University of Stirling.

Both surveys were based on case studies. In Germany six residential and nursing care homes were chosen while in Britain eleven care homes were looked at. Interviews were conducted with about 80 people – inhabitants, management, care management and staff. In Germany an additional survey with inhabitants, management and staff was undertaken in order to update the results of 1993. The surveys give an insight into the nature of institutionalized care of elderly people in both countries. To highlight the role of the home inspection units, members of inspection units in Britain and Baden-Württemberg were interviewed.

The results of the surveys show several differences between British and German care homes. Life in German care homes is much more institutionalized and less flexible than life in British care homes. In general British care homes have fewer residents than German ones and more British care homes are run by private bodies than in Germany.

As mentioned earlier there is a major difference in the underlying principles of Inspection Units in Germany and Britain. Whilst British units work to a value-based mode, as established in "*Homes are for living in*" (1989), which stresses the quality of residents' life in terms of the six basic values of privacy, dignity, independence, choice, rights and fulfilments, Germany employs a custodial model. The German model concentrates on building/technical aspects, storage of medication, hygiene and kitchen arrangements. The inspections rely very strongly on laws and regulations and they do not ask for residents' needs. Official standards for quality and quality assurance do not refer to values.

Over the last 20 years, the custodian model of inspection in Germany has proved to be too complicated and circumstantial to be successful in practice. In the past few years, a discussion about the quality of care has started to emerge in conjunction with changes in the law and with budgetary issues.

Comparison of the German and British models of quality management and quality assurance leads to the conclusion that applying the basic values of the British model

in German residential care homes, and inspecting them according to these standards, will not only have a direct influence on the quality of care provided but can also trigger a process improving quality of care provided for residents.

On the basis of these results another survey in Germany was conducted, focusing on two main questions:

- Are there similar standards of the quality of care in German homes for elderly people as in British ones and do representatives of German residential care homes share the estimation of these standards?
- Are there any indications that the adoption of systems for quality assurance will lead to an improvement in the quality of residents' life?

Questionnaires were developed, based on the value-based model laid out in "Homes are for Living In", examining elements of information management, care practice, involvement of residents and independence (see Cook & Klein 1997: 16).

The questionnaires were distributed to management (who were given an additional questionnaire concerning quality assurance) and to representatives of residents (who received an additional questionnaire concerning their living situation). The results of the survey show that the given values in the questionnaires were highly estimated by both the management and the representatives of residents. But, being asked for evidence about the transformation of the values to the every day life of the care home, more representatives of the management affirm the existence of the values than do representatives of residents. Furthermore, answers to questions on care practice show that the management still treat the residents more as patients than as customers.

The results of these several surveys lead to the following conclusions:

- From the point of view of the recipients of care, the British value-based model of quality assurance and inspection is more successful than the German one.

An essential component of any quality system for care homes is the involvement of not only the management and staff who provide the service, but also those who receive it, the residents.

The current discussion, legal changes, the introduction of courses in care management in higher education, the emergence of systems for quality management and assurance, the results of the several surveys (and other projects of the IAT – see references) and consultations with nursing care show that there is a strong need for the introduction of standards and instructions to undertake a process of quality management and assurance, especially in Germany.

### **Proposed Course – Quality Management and Assurance in Social Service Provision**

#### Target Groups

The course will be designed with two audiences in mind: students in universities and polytechnics undertaking initial training in the field of care management and managers of care homes.

The first students to take the course will come from the University of Bremen. In conjunction with colleagues from the University of Stirling the course will later be

extended to cover the more general concerns of quality management in the social services.

## Content

There are several issues that have to be part of the content of a course for quality management and assurance:

- The history of quality management and assurance, reasons for the need of quality management and background.
- Overview and comparison of laws and regulations in different countries and the effects and experiences with these regulations.
- Overview and comparison of different quality management systems (e.g. ISO, EFQM...).
- Closer look at institutions and groups that are involved in quality management such as inspection units.

## Structure:

The course to be piloted in autumn 1999 will combine several activities:

- Theoretical background in form of documents
- Combination of on- and off-line activities: in addition to the theoretical background, students will have to get their own experience with systems of quality management through visiting nursing care homes, conducting interviews with the home management about their strategies of quality management and their experiences.
- The experiences the students gather in nursing care homes will be shared with other students, leading to direct comparisons and evaluations.

In such a form the course will give the possibility to meet the demands of the social constructivist approach adopted by SCHEMA, linking computer-based and other activities, situated learning and networked learning.

## Delivery

The delivery of the course via the Internet (with *TELSIpro* or *ProTo*) will be an appropriate way to give students the theoretical background of quality management. In addition to providing a platform for the delivery of theoretical background resources, the learning environment will support the interaction of the students with each other, enabling them to exchange their experiences with quality management.

## European Dimension

Quality discussion is a major issue in all European countries. Different course modules, developed in SCHEMA partners' countries, will give an overview of current discussions and an overview of quality systems and their effects in the

different countries. In addition to this overview of different European countries, their standards and systems of quality management, students of these countries will be able to interact via *TELSIpro* or *ProTo* in order to exchange their experiences in their home countries, to compare different laws, standards and systems and to learn from each other.

### Technology

Participants of the universities and polytechnics have access to the Internet via PCs as well as most of the participants coming from care home management. However, many students would be content to have the possibility of testing NCs/set-top boxes, especially in order to have the possibility of taking the course at home (if they do not have an own PC).

### Development of Course Materials

The development of the course will be undertaken by staff in the IAT, Stuttgart and the University of Bremen, with the collaboration of SCHEMA partners in Scotland.

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### **IAT projects conducted in the field of quality management in hospitals and nursing care homes:**

- Arbeitswissenschaftliche Untersuchung Zur Erstbelegung Eines Pflegeheimes* (1993 - 1994)  
Study on how to design and to organize a new nursing care home.
- Studie Zur Analyse Von Ergonomischen Defiziten In Seniorenwohnheimen (1995)  
Ergonomic analyses: Deficits in nursing care homes.
- Qualitätskonzepte In Alten- Und Pflegeheimen* Concepts for quality standards in nursing care homes.  
(EU Human Capital and Mobility Programme, University of Stirling, 1997)
- Unterstützung Bei Der Einführung Von Total Quality Management (TQM) In Einem Kreiskrankenhaus (1997)  
Introduction of total quality management in a hospital.
- Introduction Of A Quality Self-Assessment System In Nursing Care Homes (1998-1999)  
Introduction of the self-assessment quality system (developed in cooperation between Fraunhofer IAO, BETTAL Quality Consultancy, Pilota – consultancy for vocational training - and several welfare organizations) in a number of nursing care homes.
- Forschungsprojekt “Regionale Versorgungsketten” (1997 - 1999)  
Social and medical support for elderly, ill and disabled people.
- Häusliche Technik Zur Unterstützung Einer Selbständigen Lebensführung (1996 - 1998)  
Technological support for elderly people in their own households.



## Appendix F: Training Needs of Teachers in Finland

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### Background

This analysis of needs is based on interviews with planners and experts involved in the supplementary education of teachers working in the University of Oulu as well as on discussions with the representatives of the National Board of Education in Finland. The experts had a good idea about the skills of the teachers and the current state of schools in the use of information technology in teaching in Finland.

In addition to this analysis, an analysis of teachers' needs in relation to communications and information technology has also been made in the T3 project. The relevant report can be found on the T3 Web site at <http://telematics.exeter.ac.uk/>. Although the information is specific to the needs of teachers it is believed that many of the points raised can be generalised to other professions working in the health and welfare field, especially those who have a training remit.

The analysis has also taken into account recent research data available on the field, the follow-up report on the information society strategy of Finnish education as well as discussions with teachers. No statistical data has been gathered in the analysis.

A set of topics common to all those interviewed was formed by three general themes:

1. Changes in pedagogical and organisational cultures and technologies
2. Learning and the open learning environment
3. Information and communication technology in open learning environments.

In our discussions about these themes, the following were some of the topical questions that emerged. The perspective adopted is generally that of the individual teacher.

#### Changes in Pedagogical and Organisational Culture and Technologies

- What is an “information society”? How is it reflected in the activities of schools?
- How can the business culture of a school be changed?
- Am I capable of working under the pressures for change caused by the information society?
- What kind of know how is needed by my students in the future? How can I support them in the new situation?

#### Learning and Open Learning Environments

- What is open learning/teaching?
- How successfully do the underlying learning theories work in practice?

- How could I put these theories into effect in my own teaching to aim at deeper learning?

#### Information and Communication Technology in Open Learning Environments

- How can the developing learning environments contribute to my teaching?
- Do I have the skills and the motivation to make use of the new opportunities?
- How can I apply computer-assisted instruction in my own work?
- How do I use information networks and the services that support learning to use them in a rational and efficient way?

#### **Conclusion: Topics for Further Consideration**

From the above questions, raised by respondents, a number of practical topics related to the use of C&IT networks in teaching can be suggested for further consideration:

- Making the transition from learning theory to learning environment
- The role and training needs of teaches in distance education
- Co-operation between schools and other learning centres
- Identification of a school's learning culture
- New technology and new learning environments
- Text-based communication over networks - netiquette
- Information networks and the services to support learning to use them
- Web documents as a source of information
- Information networks of schools and their protection
- CAI - teaching and learning
- Evaluation and selection of learning materials

Although many of these points are specifically directed at the implementers of Internet-based training in the schools' sector, they have general relevance for the design of C&IT-based continuing professional development courses and point to the need to ensure that learning environments and pedagogies are appropriate to both the teachers and the learners involved. In the 1999-2000 academic session it is intended to explore a number of these issues in relation to the experience and needs of teachers in secondary schools. Reflections on the course and on its implications for the use of telematics in other forms of continuing professional development for health, education and welfare workers will be included in the proceeding of the end-of-Project Conference.