Theoretically Informed Case Studies

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Introduction

In this report the central findings of the work done in work package 7 will be presented. This work package focused on theoretically informed case studies which complement the visualisations produced in work packages 5, 6 and 13. As a well established method of empirical social sciences research, case studies can capture the different perspectives of complex social phenomena. Therefore case studies refer to an evidence-based empirical approach and aim to provide rich and in-depth information (Lee et al. 2010: 683). Overall case studies have a close association with theory and can either be theory testing (deductive) or theory building (inductive) using qualitative or quantitative methods or a combination of both (Lee et al. 2010: 684). Important criteria which have to be considered when evaluating a case study are transferability (how consistent findings are in similar contexts), credibility (internal coherence of findings), confirmability (a logical conceptual link among the constructs studied in the case and the measures used) and dependability (can the study be repeated to yield the same findings?) (ibid.).

In addition to the case studies, the following reflections draw on the literature review completed in work packages 1 & 2 as well as on the analysis of the "snowball sampling" in work packages 3 & 4. The evaluation of the case studies will consider the results and lessons of these work packages. At the same time, the analysis follows an inductive approach: Based on the empirical material, we are looking for typical patterns and analytical categories. These preliminary categories will guide our further elaboration of criteria for innovation in social services.

The following chapters start with presenting the key findings of the empirical analysis. As a next step, the different tasks that led to the theoretically informed case studies will be described (chapter 2). We then explain the blueprint of a case study to stress the connection between the theoretical work done in the previous work packages and the specific focus on innovation in social services (chapter 3). In addition, some key characteristics of the selected innovative projects will be summarised and general tendencies will be highlighted (chapter 4). In chapter 5, we present a compilation of all case studies. This compilation can also be found on the website of the project (www.inno-serv.eu).
1. Highlights and central findings of empirical case studies

The theoretically informed case studies point to a wide and differentiated range of factors that drive innovation in social services as well as a broad variety of responses. Despite all variation, a first observation is that most of the project examples focus on process innovation rather than on product innovation. Often this process innovation is accompanied by an increased professionalism in service delivery. But what stimulated these innovations? We can identify hard and soft drivers. Hard drivers mainly appear at macro or meso levels, often in the form of legal developments and regulations. On the contrary, soft drivers relate to ideas, attitudes and discourses. Very often a combination of different soft and hard drivers can be found in the selected innovative project examples (see chapter 4.1 for details). With regard to organisational responses, we can identify five approaches, which are often interlinked: inclusion, individualisation, informalisation, outreach and lowering thresholds to access, influencing public opinion and resource mobilisation or transformation (see chapter 4.2 for details). With a comparative analysis of the case studies, some main Incubators of innovation and interdependent factors in innovative processes could be found: Most important here are the agents of change (see chapter 4.3). The described and analysed categories can be merged to three different clusters of innovation: A Nonprofit-Public Alliance, a Professional-Advocacy-Alliance and a cluster on Public Initiatives (see chapter 4.4). Projects belonging to the Nonprofit-Public Alliance generally have an agent of change at the organisational level (e. g. a manager). This agent of change often supports the conception of new innovative services on the basis of pilot projects. Innovative projects that are mainly initiated through organisational agents of change are usually financed through public resources. On the contrary, projects belonging to the Professional-Advocacy-Alliance are mainly pushed forward by agents of change at the professional level. They often seek for cooperation with users’ initiatives and are building advocacy coalitions to reach their objectives. The third cluster focuses on nonprofit organisations. Projects of this category are generally driven by agents of change in the form of policy makers or framework setters. The focus on inclusion is one key aspect of this cluster. These projects often try to bring people back into society through providing them with specific knowledge, a specific level of education or similar resources. In the following chapters these key findings as well as interesting side effects are illustrated in detail.
2. The aim and meaning of work package 7: description of activities

The objectives of work package 7 as defined in WT 3: work package description:
The aim is to produce background material on the visualised innovative practice example.

- Connection of visual material with earlier theoretical work and the developed matrixes.
- Systematic documentation (written case study) of activity of the selected, innovative projects/stake-holders.
- Discussions on the collected information and visual material with the selected stakeholders, selected members of consortium and advisory board.

2.1 Activities of WP leader and national partners

The visualisations will be explained and re-embedded in their institutional and methodological framework by providing a theoretically orientated case study on each innovative practice example. The theoretical work completed in work packages 1 and 2 functions as helpful input for setting up these case studies. A case study will be about 2 to 5 pages long and includes a short explanation of the specific framework, the innovativeness, the potential and the added value. The role of different participants can be summed up as follows:

- HAW Hamburg: Monitoring process, supporting national task forces
- Consortium partners: gathering and recording information about the selected organisation and its history as well as current social and economic circumstances, sharing this information with peers and advisory board
- Stakeholders: taking part in the process of gathering information, critical review of the final material by specific online access
2.2. Process of discussion, consensus building and construction of case studies

2.2.1 The blueprint method

The case studies are described as theoretically informed. This means that they do not only specify an empirical phenomenon but also highlight a meta-theoretical description and analysis of an innovative project example. The theoretical impulses that are integrated in the study focus on the perspective of the data to be collected.

The WP leader (HAW Hamburg) developed a blueprint version (a draft version of a case study structure) and applied this exemplarily to the Norwegian case. At the INNOSERV consortium meeting in Dublin (November 2012), partners discussed the blueprint and decided that each case study has to refer to the criteria model of work package 2 and work package 4 (hence the title “theoretically informed”). Furthermore, the consortium agreed that the ultimate function and purpose of the case studies is to accompany and explain the video material. Consortium members discussed controversially the level of detail concerning information about welfare policies and national contexts. It was agreed to include national context information and specify the information provided so that the users of the case study can understand what is meant by a “high” or a “low” level (compared to what) of a certain criteria. The consortium came to the conclusion that each case study needs to explain the specific reference points in order to adjust the information to local discussions.

2.2.2 Construction of case studies

With the blueprint at hand each national partner was asked to submit a first draft version of their case study to HAW Hamburg by 15th of January 2013. Prior to this the national teams were requested to send their schedule to HAW Hamburg by 29th of November 2012. Due to some unforeseen delays in the filming process, the last case studies were submitted in the middle of March 2013. The team of HAW Hamburg revised each case study, gave detailed feedback to the national partners and assisted in finalizing the case studies. In addition, the background material was reviewed by selected members of the consortium and the advisory board.
The development of the case studies reflected the broader methodological and conceptual decisions of the INNOSERV platform. They neither simply follow a deductive nor an inductive model but rather a heuristic approach in the context of multi-level governance, which characterizes the constitution and structure of social services (Langer 2012).

The case studies were prepared in close cooperation with supporting actors of the specific innovative projects. The practitioners proposed the most important impulses, contents and empirical data for the specific case study. This input focused mainly on the description of the innovation and the immediate context. The wider framework conditions (political programs, life courses, national systems of social benefits, drivers of innovations, weaknesses of the system) were provided by the national project partners which can be seen as experts for the specific national social policy: They do not only have a detailed knowledge considering the situation of the structures of social policy but also know the background and the policy processes as well as the specific features and characteristics of the system. In their contributions, the national partners drew on the conceptual considerations of previous work packages about potential factors influencing the particular case (drivers, challenges, agents of change, outcomes). But they also followed the structure of the case study which stems from preliminary work of the WP-Leader and was elaborated in the blueprint stage. And ultimately, the dialogic approach of cooperation between WP leader, national teams and local experts through exchanging draft versions and feedback shaped the final version of the case studies.

3. Conception of a blueprint for case studies

The work package leader HAW developed a blueprint for case studies which had to meet several criteria:

1. Additional information should be provided to the visualisation of the innovative social services. It is important to mention here that the main interest considering the visualisation was not to present a certain project or organisation. The aim was to bring forward the central innovative core of
the example. As an addition, the theoretically informed case study contributes to an in-depth understanding of the visualised projects.

2. Readers who are further interested in a certain project should get access to more detailed information. The accompanying case studies reduce the risk of presenting the empirical material in a too short and incomprehensible way.

3. The case studies should allow for an in-depth analysis of the innovative examples through the comprehension of a) the information collected through “snowball sampling”, b) the project descriptions presented by the different project partners and c) the knowledge gained in the process of visualisation.

4. Theoretically informed case studies are a first step towards an international comparison of the selected innovative projects.

The process of shaping and refining the blueprint is described in chapter 2. In the following section, the elements of the blueprint will be presented. The aim is to explain which theoretical influences contributed to the specific structure of the case studies:

**Cover**

Information about the authors and QR code

**CS 1: Theoretically informed case study in reference to our visualisation – in a nutshell**

The most important facts are summarised in a short profile showing the specific innovative example as a model with important influencing factors. The aim here was that the key information about the example should be given within a one page overview, in addition to a graph that shows the main influencing factors and key outcomes of innovation. The short profile was divided into three main chapters: a short description of the innovative example, a chapter on specific innovative
elements of the case and a chapter on key characteristics of the service, here mainly the criteria ‘organisation’, ‘user groups’, ‘principle’ and ‘drivers’.

**Model of innovation criteria in one graph**

This comprehensive graph can be seen as a first attempt to explore and identify how the innovative service works. It not just functions as an example. In fact, the aim is to identify the mechanisms of the specific social innovation. The project partners had the task to connect the criteria of social services to the innovation as a response (i.e. to meet social needs). The factors influencing social service innovations should be classified in the following model of a graph with elements that can be changed according to each specific case:

*Graph 1: Factors influencing social service innovation*

*These lists are key examples only and are discussed more fully in WP2.*

*Source: own research*
CS 2: Policy framework of the national welfare state related to the specific innovative example

Social services have a firm place in all welfare systems. Reflecting national, regional and local traditions, they can have many shapes and can in principle be provided by a broad range of public or private actors. In the policy debates about the EU services directive, the term “social services of general interest” (ssgi) emerged and has been intensively discussed and applied through institutions, stakeholders and publications (EU-Commission 2003, Green Paper on services of general interest; SPC 2010). This definition describes social services as

„statutory and complementary social security schemes, organised in various ways (mutual or occupational organisations), covering the main risks of life, such as those linked to health, ageing, occupational accidents, unemployment, retirement and disability; other essential services provided directly to the person. These services that play a preventive and social cohesion role consist of customised assistance to facilitate social inclusion and safeguard fundamental rights. They comprise, first of all, assistance for persons faced by personal challenges or crises (such as debt, unemployment, drug addiction or family breakdown). Secondly, they include activities to ensure that the persons concerned are able to completely reintegrate into society (rehabilitation, language training for immigrants) and, in particular, the labour market (occupational training and reintegration). These services complement and support the role of families in caring for the youngest and oldest members of society in particular. Thirdly, these services include activities to integrate persons with long-term health or disability problems. Fourthly, they also include social housing, providing housing for disadvantaged citizens or socially less advantaged groups“ (The SPC 2010, S. 3).

In this definition, social services are clearly defined as instruments to guarantee social security and promote social inclusion and cohesion, alongside social rights and income support (benefits in cash). Social services are embedded in differentiated policy frameworks.

In the case study model, four core elements of relevant policy frameworks were identified: guiding principles/guidelines of the specific policy, key organisations and actors who contribute to the provision of the social service example, services
provided by government as well as expenditures/resources. Using the Norwegian case “Ammerudhjemmet” as an example, the table below shows these four elements:

Table 1: Policy framework

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Decentralisation: from county and state to municipal level:</td>
<td>- Legal Foundation for a comprehensive service offer at local level to entire the population of the municipality</td>
<td>Legal milestones:</td>
<td>1. Costs involved in the nursing and care sector (% of the GDP):</td>
</tr>
<tr>
<td>2. Integration from special care to joint solutions: Trend to integrated home-based service offers instead of segregated special care services and institutions</td>
<td>- All Inhabitants shall have the same access to services, independent of social status, income and location. The organisational structure has three levels: the central state, the regional health care enterprise/county and the municipality (cf. Angell 2012:5)</td>
<td>- Act of municipal health services, -nursing home reform -reform for persons with intellectual disabilities</td>
<td>3.1% = 2005 3.8% = 2025 6.1% = 2050</td>
</tr>
<tr>
<td>3. Deinstitutionalisation from institution to domiciliary care services: blurring boundaries between nursing home and old people’s home, community care housing and home care services (cf.HOD2007:9)</td>
<td>- The municipality and the regional health care enterprises are responsible for the actual provision of health care services (cf. Angell 2012:5)</td>
<td>Service characteristics</td>
<td>(cf.HOD2007:10)</td>
</tr>
<tr>
<td></td>
<td>- The provision of health services has traditionally been in the hands of the public sector in Norway (cf. Angell 2012:6)</td>
<td>- The municipal long term care service is more extensive than the hospital sector: - 200.000 users in care services - 40.000 live in nursing homes - 160.000 receive home care services in community care housing or their home (cf. HOD2007:6 ff)</td>
<td>2. Financing of municipal health service - - grants local government -reimbursement by the National Insurance Scheme - out-of-pocket payments by the patients.</td>
</tr>
<tr>
<td></td>
<td>- Care of the handicapped, mentally handicapped, and care of the elderly are covered by the local level by municipalities (cf. Angell 2012:2)</td>
<td>- Some day care centres and nursing homes are managed by very few enterprises are involving commercial entrepreneurs or voluntary organisations. (cf. Angell 2012:8)</td>
<td>Municipalities receive block grants (central government) (cf. Angell 2012:6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- State grants and contribution rates are determined by the parliament (cf. Angell 2012:5)</td>
</tr>
</tbody>
</table>

Source: own research

Principle guidelines:

Social services are deeply imbedded in political agendas, concepts, programmes and processes. Therefore in the first column of the table the elements of the orientating policy discourses are collected. It is necessary at this point to differentiate between the relevant concepts, reform projects, ‘policy talk’ and the resultant conflicting
aspects. The relevant concepts are defined as programmes and agendas put into practice considering the specific service sector of the example. In addition, the case studies need to reflect the ‘policy talk’ that is going on. Social policy is a dynamic field under reform pressure and discourses play a significant role in shaping services. As an example the UN-Convention on the Rights of Persons with Disabilities (CRPD) can be mentioned. Even though in many Member States this convention has not been implemented yet, it influences the normative orientation, leading to contradictions that need to be handled by practitioners in implementation. This discourse has to be seen as a framework or guideline as well.

**Key organisations and actors:**

The aspect of interaction and allocation of social services provokes an important significance of organisations and actors. Therefore the framework of the social services has to focus on the relevant actors and organisations as well as on the cooperation and networking between them. The role of allocation between public and private actors is of particular interest here. We expect significant differences between welfare systems. Whereas independent not-for-profit organisations play (so far) a rather subordinate role in the social-democratic welfare systems, conservative-cooperatist models have a well-established third sector and liberal models a strong and established private sector. Against the different traditions, political reforms will materialise in new forms of governance and welfare mix.

**Service provided by government:**

The literature review highlighted the inclusive characteristics of social services. Social services ‘incorporate’ essential constituent parts of social security systems. They are not just predominantly immaterial commodities that are dispensed. Bellermann (2011) distinguishes social benefits between social law (social rights, legal frameworks) and social money (social allocations, social monetary beneficiaries). Furthermore social money is differentiated between benefits in cash, benefits in kind and benefits in services. At the same time benefits in service include elements of professional or sector specific expertise through their characteristic of interaction between user groups and employees of the social system. Elements of professional expertise can be leading methods of service provision, for example methods of
people-processing, people-changing or people-sustaining (Hasenfeld 1983; 1992). Knowledge, skills and values (attitudes) are expressed through the qualification of the staff and have to be understood as a framework for social services as well.

**Expenditures/ Resources:**

Finally, it is necessary to look at the invested resources. On the one hand this implies the material and immaterial resources that characterise the policy field of the social services. On the other hand the type of financing has to be taken into account as a regulatory instrument of social services.

**CS 3: Social, political and institutional context**

This third point shows a comparative perspective of the particular frameworks. Therefore population statistics are followed by essential characteristics of the particular welfare state.

**CS 3.1: Population/ Government**

Key figures of population statistics are presented. For example “Total population”, “Population projections 2010-2050”, “Proportion of population aged 65-79 years”, “Life expectancy at 60”, “Expenditure on social protection”, “Single parent families” or “Expenditure on child and youth welfare services”.

**CS 3.2: Information about the specific welfare state**

A selection of welfare state policies in the different national contexts is presented (the consortium decided to leave it at national level). The part of benefits in kind of all social protection benefits is considered as a possible point of comparison. A steady increase of expenditure in benefits in kind of social protection benefits (including social services) can be registered. This could indicate a growing relevance of services compared to monetary benefits. The table below presents the social protection expenditure of selected countries.
### Table 2: Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro.

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3,605,678.95</td>
<td>/</td>
</tr>
<tr>
<td>Norway</td>
<td>32512.53</td>
<td>80,833.67</td>
<td>152.74%</td>
</tr>
<tr>
<td>Denmark</td>
<td>45,334.15</td>
<td>78,367.78</td>
<td>102.60%</td>
</tr>
<tr>
<td>Italy</td>
<td>241,249.28</td>
<td>463,992.00</td>
<td>127.52%</td>
</tr>
<tr>
<td>Germany</td>
<td>565,683.07</td>
<td>765,717.82</td>
<td>52.53%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>262,859.71</td>
<td>478,281.18</td>
<td>124.56%</td>
</tr>
</tbody>
</table>

*Source: Eurostat 2012; own calculation*

### CS 4: Challenges and drivers of innovation

Reflecting the literature review and the case selection, section 4 highlights the drivers and challenges of innovative social services as well as the specific elements of the innovations. The elements of innovation that had been identified in the literature review served as a starting point for the project partners to present the situation of the specific case. The project partners received a ‘guide for the use of case studies’ which functioned as a ‘description of modules’. The modules of the case study are presented below:

#### CS 4.1: Weakness of the system

In general social security systems are rather characterised by their historical and path dependent constitution with different influences than by a coherent construction which is related to needs of the people. Party political calculus and strategies, traditions, values and policy processes have to be considered to the effect that the social security system can be seen as a heterogeneous composition with different and uncoordinated contexts of benefits. In addition to that, a basic rigidity and fixedness with regard to the institutionalised social security systems has to be presumed. It is assumed that new social needs will change quicker than the chance of the certain system to respond to them. As a result it is rather a normal than an exceptional case that ‘gaps’ with different specifications are developing between the evolving new needs and the provided social benefits.
CS 4.2 Challenges and drivers

In the report of work package 2 the essential drivers and challenges considered as a framework for social innovative services have been presented. These drivers and challenges are handed over to the project partners as a sample:

Table 3: Challenges and Drivers

<table>
<thead>
<tr>
<th>Social challenge/social change driving innovation</th>
<th>Meaning</th>
<th>Social service sector in which driver is key</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic change</td>
<td>Increase in numbers of over 65s; Greatest increase in over 80 age group; Increase in old age dependency ratio;</td>
<td>Health sector, Welfare sector</td>
</tr>
<tr>
<td>Aspirations</td>
<td>Rising expectations of citizens for better quality of life/better care</td>
<td>Health sector, Education sector, Cross sector services of education and health</td>
</tr>
<tr>
<td>Lifestyles</td>
<td>Increase in certain diseases related to obesity, alcohol and drug consumption, and stress; diabetes; liver disease; anxiety and depression</td>
<td>Health sector, Cross sector services of education and health</td>
</tr>
<tr>
<td>Technology</td>
<td>Access to information/ new media technology</td>
<td>Health sector</td>
</tr>
<tr>
<td>Continued inequalities</td>
<td>Continued economic inequality/ unemployment; continued poverty, including child poverty; continued institutionalisation; continued inequality for people with disabilities; ethnic minorities; gender inequalities; impact of socio-economic status on health outcomes</td>
<td>Welfare sector, Education sector, Cross sector services of education and health, and welfare and education</td>
</tr>
<tr>
<td>Independent living</td>
<td>The approach now adopted by disabled people to live as ordinary members of society and in their chosen domestic setting.</td>
<td>Welfare sector</td>
</tr>
<tr>
<td>Social roles</td>
<td>Changing families: increase in single households; increase in single parent families; changing generational relations (due to longer life expectancy); reduction in extended families. Changing gender roles; rising female employment rates</td>
<td>Welfare sector, Education sector</td>
</tr>
<tr>
<td>Organisational changes</td>
<td>Creating new organisational forms; application of more responsive management processes; performance management culture</td>
<td>Welfare sector</td>
</tr>
<tr>
<td>Changing management styles</td>
<td>Application of more responsive management processes,</td>
<td>Education sector, Cross sector services of education and health</td>
</tr>
</tbody>
</table>

Source: Hawker/Frankland 2012, WP 2, p. 19
CS 4.3: Criteria of response

With regard to the responses, we were interested in finding out what is new about it (novelty), how it effects the quality of the service and if it is sustainable.

Novelty

Innovation is understood as a response to drivers and challenges, introduced or promoted by agents of change. An innovation can be defined as a

- new service,
- a new form of delivery,
- a new form of governance,
- a new form of resourcing
- or a new way of evaluation

(Hawker/Frankland 2012, package 2, p. 13).

The following table illustrates these criteria:

<table>
<thead>
<tr>
<th>Response</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>New service</td>
<td>New or improved product of the scheme or process</td>
<td>Personalised instead of generic service</td>
</tr>
<tr>
<td>New form of delivery</td>
<td>New or improved means by which the outcome is achieved</td>
<td>Self-help or social enterprise instead of government agency</td>
</tr>
<tr>
<td>New form of governance</td>
<td>New or improved way the scheme or process is managed and where it draws authority from</td>
<td>Co-operative or user managed instead of public service</td>
</tr>
<tr>
<td>New form of resourcing</td>
<td>New or improved financial, human or physical inputs to the scheme or process</td>
<td>Grant-funded, collectively staffed organisation instead of professionally managed, government agency</td>
</tr>
<tr>
<td>New way of evaluation</td>
<td>New or improved parameters by which success is judged</td>
<td>User assessment of effectiveness instead or professional determined criteria</td>
</tr>
</tbody>
</table>

Source: Hawker/Frankland 2012, WP 2, p. 12
Quality:

It is important to highlight that an innovative approach does not automatically lead to an increase of quality (innovation but no improvement). In fact, an innovation can lead to increased but undesired choice or a loss of performance due to the process of learning (Hawker/Frankland 2012, WP 2, p. 15). It is therefore indispensable to explain in detail in which way the response to the innovation is somehow “better” than previous approaches. Referring to this improvement of social services includes for example improved quality of life and access to economic and social opportunity (Hawker/Frankland 2012, WP 2, p. 16).

Sustainability:

Moreover it is necessary to mention throughout the case studies what is done to ensure that the response to the particular innovation will be sustainable in the medium or long run. This means for example that the innovative aspects and ideas should be applied to everyday practice (Hawker/Frankland 2012, WP 2, p. 16).

By using these criteria the specific characteristic of social innovations in social services was taken into account. In the “social services sector, the characteristics of novelty, improvement and sustainability - criteria for funding innovation highlighted above – have to apply not only to new products (new social services, new form of delivery services) and new ideas (new social work method, new governance, new organizations, new partnerships) but also involve

• the sphere of social practices and
• the underlying values of these.

The social services sector is centered on people and service delivery” (Crepaldi/De Rosa/Pesce 2012, WP 1, p.14).

CS 4.4: Agent of change

For the case studies the levels of innovations found in the literature review were converted into the criteria ‘agent of change’. These are actors (individual rather than collective) at various levels that see a new challenge or trend and respond to it as advocates, often taking risks, investing extra resources and breaking routines. Levels include:
- organisational level (i.e. organisation of the provision of social services, type of service, target group, delivering logics);
- regulamentory and legislative level (‘how services are regulated, organised, provided and financed, the modalities of service provision, the types of relationships between external service providers and public authorities’);
- interactional level – connection and cooperation (partnership, networks, governance);
- professional level (social work methods and practices);
- users level;
- conceptual level and values;
- public policy level (policy framework, programs and social policies);
- financial and economic sustainability level (and scaling-diffusion-transferability of innovation);
- evaluative level and attention to quality (quality standards) (Crepaldi/De Rosa/Pesce 2012, pp. 98-99).

**CS 5: Key innovative elements of the example**

In this section the history of the service organisation or the service project should be mentioned as an additional framework factor. Important elements have been demonstrated in a table, followed by a detailed description of the organisational framework of the innovative idea.

The criteria of the table are exemplarily shown for a French project:
### Table 5: Organisation

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>Mom´artre 2007, Mom´Pelleport 2011</td>
</tr>
<tr>
<td>Type of organization (non-profit…)</td>
<td>Civil society network</td>
</tr>
<tr>
<td>Financing</td>
<td>Hybridization of various resources such as monetary resources (sale of services and public funding) and non-monetary contributions (donations, sponsorships, volunteering, free provision of staff « gratis personnel ») Mix of public subsidies (state, region and department) and donations from foundations and private funders.</td>
</tr>
<tr>
<td>Size of the organization (staff…)</td>
<td>Mom´artre network supports and rallies 7 centres, 30 employees (27 job equivalent full time), 12 young people doing a civic service in the association, and 85 volunteers.</td>
</tr>
<tr>
<td>Members and participation</td>
<td>Heterogeneous team of employees, permanent, volunteers, apprenticeship students, and artists. Beneficiaries are amounted to 600 families and 680 children.</td>
</tr>
<tr>
<td>Contact</td>
<td><a href="http://www.momartre.com/">http://www.momartre.com/</a></td>
</tr>
</tbody>
</table>

Source: own research

### 4. Summary of case studies and key findings of innovative projects

In this chapter we provide a summary of the case studies by categorizing and describing the key findings of the different innovative projects. The most significant results relate to influencing factors such as drivers and challenges as well as to the effected responses:
4.1 Influencing factors

The main factors that trigger innovation relate to weaknesses of the social security and social service system on one hand and social and demographic change on the other.

Weaknesses of the system can include insufficient policies, e.g. insufficient support of single-parent families or inadequate housing policies. Other drivers of change and challenges that call for new responses are demographic changes, new aspirations, new/changing lifestyles, new technologies, inequalities, changing social roles, organisational changes and new management techniques. We distinguish between ‘hard’ (H) and ‘soft’ (S) drivers’. These different drivers can appear on a micro, a meso or a macro level. In this sense ‘hard’ refers to laws, policy regulation or major social challenges which are more likely to be located at meso or macro level. ‘Soft drivers’ such as new ideas, values and attitudes about certain social issues can be found at all levels.

(H1) Global social and economic challenges, such as demographic changes, economic and social crisis or social inequalities, appear on a macro level and influence the particular policy field. The innovative projects that deal with services for elderly people are for example influenced by demographic changes (e.g. see projects ‘Abitare Solidale’, ‘Ammerudhjemmet’ or ‘Changing focus for a healthier old age’).

(H2) On a meso level, the weakness of the (local) system can be seen as an important driver. The weakness of a system becomes obvious when the needs of a certain group of people remain unsatisfied. This weakness can for example be expressed through inadequate policies considering housing, single-parent families, migrants or unemployed people or public spending cuts. As one example the project ‘Môm´Artre’ satisfies the needs of single-parent families that are often affected by the fact that the schedules of regular French childcare facilities are not compatible with long working hours and atypical working patterns.

(H3) A third essential ‘hard driver’ are changes of the national/regional or local regulative framework (meso level). The project ‘Light Residential’ in Italy for example
is influenced by changes in the local regulative framework considering the field of mental health. The Danish example ‘Danish center against human trafficking’ responds to migration laws that regulate the rights of migrant women regarding residence and work permission. In this case, new laws were not a positive but a negative driver: the service was delivered to support those people that suffer from the new regulations and to mitigate its negative side-effects.

As indicated above ‘soft drivers’ refer to ideas, values and attitudes that can either be found on a macro or on a micro level.

(S1) On a macro level changes in public discourses can be seen as ‘soft drivers’. One example is the paradigm shift away from a medical model of disability to a social one (e. g. see project ‘CIL’). Another example for this paradigm shift is the project ‘GPE Mainz’. This has also been influenced by the changing social role of people with disabilities in society.

(S2) On a micro level the rising individual aspirations of the users can be described as a second major ‘soft driver’. Many projects are driven by the rising expectations of users regarding an independent lifestyle, the inclusion into society or a personalised assistance. One example is the project ‘Blue Assist’ which developed an application for smartphones to help people with intellectual disabilities gaining more autonomy in everyday life. This service is amongst others influenced by the rising aspirations of the users considering autonomy, inclusion and life activity. This ‘soft driver’ is also relevant in the project ‘Changing focus for a healthier old age’. This service implements and maintains a care that involves elderly citizens in work activities rather than leaving them in a passive role. Hence this fits to the expectations of the users who want to be actively involved and stay independent as long as possible. These hard and soft drivers often appear in combination.

Maybe obvious, but there is hardly one driver alone that triggers innovation, rather a combination of hard and soft rivers and challenges that come together and create a situation that calls for change (for possible correlations see section 4.4 of this chapter).
4.2 Innovation as response:

4.2.1 Key principles and quality-impacts

As the cases show, innovation can take many forms. There are, however, a number of principles that seem to guide innovation more than others. In some cases the key principle focuses on individualization whereas in other cases the inclusion of particular groups of people into society is in the center of attention. Some projects also try to decrease a certain stigma or influence the public opinion in a positive kind of way. A key issue is also enhancing effectiveness, be it for the users of a service or providers. Having this in mind all these aspects can be summed up as “responses” (see below). Most of the innovative project examples provoke more than one of these responses.

1. Inclusion (I1)

Many projects work for an inclusive society and, for example, try to integrate elderly people or people with disabilities into society. To illustrate this, the Norwegian project ‘Ammerudhjemmet – Long term care in Norway’ is a useful example. Ammerudhjemmet is a nursing home which has taken the role of being a culture centre for the whole community. The central aim is to build up a network between the residents and their neighbourhood and to avoid a separation of users from the local community. Another example that fits into this category is the Italian project ‘Abitare Solidale – Inter- and intra-generational cohabitation’. This housing solution helps people in need with providing an affordable accommodation. It focuses on the social integration and active inclusion of the users and is mainly utilized by older people, older people’s relatives, disadvantaged people at risk of poverty and women who are victims of domestic violence. Other examples (‘GPE Mainz’, ‘European Care Certificate’, ‘Blue Assist’, ‘Môm`artre´ or ‘Place de bleu’) show the active integration into the labour market with the chance to receive equitable wages.

2. Individualisation (I2)

The aspect of individualisation and the involving effectiveness for the user are in the centre of attention in most case studies. Very often this trend to individualisation is combined with the aim to promote social inclusion (e. g. see
projects ‘Abitare Solidale’, ‘Blue Assist’, ‘Residential’, ‘Ammerudhjemmet’, ‘CIL’ or ‘GPE Society Mainz’). In many cases individualisation implies tailored support, help to self-help and more autonomy for the users. It also implies the de-institutionalisation of services. The project ‘Stroke care – Patient led rehabilitation (through ‘Early Supported Discharge’)’ is a good example for individualisation. This service is provided to patients with mild to moderate stroke that are suitable for early supported discharge because they are medically stable. Healthcare at home, personalised care as well as patient and care involvement are innovative elements of this service. Instead of staying in hospital for a longer period of time, people who are medically stable receive individualised care and set up personalised rehabilitation goals together with clinicians and therapists. At the same time, individualisation is connected with several aspects of ‘community care’ and inclusion. Clients, patients or services are no longer excluded from everyday life through hospital treatment and the focus on people with similar characteristics. Instead, social services have to be linked with the social surroundings of the people. Social services are also responsible for establishing these social surroundings. The projects `Abitare Solidale´, `Telemonitoring & Teleconsulting´, ‘Changing focus for a healthier old age’ and ‘Early supported discharge after stroke’ are excellent examples for this aspect.

3. Informalisation, outreach and lowering thresholds to access (I3)

Through informalisation or lowering thresholds, target groups that do not get in contact with the regular system of social services can be reached. The innovative project ‘Danish center against human trafficking’ is a proper example for this category. The project provides a mobile health care service for victims of human trafficking and migrant women working in prostitution. These women normally do not contact the regular health care service by themselves because of their precarious legal status. Through this project a midwife and several social workers get the chance to reach these women and to provide a solution for an otherwise unmet need. The German project ‘Eltern AG’ provides a low-threshold service as well. It supports parents with difficulties that are usually hard to reach (single parents, parents with migration background) improving their parenting skills. These user groups are often cut off from the regular service providers. The potential users are contacted in their local community through disseminators and
intermediaries. The project has a strong focus on the empowerment of the users and wants to initiate self-help network structures. Hence the aspect of individualisation is referred to as well, which is another example for a combination of different responses.

Table 6: Accessibility

<table>
<thead>
<tr>
<th>Project</th>
<th>Informalisation, outreach, lowering thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMMERUDHJEMMET</td>
<td>Soft transition from ambulant treatment to hospital treatment</td>
</tr>
<tr>
<td>DANISH CENTER AGAINST HUMAN TRAFFICKING</td>
<td>Outreach health programme for illegal female prostitutes without being entitled to benefits</td>
</tr>
<tr>
<td>ELTERN AG</td>
<td>Self-help beyond the regular system of social benefits</td>
</tr>
<tr>
<td>IRRE MENSCHLICH</td>
<td>Decreasing stigmatisation in society/ in public discourses</td>
</tr>
<tr>
<td>KATYMAR</td>
<td>Service provision close to local community</td>
</tr>
</tbody>
</table>

Source: own research

4. Influencing public opinion (I4)

A fourth important response can be categorized as ‘influencing public opinion’. This can imply decreasing stereotypes, decreasing pathologisation or initiating a paradigm shift. The two German projects ‘GPE (Gesellschaft für psychosoziale Einrichtungen) Mainz’ and ‘Irre menschlich e. V. Hamburg – Trialog’ both work on these issues. The project GPE Mainz provides users (people with disabilities, people with mental-health problems, people with chronic illnesses and unemployed people) tailor made support towards social and occupational integration into society. By doing so their aim is to influence the public discourse about topics such as disability or mental illnesses in a positive kind of way and to reduce discrimination and stigmatization. The project ‘Irre menschlich’ pursues a
similar objective. This citizens’ initiative uses the principle of trilogy: people with mental-health problems, their relatives and therapists are working together on an equal basis. The essential aim is to eliminate social stigma and discrimination of people with mental-health problems.

*Table 7: Public opinion*

<table>
<thead>
<tr>
<th>Project</th>
<th>Influencing the discourse about</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABITARE SOLIDALE</td>
<td>Inclusion</td>
</tr>
<tr>
<td>NUEVA</td>
<td>Prejudices towards people with disabilities</td>
</tr>
<tr>
<td>RESIDENTIAL</td>
<td>Self-esteem and social exclusion</td>
</tr>
<tr>
<td>IRRE MENSCHLICH</td>
<td>Stigmatisation of people with mental-health problems</td>
</tr>
<tr>
<td>GPE MAINZ</td>
<td>Employment and disability</td>
</tr>
</tbody>
</table>

*Source: own research*

### 5. Resource mobilisation and transformation (I5)

In some cases, the users themselves are identified – or rather identify themselves - as a resource which can only be provided by them as an added value. Or other Actors discover user capabilities and transfer them to valuable resources. This resource is embedded into social contexts. These social contexts allow a transformation of competences or resources into valuable and usable potentials for a third party.
### Table 8: Resource mobilisation

<table>
<thead>
<tr>
<th>Project</th>
<th>Resource mobilisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABITARE SOLIDALE</td>
<td>Sustainable housing space as a resource</td>
</tr>
<tr>
<td>NUEVA</td>
<td>Users’ expertise as a resource: new form of evaluation, added value through certification and development</td>
</tr>
<tr>
<td>AMMERUDHJEMMET</td>
<td>New service offers in social environment, upgrading of social environment</td>
</tr>
<tr>
<td>ELTERN AG</td>
<td>Consultation built on experiences as a resource</td>
</tr>
<tr>
<td>IRRE MENSCHLICH</td>
<td>Experiences made within the system as a resource</td>
</tr>
<tr>
<td>MOM’ARTRE</td>
<td>Knowledge as a resource</td>
</tr>
<tr>
<td>PLACE DE BLEU</td>
<td>Traditional skills as a resource</td>
</tr>
<tr>
<td>REAL PEARL</td>
<td>Mutual help as a resource</td>
</tr>
</tbody>
</table>

Source: own research

In addition to the described drivers and responses, a number of secondary aspects can be mentioned.

#### 4.2.2 Classification of novelties and responses

The innovative aspects of the projects can further be classified into specific forms of novelty. The novelty can be a new/better service for an existing need, an alternative approach for an existing need/new form of delivery, a new service for a new need, a new form of governance, a new form of resourcing, a new way of evaluation, increased professionalism in service or new managerial methods. It is eye-catching that most of the innovative projects provide a new form of delivery rather than a completely new service. They also have more than one origin of response. In fact very often a combination of three or four origins can be found. An illustrative example is the Dutch innovative project ‘Humanitas – Financial Home Administration Programme Improving people’s financial and administrative skills’. This project touches the service fields of education and welfare and provides support to people
not being able to manage independently their financial and administrative work. The main innovative aspect is in this case represented by the important role played by volunteers. They provide the people in need with financial and administrative support at home, which also means that the threshold is very low and people don’t have to be scared of stigmatization. According to this the project follows an individual approach instead of group consulting. Hence the project provides a new form of service delivery for an existing need as well as a new form of resourcing and an increased professionalism in service.

Another example is the French project ‘Môm’artre – Network for after school childcare’. This project creates a welcoming service for children awakening to art and culture who otherwise could not access this type of activity due to their family situation. The centre therefore adapts to the income and work schedules of single-parent families. It provides a low-threshold offer and a new form of service delivery. The resources are based on a mix of several monetary and non-monetary contributions, which is an additional innovative aspect. A similar pattern can be seen in most of the other innovative project examples as well. This indicates towards the essential distinction between product innovations and process innovations in research on innovation. So far, we can see a clear bias towards process innovation, often accompanied by increased professionalism in service delivery.

4.3 Incubators of innovation and interdependent factors in innovative processes

Social services are deeply connected with innovation. This includes product innovation as well as process innovation. The literature review has amongst other things referred to the fact that through the constitutive reference to interactions of social services, the ‘product’ of services has to be adjusted to the specific needs and demands in the context of service provision. These adjustments can’t be described as ‘innovation’ because they are rarely institutionalised. Due to this they are not sustainable, not structure-generating or structure-changing. However, professional acting, for example, could be marked through a permanent and constant ‘ad hoc’ modification of social services as a ‘product’. This leads to at least two consequences for research on innovation. In the first place social services rely on a frame that allows (e. g. through organisational regulations) and assures (e. g. through comprehensive standards in quality, qualification and professionalism) a wide scope
of actions. Secondly this constant character of modification opens the inevitable view towards the process of innovation. The following thesis could be derived from this: If one influencing factor on innovation can be found at the professional level, innovation can rarely be thought from the outside of certain social contexts. Rather, it can only be understood considering the background of previous structures and processes. Exactly these aspects can be found in the comprehensive analysis of case studies.

In the following section such criteria of innovative examples are summarised and highlighted which haven’t been in the centre of the selection but can be seen as accompanying factors of the innovative cases. One could also say that they are ‘unintended’ side effects of the selection of innovative cases.

4.3.1 Agents of change

With this category, we focus on actors. In line with neoinstitutional approaches to understanding and explaining social change, we assume that innovation doesn’t happen just behind people’s and organisations backs, but that individuals can be identified who actively advocate a new idea and invest time and/or resources and take the risk of testing something new. With regard to the selection of case studies, relevant levels, where these individuals can be found, are:

- 1. Organisational level & management (e.g. a manager)
- 2. Regulatory/legislative level/local governance (e.g. officers in a ministry or municipality)
- 3. Professional level/expertise development (e.g. a social worker or a psychologist)
- 4. Users and individual initiatives

Approximately half of the innovative projects were stimulated by more than one agent of change. Combinations of support at regulatory/legislative level and professional level can be found as well as combinations of users’ initiatives and professionals. These can be interpreted as advocacy coalitions. Further research would be needed though to identify clear patterns: Do such coalitions span across organisational boundaries, or are they rather blocked by fear of competition? How could users and regulatory level – where we see a clear gap – come closer together? Are the
changes that are introduce by coalitions of management and regulatory level further reaching than changes pushed by users only?

In most of the innovative projects a significant agent of change can be found on the professional level, such as care workers and specific trainers (e.g. ‘Eur. Care Certificate’), health professionals (e.g. ‘Sante Communautaires Seclin’), art teachers (e.g. ‘Real Pearl’), employees of welfare associations (e.g. ‘GPE Mainz’), research associates (e.g. ‘Eltern-AG’) or employees and volunteers of volunteer organisations (e.g. ‘Abitare Solidale’).

A specific lever to introduce new ideas which is often applied in social policy is the use of a pilot project. Allocated outside mainstream systems of service delivery, new approaches can be tested and evaluated.

The following table provides an overview of the different agents of change:
Table 9: Agents of change

<table>
<thead>
<tr>
<th>Project title</th>
<th>Organisational level &amp; management</th>
<th>Legislative level framework setters</th>
<th>Professional level</th>
<th>Users &amp; individual initiatives</th>
<th>Use of pilot projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abitare Solidale</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ammerudhjemmet</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue Assist</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>CIL</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Danish center against human trafficking</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early supported discharge after stroke</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Eltern AG</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Eur. Care Certificate</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>GPE Society Mainz</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humanitas</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irre menschlich</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Katymar</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Môm’ Artre</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Nueva</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Place de bleu</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Realpearl</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Residential</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sante Communautaires Seclin</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Telemonitoring and Teleconsultation</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Changing focus for a healthier old age</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: own research
Alongside this list, the impact of the five elements can be appreciated in the context of innovative processes. All the five levels present elements of social contexts in which processes of innovation in social services can be located. With this conclusion we are approaching the question of how innovation in social services arises, how it is originated. If these levels of ‘agents of change’ can comprehensively be seen as essential influencing factors as well, innovations in social services cannot only be explained as local appearances but through a path-dependency of previous developments. There is evidence to suggest that innovation in social services can be explained through the embedding in specific social contexts.

1) Organisational level: actors that function as agents of change in existing organisations (in most cases at the management level) or organisations as actors
   Significant examples for this are the projects ‘Humanitas’, ‘Place de bleu’ or ‘GPE Society Mainz’.

2) Regulatory/legislative level/local governance (e.g. officers in a ministry or municipality): actors that initiate innovation at the level of regulation in the system of multi-level interdependency, also the so called framework setters (see Judith Allen 2006 working paper).
   Good examples are the innovative projects ‘Danish Center against human trafficking’, ‘Ammerudhjemmet’ or ‘Katymar’.

3) The reference towards professional acting as an agent of change indicates in the broadest sense to professional actors and the field of ‘professional expertise’. Professional actors could be characterised through their access to specific knowledge (gained through qualification and practice), through their access to and their use of specific methods as well as through their value-based attitude. Expertise implies the compilation and the supply of practical knowledge, working knowledge and systematised academic knowledge as well as the supply of methods, standards and concepts considering the application of social services. Furthermore it implies professional values, quality principles up to ethos, ethical reflections, occupational morality and codices. Behind ‘professional’ acting, thus more or less (high) qualified, occupational acting, a social context can be identified. This social context can be seen as at least one potential for innovation.
Exemplarily the projects ‘Eltern AG’, ‘Irre Menschlich’ or ‘Môm’artre’ can be mentioned here.

4) Users and individual initiatives can function as important advocates for social change as well. Very often users or other individuals start to build an advocacy coalition with agents at the professional level to enforce their objectives. This can be seen as a strategic alliance.

Examples for innovative projects where the commitment of individuals plays an important role are ‘Sante Communautaires Seclin’ or ‘Môm’artre’.

In conclusion projects in form of processes can rather be seen as embedded in certain social contexts. This can include the organisational, professional and political level as well as user initiatives. Due to this very often no specific or single agent of change can be identified. The pilot projects can appear in several different ways. Types of pilots can, amongst others, be similar structures or previous academic evaluation, monitoring or instruction.

4.3.2 Blurring boundaries approach

The innovative projects cover three different areas of service provision: education, health and welfare. The range of case studies shows that innovative social services very often follow a ‘blurring approach’ venturing into more than one of these areas (only 7 projects out of 20 focus on just one service area). There is a clear correlation to the guiding principles mentioned above such as inclusion or individualization. Throughout the review, however, we found that the blurring approaches mainly relate to education and welfare. Therefore it can be assumed that this combination provokes innovative projects rather than a focus on just one field of service. The following table illustrates this assumption:
## Table 10: Blurring sectors

<table>
<thead>
<tr>
<th>Project title</th>
<th>WELFARE</th>
<th>HEALTH</th>
<th>EDUCATION</th>
<th>WELFARE &amp; EDUCATION</th>
<th>WELFARE &amp; HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abitare Solidale</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ammerudhjemmet</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Blue Assist</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIL</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Danish center against human trafficking</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Early supported discharge after stroke</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eltern AG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Eur. Care Certificate</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>GPE Society Mainz</td>
<td>X</td>
<td></td>
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<td>Humanitas</td>
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<td>Katymar</td>
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<td>Residential</td>
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<td>Sante Communautaires</td>
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<td>Telemonitoring and Teleconsultation</td>
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<td>Changing focus for a healthier old age</td>
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Source: own research
4.3.3 Organisation and financing

In addition to the described observations, organisational and financial aspects have to be taken into consideration. A dimension that was not considered in the selection of cases but emerged only in the review is territoriality. Most of the innovative projects are located in urban areas or in urban and rural areas, but only one project of the sample can be identified as explicitly rural (see project ‘Danish center against human trafficking’). The sample is too little to deepen this observation, but it is at least surprising and clearly calls for further research, that rural areas where service providers are under enormous pressure due to ageing and population decline, are less featured than cities.

With regard to time, overall no significant difference can be stated. Almost all projects were initiated between the years 2000 and 2011. However it is important to draw a precise distinction between the establishment of an entirely new organisation and the establishment of an innovative project within the structure of a well-established organisation. An example for this is the Italian project ‘Light Residential’. The responsible organisation, Aiutiamoli, has originally been established in 1989. In March 2007 it was set up as a non-profit organisation (Foundation Aiutiamoli) and in 2008 the innovative service ‘Light residential’ started. A second example is the project ‘GPE Society Mainz’. The general foundation took place in 1985 whereas the innovative service was established in 1992.

To summarise this: Innovative ideas come along with the establishment of new organisations. This raises the question of how well-established (large-scale) organisations can make innovations possible or how innovations can become visible in this kind of organisation.

Referring to the type of organisation (public, private for-profit, private non-profit, association/foundation, volunteer) most projects of the sample were implemented by non-profit organisations (11 out of 20 projects). Five projects are established by a public organisation and only three projects are carried by a private for-profit organisation or a combination of for-profit with other types of organisation. This calls for a closer look at the different forms of financing (public, private additional to public, direct selling, commercial sponsoring, payment by users, reciprocity resources, donations). Overall it can be summarised that most of the innovative projects rely on
mixed financing. This can be a combination of public funding, private funding and direct selling, for example. The project ‘Môm’artre´ combines even five different forms of financing which are public funding, direct selling, commercial sponsoring, payment by users and donations. Most projects receive public funding, often combined with other types of financing.

With regard to the size of the projects it can be concluded that most of them have approximately 10 to 30 staff members. Five projects can rely on a staff of approximately 200 (‘Ammerudhjemmet’, ‘Eltern AG’, ‘GPE Mainz’, ‘Humanitas’) to 600 (‘Changing focus for a healthier old age’) employees. The projects that are also supported by volunteers generally count 25 to 90 people doing their work voluntarily. One project counts even more than 11,000 volunteers (‘Humanitas’). The projects are accessed by 150 to 2,000 users. One project is utilized by nine women (‘Place de bleu’) whereas another project counts 36,000 users (‘Humanitas’).

4.3.4 Blurring professional expertise: Professionalism and knowledge in expert systems

Most of the innovative projects can rely on the knowledge and professional expertise of many different experts. These experts are, for example, consultants, social workers, legal advisors, architects, psychologists, educators, nurses, hairdresser, dressmakers, psychotherapists or rehabilitation assistants. In the present sample the blurring approach contains two consequences which should be taken into consideration even though they have to be further differentiated.

1. In most of the cases, several occupational professions are working together. Hence the boundaries of occupational professionalism are exceeded. It is particularly notable that professions, which originally have no qualifications or competencies for this field of work, expand into the ‘social’ sector. This raises the question of professional attitude as well as the question of cooperation between a diverse knowledge and different professional skills.

2. Professional expertise is in this sense no longer understood as occupational expertise. It is rather seen as a kind of expertise in a particular service field. This specific knowledge can therefore be gained through many different ways (e. g. through voluntary work) and is not automatically the result of formal education.
Therefore the concept of professional expertise has to be changed into the concept of expertise focusing on a particular service field. The consequences of this notice can at least be expanded into two different directions for raising questions: First of all it is necessary to ask which division of labour is establishing in a particular field of expertise/ in a particular field of social services regarding the cooperation of diverse actors. And secondly, what type of knowledge, competence, attitude and cooperation is generated in these different fields of expertise.

4.3.5 New Forms of Governance

Several project examples illustrate ‘new’ forms of governance of social services. The state-dominated governance through laws, regulation and financing is changing clearly to a more recursive and participative role. Thus it focuses on generation, development and protection of frameworks and structures of social services. With the help of a few examples these new forms of governance will be illustrated below:

- **Multi-Level Governance**: Exemplarily the project ‘CIL´ influences and shapes the national legislation through the principles of the disability rights movement ‘Independent Living’. At the same time it affects the local level through the establishment of centers for independent living. These centers do not just offer services they rather establish a new culture of assistance for people with disabilities through trainings and public relations. Due to this ‘CIL´ operates at a micro, meso and macro level and combines these three levels to a policy-approach.

In addition to that diverse governance principles can be seen on the regional and local level.

- **Bottom-up Governance**: Especially in structurally weak areas the regulation of social services is allocated to different initiatives (see project ´Real Pearl´), what we call ‘bottom-up-governance’. The creation of a service structure at the micro level is left to the projects. The state intervenes in the generation and creation of structures neither through laws and programs nor through types of financing or organisation.
• Subversive Governance: In dependence on the discussion about ‘resistance’ and ‘subversive practices’ of frontline workers especially in public services (Barnes and Prior 2009) several innovative projects clearly show that innovative social services also have the potential of “counteract aspects of worker agency that undermines the achievement of policy objectives” (Barnes and Prior 2009). Exemplarily this can be illustrated through the projects ‘Realpearl’ oder ‘Katymar’. These projects evolved as a counter-strategy to the new legislation.

• Local-network governance: A strategy of networking which remains at the local level but seeks towards an intersectoral collaboration and comprehensive sector alliances is in this context called local-network governance (cf. Davies 2011). At this point it is particularly important to analyse the strategies of political networking used by different partners.
### Table 11: Governance

<table>
<thead>
<tr>
<th>Project title</th>
<th>Bottom-up Governance</th>
<th>Subversive Governance</th>
<th>Multi-level governance</th>
<th>Local-network governance</th>
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<tbody>
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<td>Abitare Solidale</td>
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<td>Ammerudjemmet</td>
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<td>CIL</td>
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<td>Danish center against human trafficking</td>
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<td>Early supported discharge after stroke</td>
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<td>Eltern AG</td>
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<td>Eur. Care Certificate</td>
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<td>GPE Society Mainz</td>
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<td>Humanitas</td>
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<td>Irre menschlich</td>
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<td>Katymar</td>
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<td>Changing focus for a healthier old age</td>
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Source: own research
4.4 Innovation cluster

The described and analysed categories in the previous chapters can be merged to three different clusters of innovation:

- Cluster I: Nonprofit-Public Alliance
- Cluster II: Professional-Advocacy-Alliance
- Cluster III: Public Initiatives

4.4.1 Cluster I: Nonprofit-public alliance

This cluster is called nonprofit-public alliance because in this strategy of innovation a specific framework is concentrated to innovation-supporting requirements. It is an alliance of established nonprofit organisations in a certain field that accesses a specific culture of public support, particularly public financing. The cluster consists of several different elements. Projects that belong to this category generally have an agent of change at the organisational or management level. A second essential aspect is indicated through the collaboration with public institutions via the granting of public resources. In addition, many of these innovative projects are built upon pilot projects or similar forms of previous structures or activities. The projects can be found in an urban area and are financed through public resources. In general, these innovative social services are based upon and supported by occupational commitment and can be found in the service field of welfare. Furthermore, there is a tendency that indicates that projects which are promoted by organisational agents of change are more likely to be evaluated or monitored than other projects (e.g. in comparison to projects promoted by users’ initiatives). The innovative examples belonging to this cluster are additionally characterised through a blurring occupational knowledge. This means that the professional expertise of different occupations is brought together in these innovative services. Amongst others, the projects ‘Abitare Solidale’ or ‘Early supported discharge after Stroke’ are good examples for this cluster.

4.4.2 Cluster II: Professional advocacy-alliance

The cluster of professional advocacy or professional user initiative alliance should be understood as a counter model to the organisational public alliance. An alliance between actors and service users or persons concerned can be seen here. This
alliance orientates to the objective of the advocacy, the lobby for a specific concern, and therefore promotes an innovation. This second cluster includes projects that are promoted by agents of change at the professional level as well as users’ initiatives. These projects are in general financed on a basis of mixed resources mostly without public funding. In many cases, these innovative services rely on the commitment and on the resources of volunteers (volunteers are underestimated in the organisation-public alliance). Supplementary these projects can be found more in the service field of education and often follow a blurring approach by combining health or welfare services with the field of education. In contrast to cluster I, projects summarised in cluster II rely on a mix of occupational knowledge and knowledge of the users themselves – here a sort of expert system is generated, not a sphere of “boundary spanners” (Williams 2012) through occupations. As indicated above, these projects are rarely evaluated or monitored. The cases ‘Irre Menschlich’ and ‘Sante Communautaires Seclin’ can be listed as significant examples for this cluster.

4.4.3 Cluster III: Public initiatives
Projects that are driven by agents of change in the form of policy makers or framework setters which are setting initiatives through the public framework are subsumed in the third cluster. These projects are financed through public resources and addresses rural areas as well as urban areas more than the other clusters. The innovative services belonging to this cluster are generally implemented through nonprofit organisations. Just like the projects of cluster II, projects in cluster III are rarely evaluated or monitored. This underlines the assumption, that a significant and stringent evaluation can only be found in cluster I (projects originated at an organisational level). In addition, this cluster is characterised by a blurring approach in reference to the service fields of welfare and health – health is the only service field that can be prominently found in this cluster, whereas it is underrepresented in the other clusters. Another key aspect is the focus on the adequate help and access of the users. In contrast to other projects the aspect of empowerment as well as the aspect of mobilization and transformation of resources only plays a minor role. Rather, these projects focus on the inclusion of the weakest and marginalized members of society (e. g. people in need of care who can no longer live independently, people deprived of their rights, poor people, people who work under precarious conditions) into the relevant systems through specific assistances.
Therefore clients are provided with a specific knowledge (e.g. ‘European Care Certificate’), medical resources (e.g. ‘Danish Center against human trafficking’) or education (e.g. ‘Katymar’). Concrete examples for this cluster are, amongst others, the projects ‘Danish Center against human trafficking’ or ‘Katymar’.

Overall two key conclusions can be drawn from this cluster analysis. In the first place the categories referring to agents of change, type of financing, type of blurring experience and volunteering play a significant role considering innovations in social services. As described above a combination of these three aspects is related to the process of innovation in one way or another. Secondly the role of ‘drivers’ (e.g. global social economic challenges, weakness of the local system, changes of the regulative framework, paradigm shifts) in the context of social innovations is not as strong and significant as it might be assumed. Even though these drivers play an important role (see chapter 4 of this report), this seems to be a side effect rather than a key stimulus for innovation.

5. European compared selection of case studies

5.1 Overview: Case studies with short descriptions

Responses: Impact/Outcome (see chapter 4.2):

Inclusion (I1), Individualisation (I2), Informal/low threshold (I3), Influencing public opinion (I4), Resource mobilization & transformation (I5)

Hard & Soft Drivers (see chapter 4.1):

Hard drivers: Global social & economic challenges (H1), Weakness of the system (H2), Changes of national/regional/local regulative framework (H3)

Soft drivers: Changes in public discourse (S1), Rising aspirations of users (S2)

<table>
<thead>
<tr>
<th>Project</th>
<th>Area</th>
<th>Issue &amp; Drivers</th>
<th>Action</th>
<th>Responses Impact/Outcome</th>
<th>Innovation(s)</th>
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<tbody>
<tr>
<td>Ammerudhjemmet</td>
<td>Older People</td>
<td>Inclusion H1, H2, H3</td>
<td>Using care facilities on a communal basis</td>
<td>I1, I2, I5</td>
<td>Opening up care facilities</td>
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<td>Reducing isolation/Increased contact with local community</td>
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<td>AUSER Arbitare Solidale</td>
<td>Housing needs</td>
<td>Lack of employment and needs of integrating needs/ finding joint solutions</td>
<td>I1, I2, I5</td>
<td>Providing</td>
<td>New solutions to accommodatio</td>
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<td>Work Package 7 – Theoretically Informed Case Studies</td>
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<td>older people</td>
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<td>employment and accommodation solutions, empowerment of users, social cohesion</td>
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<td>n and inter generational support</td>
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<td>Blue Assist</td>
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<td>Independent Living</td>
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<td>H1, S1, S2</td>
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<td>Using smartphone app to enable individuals to get help</td>
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<td>I1, I2</td>
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<td>Individuals can move around their locality independently</td>
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<td>Using smartphone technology for people with learning disabilities</td>
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<td>Center against human trafficking</td>
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<td>Trafficked women prostitutes</td>
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<td>Health support and guidance</td>
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<td>H2, S1</td>
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<td>Outreach health programme</td>
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<td>I3</td>
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<td>Improved quality of life for prostitutes</td>
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<td>Low-threshold mobile healthcare</td>
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<td>CIL Serbia</td>
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<td>Disabled people</td>
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<td>Promoting Personal Assistance Service</td>
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<td>H2, S1, S2</td>
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<td>Obtaining legal framework and development programme</td>
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<td>I1, I2</td>
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<td>Personal Assistants now available/ independent living movement established</td>
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<td>Programme driven by people with disabilities</td>
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<td>Early Supported Discharge after Stroke</td>
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<td>Stroke care patients</td>
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<td>Empowering patients/ improving outcomes</td>
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<td>H3</td>
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<td>Providing community based rehabilitation service</td>
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<td>I2</td>
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<td>Patients achieve goals relevant to them/ self confidence improved</td>
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<td>Patients set the agenda for rehabilitation programme/ personalised service</td>
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<td>Eltern AG</td>
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<td>Disadvantaged parents</td>
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<td>Helping ‘hard to reach’ parents improve their parenting skills</td>
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<td>Intensive outreach</td>
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<td>I2, I3, I5</td>
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<td>Prevents family problems in raising children/ stops cycle of disadvantage</td>
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<td>Intervening at very early stage in disadvantaged family development</td>
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<td>European care Certificate</td>
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<td>Care Workers</td>
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<td>Common basic skill set</td>
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<td>H1, H2</td>
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<tr>
<td>Entry level award across 16 countries</td>
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<td>I5</td>
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<tr>
<td>Establishes positive and shared entry point to care profession</td>
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<tr>
<td>Unified approach to care standards</td>
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<td>GPE Society Mainz</td>
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<tr>
<td>Mental Health/ Learning Disabilities</td>
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<tr>
<td>Confidence and independence</td>
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<tr>
<td>H2, S1, S2</td>
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<tr>
<td>Real supported work opportunities</td>
<td></td>
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<tr>
<td>I1, I2, I4</td>
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<tr>
<td>Employment skills/Social inclusion</td>
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<td>Creating supported real work situations</td>
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<tr>
<td>Humanitas Financial Home Administration Programme</td>
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<td>Anti poverty</td>
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<td>Personal finance management</td>
<td></td>
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<tr>
<td>H1, H2, S2</td>
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<tr>
<td>Volunteers provide advice and learning support for people with poor finance management skill/knowledge</td>
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<tr>
<td>I1, I2</td>
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<tr>
<td>Social Inclusion/ reduce effects of poverty</td>
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<td>Knowledge sharing in basic living skills</td>
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<td>Irre Menschlich</td>
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<td>Mental Health</td>
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<tr>
<td>Social Inclusion</td>
<td></td>
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<tr>
<td>H2, S2</td>
<td></td>
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<tr>
<td>Users and carers provide community education on mental health</td>
<td></td>
<td></td>
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<tr>
<td>I4, I5</td>
<td></td>
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<tr>
<td>Local institutions and organisations provide better support for people with mental health problems</td>
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<tr>
<td>Users engage directly with local organisations to change perceptions and local support systems</td>
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<tr>
<td>Disadvantaged Employment</td>
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<td>Basic skills for</td>
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<tr>
<td>I2</td>
<td></td>
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<tr>
<td>Finding</td>
<td></td>
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<tr>
<td>Project</td>
<td>Focus Area</td>
<td>Type of Service</td>
<td>Goals of Service</td>
<td>Source: Chris Hawker 2013, own research</td>
<td></td>
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<tr>
<td>KATYMAR</td>
<td>ed Roma families and economic development</td>
<td>local employment</td>
<td>Positive approaches to work and earning income</td>
<td>Economic solutions to disadvantage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H1, H2</td>
<td>Helping unskilled people obtain work</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Providing very flexible child care</td>
<td>I1, I5</td>
<td>Addressing work patterns for low paid people</td>
<td></td>
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<td></td>
<td></td>
<td>Enabling low income shift workers to obtain good quality child care/ preventing double disadvantage</td>
<td></td>
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<tr>
<td>MOM’ARTRE</td>
<td>Child care</td>
<td>Enabling poorer people access appropriate child care</td>
<td>I1, I2, I3, I5</td>
<td>User led service evaluation</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Providing very flexible child care</td>
<td>Improving quality and responsiveness of services</td>
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<tr>
<td></td>
<td></td>
<td>Quality of social care/housing</td>
<td>Developing new kinds of employment</td>
<td></td>
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<tr>
<td>NUEVA</td>
<td>People with learning disabilities/ Communication difficulties</td>
<td>Enabling effective user evaluation</td>
<td>I1, I2</td>
<td>Education to build on community culture</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Enabling self confidence and skills</td>
<td>New forms of education/ fit with community cultures</td>
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<tr>
<td>Place de bleu</td>
<td>Vulnerable immigrant women</td>
<td>Integration in labour market</td>
<td>I1, I2</td>
<td>Developing new kinds of employment</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Attractive sewn products for sale</td>
<td>Using individual skills to create new jobs/ learning work skills</td>
<td></td>
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<tr>
<td>Realpearl</td>
<td>Education and anti poverty for excluded groups</td>
<td>Building self confidence and skills</td>
<td>I1, I</td>
<td>Education to build on community culture</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Using art skills to make products for sale</td>
<td>Improved personal health and well being</td>
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<tr>
<td>Residential</td>
<td>Mental Health</td>
<td>Autonomy and social reintegration</td>
<td>I1, I2</td>
<td>Responsive social action in mental health</td>
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<td></td>
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<td>Sheltered accommodation and community support</td>
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<tr>
<td>Sante</td>
<td>Public Health</td>
<td>Self esteem/ improving personal health</td>
<td>I2, I3</td>
<td>Community determines solutions to public health problems</td>
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<tr>
<td>Communitaires</td>
<td></td>
<td>Using acting to develop self confidence/ explore local health issues</td>
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<tr>
<td>Seclin</td>
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<td>Improve personal health and well being</td>
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<tr>
<td>Somerset Pain</td>
<td>People with long term health problems/ Pain</td>
<td>Improving skills in managing own health</td>
<td>I2</td>
<td>Using internet and an ‘on-line’ community to improve self confidence in managing health</td>
<td></td>
</tr>
<tr>
<td>management</td>
<td></td>
<td>Internet web facility to provide information and develop self help communities</td>
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<tr>
<td>Service and Know Your Own Health</td>
<td></td>
<td>H2, H3, S1</td>
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<tr>
<td>VITALITY –  Changing focus for old age</td>
<td>Older people</td>
<td>Improving independence</td>
<td>I1, I2</td>
<td>Using care staff to reduce dependency</td>
<td></td>
</tr>
</tbody>
</table>
5.2 Case studies

See Annex after page 46

References


This report is a product of the INNOSERV project (grant agreement nr. 290542) which is funded by the European Union under the 7th Framework Programme.
Theoretically informed case study accompanying the film
Ammerudhjemmet - Norway

Author:
Diakonhjemmet
Olav Angell, Hilde Thygesen

WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/ammerudhjemmet

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a European-wide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Ammerudhjemmet: The innovation focus on such service users who are not able to live autonomous in their homes.

Specific innovative elements of Ammerudhjemmet

**Network approach**
Integrated approach to network analysis and integration for the service users. Aim: Connection of users (residents and their networks to the community).

**Community based Meeting place**
Social service provider: open and embedded element of community and neighbourhood.

**Cultural turn in long term care**
Long term care turns from a medical approach to a cultural approach.

**Key characteristics of the service**

**Organisation:**
Ammerudhjemmet (owned by the Church City Mission, Oslo) is a nursing home and a local community cultural centre at the same time. It is a private non Profit organization, offering a total of 102 Beds and in addition 27 places for day care patients.

**Principle:**
The main ideology is to create and keep up an ‘open nursing home model’ in order to avoid a separation of users from community (‘ghettoisation’). Ammerudhjemmet is a special nursing home, in which inpatient & short term care is offered to people in need.

**User groups:**
User groups are elderly people (average age is app. 67 years) who need care and some of them are sick as well (for example, 80% suffer from dementia). The project is also open to people from the community. This way, the elderly are not separated but part of the society and able to participate.

**Driver(s):**
The reason for this innovative project is the insufficiency and the unfulfilled social and cultural needs of elderly people living in nursing homes.
Factors influencing Social Services Innovation Ammerudjhemmet

Drivers and challenges
Demand side: (drivers) Individual and collective needs in a newly established part of town; (challenges) Nursing homes are usually fairly closed systems; residents socially and culturally isolated/excluded; Supply side: Values, ideology and resources of owner organisation;

Agents of change
The owner organisation (Church City Mission) established a café, which became an important link to and resource for the surrounding community; serviced the community establishing facilities lacking elsewhere: chapel, health clinic, senior's space for radio and TV broadcasting, swimming pool etc.

Novelty
Network approach; Community based meeting place; Cultural turn in long term care

Sustainability
Sustained public funding + Flexibility: ability of Ammerudjhemmet and owner organisation to respond flexibly to shifting demands of users and surrounding community

Response
Quality
Contribute to users' quality of life through the integration of the institution in the surrounding community (open borders) and to the well-being of the community as a cultural centre (meeting place)
### 2. Policy Framework related to long term care in Norway

<table>
<thead>
<tr>
<th>Principles / Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Decentralization from county and state to municipal level:</td>
<td>- Legal Foundation for a comprehensive service offer at local level to entire the population of the municipality municipal authorities from national county administration levels have the responsibilities (cf. HOD 2007:7-9)</td>
<td>Legal milestones:</td>
<td>1. Costs involved in the nursing and care sector (% of the GDP): 3.1% = 2005 3.8% = 2025 6.1% = 2050 (cf. HOD 2007:10)</td>
</tr>
<tr>
<td>2. Integration from special care to joint solutions:</td>
<td>- All Inhabitants shall have the same access to services, independent of social status, income and location. The organisational structure has three levels: the central state, the regional health care enterprise/county and the municipality (cf. Angell 2008:109).</td>
<td>- Act of municipal health services, -nursing home reform -reform for persons with intellectual disabilities</td>
<td>- The municipal health service is financed through a combination of grants from the local government, retrospective reimbursement by the National Insurance Scheme (NIS) for out-of-pocket payments by the patients and services supplied (cf. Angell 2008:109).</td>
</tr>
<tr>
<td></td>
<td>- The provision of health services has traditionally been in the hands of the public sector in Norway (cf. Angell 2008:110).</td>
<td>- Care of the disabled, mentally disabled, and care of the elderly are covered by the local level by municipalities (cf. Angell 2008:104).</td>
<td>- The NIS is financed by contributions from employer taxes (40%), National Insurance contributions from employees, pensioners (about 30%), the state (about 30%) (cf. Angell 2008:109).</td>
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<tr>
<td></td>
<td>- Some nursing homes and day care centres are managed by voluntary organisations, including church parishes and other church-based organisations, but funded by the municipalities (Angell 2008:112-113, cf. Szbehely 2005). Over the years a larger share of health care services has been entrusted to non-profit/for-profit organisations. The new competitive regime (consequence of New Public Management ideas in the public sector) has had the (unintended) consequence that voluntary organisations have lost to private for-profit organisations. To strengthen the voluntary sector’s position in the welfare services markets the government has recently signed an agreement with representatives of the voluntary sector and the municipalities to improve the position of the voluntary sector against for-profit organisations in the health and social services market (Regjeringen et al. 2012).</td>
<td>- Some nursing homes and day care centres are managed by voluntary organisations, including church parishes and other church-based organisations, but funded by the municipalities (Angell 2008:112-113, cf. Szbehely 2005). Over the years a larger share of health care services has been entrusted to non-profit/for-profit organisations. The new competitive regime (consequence of New Public Management ideas in the public sector) has had the (unintended) consequence that voluntary organisations have lost to private for-profit organisations. To strengthen the voluntary sector’s position in the welfare services markets the government has recently signed an agreement with representatives of the voluntary sector and the municipalities to improve the position of the voluntary sector against for-profit organisations in the health and social services market (Regjeringen et al. 2012).</td>
<td>- State grants and contribution rates are determined by the parliament (cf. Angell 2008:109).</td>
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<tr>
<td></td>
<td>- The family is the basic unit in the provision of care. The family is still very important as a social support system, but the government and the municipalities have taken over the responsibility for the care of the elderly and children to a great extent (Angell 2008:114). During the past two decades there is a tendency that next of kin must take over more of the responsibility for the care of the elderly (Szbehely 2005).</td>
<td>- The municipalities provide the social services. The personnel working in the sector are directly employed by the municipality (cf. Angell 2008:112).</td>
<td>The expansion for providing health and social care services has not reduced the amount of care, in terms of time, provided by families (cf. Angell 2008:111). Volunteers play a role in care not least in informal services, like visiting and practical services organised by voluntary organisations and voluntary service centres (Lorentzen 2010). Private funds play little role in funding care services.</td>
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3. The social, political and institutional context

3.1 Population/ Government

<table>
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<tbody>
<tr>
<td>Total Population in person:</td>
<td>4858199</td>
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<tr>
<td>Population projections 2010-2050</td>
<td>6365895</td>
</tr>
<tr>
<td>Proportion of population aged 65-79 years:</td>
<td>10.3 %</td>
</tr>
<tr>
<td>Proportion of population aged 80 years and more:</td>
<td>4.5 %</td>
</tr>
<tr>
<td>Proportion of population aged 65 and over:</td>
<td>14.9 %</td>
</tr>
<tr>
<td>Old-age-dependency ratio: (15-64 to 65+)</td>
<td>22.5 %</td>
</tr>
<tr>
<td>Projected old-age dependency ratio 2010-2050</td>
<td>40.29%</td>
</tr>
</tbody>
</table>

| Life expectancy at 60 (2009) in years | Males: | 22 years | 21.1 years |
|                                         | Females: | 25.4 years | 25.1 years |

| Expenditure on social protection (% of GDP) 2009 | 26.41% | 29.51% |
| Expenditure on care for elderly (% of GDP) 2008 | 1.61% | 0.41% |
| Pension expenditure projections (% of GDP) 2050 | 13.3% | 12.3% |

3.2 Information about the specific welfare state: Norway

There is a steady increase of expenditure in benefits in kind of social protection benefits (including social services), that shows the growing meaning in comparison to social protection benefit in cash. The table below presents the social protection expenditure of selected countries.

Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>/</td>
<td>3.605.678,95</td>
<td>/</td>
</tr>
<tr>
<td>2010</td>
<td>3.605.678,95</td>
<td>/</td>
<td>34,07%</td>
</tr>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3.605.678,95</td>
<td>/</td>
</tr>
<tr>
<td>Norway</td>
<td>32512,53</td>
<td>80833,67</td>
<td>152,74%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>262.859,71</td>
<td>478.281,18</td>
<td>124,56%</td>
</tr>
<tr>
<td>Germany</td>
<td>565.683,07</td>
<td>765.717,82</td>
<td>52,53%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

4. Challenges and Drivers of Innovation

Structural weaknesses of the system:

- High percentage of personnel with no health and social care qualifications, low personnel with university college qualifications, high sickness absence levels
- More emphasis on adapted services with a multidisciplinary approach and a key focus on the interaction with the individual user
- Weaknesses in the health service offer, the medical follow-up of long term care service users, patients in nursing homes, users of the home care services and community care housing residents
**Innovation**: Ideas, criteria, levels and added values

The need for nursing and care services in Norway is expected to increase. Reason for this is the age structure of the population, especially the number of elderly people over the age of 80 years (cf. Angell 2008:113).

The basic principle of care for the disabled and the elderly people in Norway is that individualised support and services should be arranged in ways that enable care in people’s home communities. Most of the municipalities (80%) now provide home care services 24 hours a day. Persons with disabilities and the elderly should have the opportunity to live in their own home for as long as possible (cf. Angell 2008:112).

The visualized case focus on three core Innovation ideas in social services. The innovations focus on such service users who are not able to live autonomous in their homes.

Ammerudhjemmet’s vision is the idea that learning and development are for all people throughout their lives. Although life opportunities are limited, all aspects of life are present as long as one lives. That means that everyone should have a chance at a full life on their own premises, not least socially and culturally.

**Network approach:**

A core element of the highlighted service is the integrated approach to network analysis and integration for the service users. The aim is to connect the users, who are living in the project and their networks to the community.

**Community based meeting place:**

The second innovation represents a social service provider as an open and embedded element of community and neighbourhood. On a daily basis nursing homes tend to be socially and culturally isolated, excluded from the “vibrant life” of the community where the nursing home is located because of age-related frailties. Social and cultural interaction with the surrounding community is most often restricted to special occasions, with predominantly unilateral relationships: arrangements are primarily meant for the residents, and the events are organised as a visit to the institution. What Ammerudhjemmet aims at, is for the institution to be a resource to the community so that exchanges between the institution and its environment take place with a higher degree of mutuality (relationships marked by mutual resource dependency), be it children in the neighbouring kindergarten and school, youth, adults and elderly people who need a meeting place. In practice it means, for instance, that the reception floor is open, community space with a café and shops for personal services, and space for cultural events in the community. In practice it also means people living alone, especially elderly people, who regularly visit Ammerudhjemmet for such reasons, may be attended (worried about) if they “disappear”; staff take on network functions for people in the community. In this way the nursing home and its residents become more “naturally” integrated in the community than is usually the case.

**Cultural turn in long term care:**

The principle in long term care turns from a medical approach to also including a cultural approach. Meeting and fulfilment of general human needs are understood as including meeting and supporting the cultural needs and wishes of everyday life of users and community.
Agents of Change
Need for nursing and care services in Norway expected to increase because of the age structure of the population, especially the number of elderly people over the age of 80 years (cf. Angell 2008:113).
The owner organization (Church City Mission) established a café, which became an important link to and resource for the surrounding community; serviced the community establishing facilities lacking elsewhere: chapel, health clinic for babies, space for radio and TV broadcasting; swimming pool etc.

5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Heath and Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>1970</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Private non profit organization</td>
</tr>
<tr>
<td>Financing</td>
<td>Activities are to a great extend run by volunteers. Funded through private donations</td>
</tr>
<tr>
<td>Size of organization</td>
<td>More than 200 employer: nurses, one doctor, one priest, one cultural leader, 75 volunteers (80-90 years old), cooks, cleaning staff, one self-employed hairdresser, who is also a foot therapist and one volunteer coordinator 102 Beds, 27 places for day care patients, open, community space with a café and shops for personal services, and space for cultural events</td>
</tr>
<tr>
<td>Members and participation</td>
<td>Volunteers, close cooperation with the labor market business, community, hairdresser, café, library, swimming pool and pedicure</td>
</tr>
<tr>
<td>Contact</td>
<td></td>
</tr>
</tbody>
</table>
Name of the innovative example  | Homepage |
| | http://www.bymisjon.no/no/Virksomheter/Ammerudhemmet-Bo--og-Kultursenter/Hvem-e... |
| Organization | Kirkens Bymisjon, Tollbugata 3, 0152 Oslo |
| Address | Ammerudveien 45, 0958 Oslo |
| Contact person | Øyvind Jørgensen |
| Phone | (+47)23335323 |
| Email | firmapost.ammerudhjemmel@bymisjon.no |
6. References


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Theoretically informed case study accompanying the film

Abitare Solidale - Inter- and intra- generational cohabitation – Italy

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QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/abitare-solidale

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a europeanwide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Abitare Solidale

Abitare Solidale is a project carried out by AUSER together with the municipality of Florence and three small towns in the province of Florence, the association ARTEMISIA and other associations. The project supports inter- and intra-generational cohabitation as an integrated solution to tackle different kinds of social problems. Abitare Solidale offers an innovative and sustainable solution to self-sufficient older people in need of help for household maintenance and household keeping, to persons experiencing economic difficulties who are in need of an affordable and decent accommodation as well as to women who are victims of domestic violence and in need of a temporary shelter.

Specific innovative elements of Abitare Solidale

New form of service:
The project promotes the idea of cohabitation as a new form of service, providing an integrated response to different kinds of problems and needs and overcoming classical sectoral boundaries in social services.

Governance:
The service is provided by an innovative form of broad and integrated partnership involving public authorities, private actors (architects, artisans), volunteering organizations and paid staff (social workers, consultants, psychologists, legal advisor).

Resourcing:
The project is financed by reciprocity resources (private and public resources to retrofit the apartments; public workers and volunteers working together to involve people in the project, support and monitor the cohabitation).

Sustainability
The project is highly sustainable because it implies the optimisation of the existing housing stock and it promotes social and urban mix.

Key characteristics of the service

User groups
- Older people living in apartments, which are too big or not adapted to their needs, who risk to lose their self-sufficiency and to be isolated from society.
- Older people’s relatives in need of new care solutions more adapted to their needs and their life style.
- Disadvantaged people at risk of poverty and in need of decent and affordable housing. These are mostly represented by families of migrants, unemployed people and students.
- Women who are victim of domestic violence in need of a temporary shelter to start a new life.

Driver(s)
The province of Florence is characterised by:
- demographic change: older people mostly living alone in houses that are too large for their needs,
- continued inequality: population at risk of poverty and new forms of social exclusion: unemployed people, divorced parents, women victims of violence, precarious workers.
Factors influencing Social Services Innovation

Agents of change
- analysis of social situation in
  Florence
- realisation: need to overcome
  traditional policy approach
- test new forms of interventions
- offering integrated solutions
- different kinds of social needs

Drivers
- demographic changes
- continued inequalities/selection.

Challenges:
- increasing most diversified
demand
- tries to overcome
  traditional sectoral boundaries
- Unmet needs
- offer integrated
  responses

Response

Novelty
- promotion of cohabitation
  new form of service
- providing integrated
  responses to different
  problems & needs

Sustainability
- efficient use of available
  resources
- innovative partnership
  optimization
- use of existing housing
  stock

Quality
- tailored support
- creation of social & human relations
- empowerment of users
- social cohesion
- active inclusion
2. Policy Framework related to social services for older people and disadvantaged groups in Italy

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decentralisation of social services</td>
<td>State (providing basically cash benefits to disadvantaged groups and pensions for older people).</td>
<td>National level (the State) provides basically cash benefits directly to individuals (e.g. “Indennità di accompagnamento” to older people and disabled adults and family benefits based on family size and income (e.g. If a family member is disabled, the family will receive an increase in the allowance).</td>
<td>The ‘Fondo Nazionale per le politiche sociali’ (national found for social policies) is provided by the state to guarantee additional resources to local authorities to implement their social programmes in support of families, older people, disabled people, disadvantaged groups. In the last year it has been drastically reduced.</td>
</tr>
<tr>
<td>Fragmentation institutional context</td>
<td>Local authorities (Regions and Municipalities implementing programmes and providing services) Family (elderly care is still, in many ways, a responsibility of the family) Private carers (most often immigrant care givers operating in the black or grey market).</td>
<td>Local authorities are responsible for the joint programming of activities and services in the domain of social services and social protection. Italy depends heavily on the local communities to provide social services to older people, disabled, and needy families. Local authorities can also provide services to schools such as assistance with the supply of food and transportation.</td>
<td>In recent years, there has been an increasing spending on social assistance managed by the municipalities in relation to GDP, from 0.39 in 2003 to 0.46 in 2009. At the regional level, large differences, with the cost of benefits per capita higher in northern regions, as shown in the graph below. Expenditure for social services offered by municipalities in Italian regions (Euro/inhabitant).</td>
</tr>
<tr>
<td>Family-based welfare system</td>
<td>3rd sector (strong tradition of not-for-profit and volunteering associations proving support and assistance services to older people, other disadvantaged groups and their families).</td>
<td>3rd sector Services provided by NGOs and volunteering associations to older persons and other disadvantaged groups such as: training, counselling, psychological support, empowerment, employment integration.</td>
<td></td>
</tr>
</tbody>
</table>

### Expenditure Table

<table>
<thead>
<tr>
<th>Regions</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trento</td>
<td>294,7</td>
</tr>
<tr>
<td>V. d'Aosta/V. d'Aoste</td>
<td>269,3</td>
</tr>
<tr>
<td>Bolzano/Bozen</td>
<td>228,4</td>
</tr>
<tr>
<td>Friuli-Venezia Giulia</td>
<td>215,1</td>
</tr>
<tr>
<td>Sardegna</td>
<td>199,1</td>
</tr>
<tr>
<td>Emilia-Romagna</td>
<td>174,6</td>
</tr>
<tr>
<td>Piemonte</td>
<td>148,6</td>
</tr>
<tr>
<td>Lazio</td>
<td>140,5</td>
</tr>
<tr>
<td>Liguria</td>
<td>139,5</td>
</tr>
<tr>
<td>Toscana</td>
<td>136,9</td>
</tr>
<tr>
<td>Lombardia</td>
<td>123,5</td>
</tr>
<tr>
<td>Veneto</td>
<td>113,8</td>
</tr>
<tr>
<td>Marche</td>
<td>107,2</td>
</tr>
<tr>
<td>Umbria</td>
<td>95,4</td>
</tr>
<tr>
<td>Sicilia</td>
<td>77,0</td>
</tr>
<tr>
<td>Basilicata</td>
<td>63,0</td>
</tr>
<tr>
<td>Abruzzo</td>
<td>62,3</td>
</tr>
<tr>
<td>Puglia</td>
<td>54,7</td>
</tr>
<tr>
<td>Campania</td>
<td>53,9</td>
</tr>
<tr>
<td>Molise</td>
<td>35,9</td>
</tr>
<tr>
<td>Calabria</td>
<td>25,5</td>
</tr>
<tr>
<td>Italia</td>
<td>115,9</td>
</tr>
</tbody>
</table>

Source: ISTAT

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2 http://noi-italia.istat.it/index.php?id=7&user_100ind_p1[id_pagina]=108&cHash=c213451c48240f19597ee562ae552814
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th>Year</th>
<th>Italy</th>
<th>EU27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>2011: 60626442</td>
<td>502404702</td>
</tr>
<tr>
<td>Population projections 2010-2050</td>
<td>2011: 65915103</td>
<td>524052690</td>
</tr>
<tr>
<td>Proportion of population aged 65-79 years:</td>
<td>2011: 14.3</td>
<td>12.7</td>
</tr>
<tr>
<td>Proportion of population aged 80 years and more:</td>
<td>2011: 6.0</td>
<td>4.8</td>
</tr>
<tr>
<td>Old-age-dependency ratio (15-64 to 65+)(^3)</td>
<td>2011: 30.9</td>
<td>26.2</td>
</tr>
<tr>
<td>Expenditure on social protection (% of GDP)</td>
<td>2010: 29.875540</td>
<td>29.366166</td>
</tr>
<tr>
<td>Expenditure on care for elderly (% of GDP)</td>
<td>2008: 0.14</td>
<td>0.41</td>
</tr>
<tr>
<td>Pension expenditure projections (% of GDP) 2050</td>
<td>2009: 14.7%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Population at risk of poverty or exclusion (%)</td>
<td>2009: 24.7%</td>
<td>23.1%</td>
</tr>
<tr>
<td>Population with severe housing deprivation (%)</td>
<td>2009: 7.3%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

3.2 Information about the specific Welfare State: Italy

**Social policies for self-sufficient and non self-sufficient older people in Italy**

The Italian social welfare system is family-based and this value is embedded in the culture. The state is responsible for providing mainly cash benefits, such as the ‘*indennità di accompagnamento*’, which is provided directly to adults with disabilities meeting given law criteria\(^4\). However, this measure was not originally designed to respond to care needs of older people but mainly as form of individual support to people with disabilities. Afterwards, it can hardly be framed as an intended long-term care policy though it represents the most significant form of support for older people.

Traditionally, members of the family (in particularly women) take care of the needs of dependent and/or self-sufficient older relatives. This is understood as a moral value. However, increased life expectancy in Italy, changing social rules and family structures, and women’s increased engagement in labour market make the practice of familial reciprocity difficult. Most of the time, this problem is solved thanks to the availability of immigrant caregivers (the so called ‘*badanti*’), mostly operating in black or grey market and representing a cheap alternative to institutionalisation. Other actors, such as volunteering associations and civil society can have an important role if integrated in policies and activities run at local level.

**Social policies for disadvantaged groups in Italy**

In recent years, the welfare and social protection systems are strongly challenged by the increase and diversification of demand as well as by the decrease of available resources. The combination of these elements makes the traditional policy approaches inadequate, as they are too “sectorial” and not flexible. The weakness of the classical responses is represented by the following elements:

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\(^3\) This indicator is the ratio between the total number of elderly persons of an age when they are generally economically inactive (aged 65 and over) and the number of persons of working age (from 15 to 64). Source: EUROSTAT.

• Inappropriate housing policies
• Inappropriate home care services provided at institutional level
• Inappropriate social policies to protect unemployed people and other disadvantaged groups from poverty

There is a steady increase of expenditure in benefits in kind of social protection benefits (including social services), that shows the growing meaning in comparison to social protection benefit in cash. The table below presents the social protection expenditure of selected countries.

**Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro**

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1996</td>
</tr>
<tr>
<td>1996</td>
<td></td>
<td></td>
<td>/</td>
</tr>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3,605,678,95</td>
<td>/</td>
</tr>
<tr>
<td>Italy</td>
<td>241,249,28</td>
<td>463,992,0</td>
<td>127,52%</td>
</tr>
<tr>
<td>Germany</td>
<td>565,683,07</td>
<td>765,717,82</td>
<td>52,53%</td>
</tr>
<tr>
<td>Belgium</td>
<td>60592,78</td>
<td>106492,16</td>
<td>110,88%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

4. Challenges and Drivers of Innovation

**Drivers and Challenges**

The results of analysis of the social situation made by AUSER in the province of Florence contributes to test new forms of interventions offering integrated solutions to different kinds of social needs. The project represents a solution for both of these target groups: they can have free housing, in exchange for support. It is like giving them a chance to have the basic right of decent and affordable accommodation to be able to exercise other rights through an active participation in society (aspiration). Leaving up to the cohabitants the right to decide the conditions of cohabitation, the project did not only provide answers to current problems, but it also built the basis for a relationship of mutual assumption that, with the help of volunteers and professionals, is becoming more mature and sustainable (economically and socially).

**Demographic changes**

- The project represents a solution to cope with the problem of isolation and social exclusion of older persons;
- It allows older people to stay longer in their homes improving their active participation in society;
- The project improves older people’s independent living and self-determination;

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5 Hawker, C. and Frankland, J. (2012) Theoretical trends and criteria for ‘innovative service practices’ in social services within the EU. INNOSERV Work Package 2 report
• It represents a solution to the decreasing availability of informal care givers (women, family networks);
• It represents an alternative to retirement houses, which are not sustainable in a long-term perspective for structural and environmental reasons.

Continued inequality
• The project helps people in need to find an affordable and decent accommodation allowing them to actively participate in society;
• The project offers an innovative solution to new causes of poverty and social exclusion: precarious jobs, migration, people not entitled to public protection schemes and/or to public care services;
• Through the idea of mutual aid, the project represents an alternative to isolation and stigmatisation of people facing economical or personal difficulties.

Aspirations
• The project improves the independent living and self-determination of older people, allowing them to stay longer in their homes and to participate in a mutual aid activity based on the idea of solidarity between generations.

Structural weaknesses of the system:
Inadequate housing policies and insufficient social policies to support young adults, families of migrants, young mothers and unemployed people. This implies the need to provide integrated services and to overcome sectorial boundaries.

Innovation: Ideas, criteria, levels and added values
The following innovative aspects have been identified in the selected project

• New form of service: The project promotes the idea of cohabitation as a new form of service providing an integrated response to different kinds of problems and needs and overcoming classical sectoral boundaries in social services.
• Governance: The service is provided by an innovative form of broad and integrated partnership involving public authorities, private actors (architects, artisans), volunteering organisations and paid staff (social workers, consultants, psychologists, legal advisor).
• Resourcing: The project is financed by reciprocity resources (private and public resources to retrofit the apartments; public workers and volunteers working together to involve people in the project, support and monitor the cohabitation).

Governance
The service is provided by an innovative form of broad and integrated partnership involving public authorities, private actors (architects, artisans), volunteering organisations and paid staff (social workers, consultants, psychologists, legal advisor).
Resourcing
The project is financed by reciprocity resources (agreement with the Municipality of Florence, protocol agreement with the Municipalities of Bagno a Ripoli, Scandicci, Sesto Fiorentino, Cascina; private and public resources to retrofit the apartments; public workers and volunteers working together to involve people in the project, support and monitor the cohabitation).

Sustainability
The project is highly sustainable because it implies the optimisation of the existing housing stock and it promotes social and urban mix.

Principle and other innovative aspects:

The project is based on the idea of mutual aid and it represents:
- an alternative solution to retirement houses for older people;
- an affordable and decent housing solution for persons at risk of poverty and exclusion or experiencing economic difficulties (families of migrants, students, unemployed persons);
- a shelter for women who are victims of domestic violence.
- It involves various and different target groups and stakeholders;
- It provides the use of legal tools that have been created to legally formalize the cohabitation (the Housing Covenant, and the Free Use of Property).

Positive externalities of the project are:
- it is environment-friendly: it is based on the optimization of the existing housing stock and it represents an alternative to retirement houses which are not sustainable on a long-term for structural and environmental reasons.
- social inclusion and integration: the project facilitates the creation of interpersonal relationships and promote the value of solidarity between generations as a way to actively participate to society and combat isolation. Moreover, the project shows the added value of volunteering by, and for, older people to active ageing, solidarity between generations and active citizenship.

Agents of Change
The volunteer organisation AUSER is to be considered as the most important agent of change. AUSER carried out an analysis of the social situation in Florence and it turned out that demographic changes and the current socio-economic situation drive the need to overcome traditional policy approaches and to test new forms of interventions offering integrated solutions to different kinds of social needs.

Please see also pag. 9
5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>2009 and 2012 first partnership with local authorities</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Combination of private organization – non/not for profit and volunteer association</td>
</tr>
<tr>
<td>Financing</td>
<td>Reciprocity resources (agreement with the Municipality of Florence, protocol agreement with the Municipalities of Bagno a Ripoli, Scandicci, Sesto Fiorentino, Cascina; private and public resources to retrofit the apartments; public workers and volunteers working together to involve people in the project, support and monitor the cohabitation).</td>
</tr>
</tbody>
</table>
| Size of the organization | Number of staff: 70 (50 volunteers, 1 coordinator and 2 people as AUSER professional staff, 2 psychologists, 1 lawyer, 12 social workers. So far, 59 cohabitations have been realised, including 118 families.  
Number of users: Total number of intervention in 2009: 2,260,804 (an intervention can be offered many times to the same person)  
Number of members (if network): 298,000 (of which 152,000 women)  
Other: Volunteers 45,800 (of which 17,300 women) |
| Members and participation | Broad and integrated partnership involving public authorities, private actors (architects, artisans), volunteering organisations and paid staff (social workers, consultants, psychologists, legal advisor).  
AUSER Association is a member of SOLIDAR, a European network of 59 NGOs active in over 90 countries working to advance social justice in Europe and worldwide. |
| Contacts | www.auser.it  
Contact: abitaresolidaleauser@gmail.com |

AUSER is an Italian association, which aims at promoting the self-management of services and actions for solidarity, supporting the right of older people to continue to play an active role on a social and economic level by making the most of their specific experiences, skills and abilities. The mission of the AUSER Association is to promote older people’s work as volunteers in several areas of activity such as training and education, social utility and international solidarity. On a European level, AUSER Association is a member of SOLIDAR, a European network of 59 NGOs active in over 90 countries working to advance social justice in Europe and worldwide.

Abitare Solidale involves 50 volunteers, 1 coordinator and 2 people as AUSER professional staff, 2 psychologists, 1 lawyer, 12 social workers. So far, 59 cohabitations have been realized, including 118 families.

The following stakeholders are involved in the project:
- AUSER: volunteering association working with older people
- ARTEMISIA: volunteering association working to protect women and children who are victims of violence
- Municipality of Florence, Bagno a Ripoli, Scandicci, Sesto Fiorentino, Cascina
- Housing Agency of the Municipality of Florence (public authority)
- Private architecture offices providing retrofitting services at favorable prices (because of certain agreements with the public authorities) (private actors)
- Confederazione Nazionale dell'Artigianato e della Piccola e Media Impresa (National confederation of artisans and SMEs) offering small repairing services (trade association)

The municipality of Florence presents the following characteristics:
- A large number of older people living alone in houses that are too big for their needs and, as a consequence, in need of support for household maintenance and household keeping;
- A large number of social needs connected (and in some cases derived from) inadequate housing policies (young/unemployed people looking for affordable and decent accommodation, women victim of domestic violence looking for a safe shelter);
- A very well developed network of volunteering organizations and associations used to work together and provide mutual support.
- The willingness of the municipality to work in partnership with the civil society to improve social services.

The following phases can be distinguished in the project:
1) Through the use of its network and its national hotline, AUSER gets in touch with older people living in houses, which do not respond to their needs (too big, not retrofitted) or who are in need of help to administrate housing duties (small reparation, housekeeping) or who wish to start an experience of cohabitation.
   Some other volunteering organizations active at local level get in touch with people experiencing economic difficulties who are in need of affordable and decent housing solutions as well as persons in need of temporary shelter (i.e. women victim of domestic violence).
2) Persons willing to start the cohabitation have preliminary meetings to know each other's and exchange their ideas. A group of experts (psychologist, social workers and volunteers) supports, monitors and evaluates this process.
3) The cohabitants start a “trial period” of cohabitation signing the Housing Covenant (Patto Abitativo), which is a written agreement between cohabitants containing reciprocal commitments.
   The cohabitants share responsibilities on the household maintenance and household errands according to their needs (it is important to underline that the cohabitation does not replace personal and care services but it is based on the idea of mutual aid).
4) The apartment is suited to cohabitation and facilities are retrofitted using public and private funds.
5) The cohabitation is officially recognised using ad hoc legal tool: the Free Use of Property (Comodato d’uso gratuito d’immobile), which is a new legal instrument, elaborated for the purposes of the project and registered with the local public authority, which officially recognizes the cohabitation and guarantees the opportunity to stop living together in the case of a violation of the Covenant Housing.
6. References

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Hawker, C. and Frankland, J. (2012) Theoretical trends and criteria for ‘innovative service practices’ in social services within the EU. INNOSERV Work Package 2 report

ISTAT (2011), Noi Italia. 100 statistiche per capire il Paese in cui viviamo. Available at: http://noi-italia.istat.it/ (Date of Access: 09.03.2013)

Theoretically informed case study accompanying the film
Center for Independent Living of Persons with Disabilities in Serbia
(CIL Serbia)

Author:
Enil
Sanja Nikolin, Jamie Bolling, Gordana Rajkov Mimica Živadinović
WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/cil

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a europeanwide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Center for Independent Living of Persons with Disabilities in Serbia - CIL

Center for Independent Living provides persons with disabilities personal assistance and training for Personal Assistance (PA) service providers from the public, private and non-profit sector. It has evidence on user driven change encompassing legislative, policy, normative and social change, and resulting in an innovative social service of training for PA service. This innovation rests on an active and formalized role for service users and a disabled people’s organization in maintaining service quality and integrity. The service bridges a significant gap between rules on the book and situation in local municipalities in Serbia.

Specific innovative elements of CIL

Operationalizing normative paradigm shift in service provision to persons with disabilities (PWDs):

The main idea is to demonstrate that user involvement in every step of service design, implementation and monitoring is both possible and desirable in Serbia as resource constrained environments dealing with deficiency in human and institutional capacity. CIL mobilizes service users to take on the role of service monitors and build pressure on the government to formalize standards. Therefore, CIL is making the new paradigm possible and real for a growing number of PWDs.

New stakeholder roles

CIL develops local disabled people’s organization (DPO) capacities for local budget process monitoring, familiarizes them with legislative and regulatory framework with regards to local social service provision and strengthens their lobbying and advocacy capacities so that they can effectively win local self-government representatives over for provision of PA service¹. DPOs and PA service users are now much more concerned with ways in which their local self-governments spend public monies and they are more interested in local budget monitoring. In the long run, this will contribute to a broader PA service availability/increased user number, greater need for CIL training and service standards.

New engagement model

CIL’s engagement model steps away from the traditional pyramid, ladder, or funnel model and looks more like a vortex.

Key characteristics of the service

Organization

CIL Serbia is a national cross-disability organization established, governed and managed by persons with disabilities with a staff of 27. CIL was founded in 1996.

Users: Personal assistants and persons with disabilities

User groups: Persons with disabilities, organizations of persons with disabilities and PA service providers from the public, private and non-profit sector.
Number of users: 285 PAs trained and 275 service users trained.
Factors influencing Social Services Innovation

Drivers

Enabling system
Disability paradigm:
- holistic approach
- society recognises potential of individual

Decentralization
Knowledge
Inspiration from IL-movement

Response: CIL

users involvement
- every step of service
New stakeholder roles
Development of local DP organization
- local budget process monitoring
New engagement model:
Away from traditional models

Institutionalised System
Disability paradigm:
- medical approach
- person viewed as defective
- not capable

Structural weakness
- discrepancy
- poor targeting
- no user involvement
- no standards
- no appeal procedure
Funding allocation system as a barrier

Deinstitutionalization strategy with no adequate transition phase

Public sector weakness
Identifying & opening up space for innovation resulting from:
- paradigm shift
- introduction of pluralism
- decentralisation of social service
- the fact that PA service was ind.in law

New stakeholder roles
- fighting essence of system which is
- resistant to change
- arrogant
- centralized

Agents of change
- people w. physical disability
- experienced ILM
- Group leader also PA service
- user
- experienced center for IL in Dublin

PA
Personal assistance and PA service

Independent living movement

Paradigm change
## 2. Policy Framework related for Persons with Disabilities in Serbia

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources²</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Pluralism of service providers: Shift away from the state as sole service provider to pluralism in service provision, albeit with acute desire of state institutions to remain sole providers and with significant gaps in public procurement procedures for services.</td>
<td>Caveats in the system: PA service training is accredited by the Institute for Social Protection but it is not mandatory. Issue of quality of social services that are being provided by non-trained actors. Monitoring of actual service provision is not clearly defined and CIL fills in a gap in this area for 7 municipalities/cities, but a more permanent solution to funding of monitoring activities and full coverage needs to be developed. CIL PA service training program targets the service for persons with physical disability.</td>
<td>Service characteristics 300+ PWDs are members of organizations that completed CIL training. Approximately 100+ PWDs receive services from persons who are not CIL trained service providers and there is no other accredited training provider. Most services are funded from the so called ‘public works’ that are funded for a period of 6 months and then discontinued. CIL-trained organizations lobbied local self-governments in 7 municipalities for a continuing funding support for users.</td>
<td>In 2012, local government units set aside approximately 178,000 Euro for PA service. Central government provided an additional 359,000 Euro through public works. PAs receive approximately 200 Euro net salary (gross monthly salary about 360 Euro) plus monthly local transportation cost. CIL PA training costs are negotiated on a case by case basis and sometimes provided at no cost or with only partial funding. Underdeveloped municipalities should receive block grants from central government if they adopt local social protection strategy and identify service provision as a priority but grants are not available yet. Users of PA service provided by CIL pay participation fee for PA service amounting to 20% of their allowance for help by another person. Allowance ranges from 100 to 200 Euro/ month.</td>
</tr>
<tr>
<td>3. From institution to community-based social services: greater responsibility for local self-governments but without adequate financial and/or human capacity. Welfare system gaps include: Disconnect between policy and practice. Lack of bylaws and procedures and law. Lack of clarity among experts working on Social Service Procedures on whether and how PA service is to be applied to persons with intellectual disabilities.</td>
<td></td>
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</tbody>
</table>

In 2012, local government units set aside approximately 178,000 Euro for PA service. Central government provided an additional 359,000 Euro through public works. PAs receive approximately 200 Euro net salary (gross monthly salary about 360 Euro) plus monthly local transportation cost. CIL PA training costs are negotiated on a case by case basis and sometimes provided at no cost or with only partial funding. Underdeveloped municipalities should receive block grants from central government if they adopt local social protection strategy and identify service provision as a priority but grants are not available yet. Users of PA service provided by CIL pay participation fee for PA service amounting to 20% of their allowance for help by another person. Allowance ranges from 100 to 200 Euro/month.
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th>Table 1 Key statistical data</th>
<th>Serbia</th>
<th>EU27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>7,241,295&lt;sup&gt;15&lt;/sup&gt;</td>
<td>503,824,373&lt;sup&gt;16&lt;/sup&gt;</td>
</tr>
<tr>
<td>GDP per capita in PPS in 2011, EU27 = 100</td>
<td>35&lt;sup&gt;17&lt;/sup&gt;</td>
<td>100</td>
</tr>
<tr>
<td>Estimated proportion of persons with disabilities in total population</td>
<td>15,0 %</td>
<td>15,0%&lt;sup&gt;18&lt;/sup&gt;</td>
</tr>
<tr>
<td>Membership of persons with physical disabilities in DPOs</td>
<td>6,000</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of PA service users</td>
<td>400+&lt;sup&gt;19&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>National government spending on social services</td>
<td>Data unavailable&lt;sup&gt;20&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>Local government spending on PA service in 2012</td>
<td>19,800,000 RSD</td>
<td>N/A</td>
</tr>
</tbody>
</table>

3.2 Information about the specific welfare state: Service Orientation Serbia

Serbia’s welfare services infrastructure targeting persons with disabilities evolved around medical approach to disability and with institution as the welfare solution within a socialist state-as-the-service-provider. Over the past 12 years, the country’s legislation gradually shifted to social model of disability. Unfortunately, a requisite shift in funding for and management of social services has not followed suit, or not at the same pace. In 2005, CIL demonstrated that benefits of PA service outweighed costs in an Analysis of Investing In the Organization of Personal Assistant Service Network for Persons with Disabilities in Serbia<sup>21</sup>

Today, social care institutions are eroded and scheduled for closure due to policy emphasis on deinstitutionalization<sup>22</sup>, without real alternatives on offer on the ground for persons with disabilities<sup>23</sup>. The majority of PWDs, however, live at home and rely on family support and assistance. Without access to support services, including PA, even the socially and professionally active persons with disabilities remain dependent on their kin, out of the labour market and - more often than not - in poverty.

In addition to institutional care and allowance for help by another person, the following social services are available to PWDs in Serbia: personal assistance service only in 7 out of 168 municipalities, supported housing, home help, day care centres, respite care and SOS hotline for victims of domestic violence against persons with disabilities<sup>24</sup>.

Table 2 presents CIL target groups for personal assistance service provider training in relation to the full universe in Serbia

<table>
<thead>
<tr>
<th>Target groups</th>
<th>Total trained by CIL by Dec 2012</th>
<th>Total in Serbia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with disabilities</td>
<td>300</td>
<td>6,000&lt;sup&gt;25&lt;/sup&gt;</td>
</tr>
<tr>
<td>Organizations of persons with disabilities</td>
<td>60</td>
<td>Approximately 500&lt;sup&gt;26&lt;/sup&gt;</td>
</tr>
<tr>
<td>PA service providers from the public, private and non-profit sector</td>
<td>10 local self-governments 9 NGOs service-providers&lt;sup&gt;27&lt;/sup&gt;</td>
<td>168 500 disabled people’s organizations X companies providing social services&lt;sup&gt;28&lt;/sup&gt; (number not available)</td>
</tr>
</tbody>
</table>
For a new social service to be launched, a social institution or another service provider organization must obtain license from the Ministry of Labor and Social Policy. Local self-governments wanting to procure a new social service need to launch a public tender for eligible licensed service providers. Once service providers are selected, service users apply with Center for Social Welfare for joint assessment of needs and status. If it is determined in the assessment that a person is eligible for PA service, then s/he is free to choose from available licensed service providers. Criteria are prescribed by the Minister of Labor, Employment and Social Policy. For a new service, potential service users can raise their claim with the local self-government and, pending a favorable funding decision, the tender procedure can be launched – once bylaws are in place.

The goals of Serbia’s new social service orientation are:
- Continuum of service provision
- Community-based services as a priority
- User able to select a service and service provider
- User participates in service design and service delivery
- User as partner in service delivery

A social welfare system that enables users to satisfy various needs

CIL PA service provider training is instrumental to the development of the following relationships:
- licensed service provider organization and service user
- licensed service provider organization and personal assistant
- service user and personal assistant

According to the Ministry of Labor, Employment and Social Policy official, CIL training design is an early bird, a champion of change that sets a path for standardization leading to accreditation of other types of training, assistance and support programs. The training clarifies PA scope of work through two specific groups of tasks: assistance in everyday operation and assistance in performing formal and professional duties. At the level of educational tools and methodologies, the Program contains a variety of interactive, multimedia and multi-technical tools, including interactive presentations, guided discussions, demonstrations, simulations and role plays, film and video materials, stories with illustrations and other tools. The program is relevant, comprehensive, innovative, coherent and of a high quality standard. The CIL training program was accredited by the National Institute for Social Protection in February 2011.

There is a steadily increase of expenditure in benefits in kind of social protection benefits (including social services), that shows the growing meaning in comparison to social protection benefit in cash. The table below presents the social protection expenditure of selected countries.
4. Challenges and Drivers of Innovation

Structural weaknesses of the system
- Discrepancy between entitlements *de jure* and *de facto* situation on the ground
- Poor targeting and fragmented entitlements that are not individualized
- No user involvement, no effective monitoring system in place and no feedback loop
- No standards of service provision
- No appeal procedure

Innovation: Ideas, criteria, levels and added values
The innovation focuses on public sector weaknesses as opportunities. It identifies and opens up space for service innovation that resulted from: a) paradigm shift; b) introduction of pluralism of service providers; c) decentralisation of social services; and d) a fact that PA service was included in the law as a social service option. CIL managed to connect the dots and fill in for public sector capacity gaps. CIL - PA training and follow up work further make up for lack of adequate guidance and/or monitoring systems.

*Operationalizing normative paradigm shift in service provision to PWDs:*
The main idea is to demonstrate that user involvement in every step of service design, implementation and monitoring is both possible and desirable in Serbia as resource constrained environments dealing with deficiency in human and institutional capacity.

It has been noted above that a normative shift away from medical to social approach to disability is poorly implemented due to a very real gap in capacities, lack of service standards and inexistence of a monitoring function. Accredited CIL training is currently the only quality assurance mechanism available for PA service provision. It is aligned with global disability movement standards for PA service and they guide service users and providers through the process to ensure at least minimum service quality. By involving persons with disabilities in training provision and training participation, CIL mobilizes service users to take on the role of service monitors and build pressure on the government to formalize standards. Therefore, CIL is making the new paradigm possible and real for a growing number of PWDs.
The complexity of a paradigm shift in the context of South East Europe is presented in graph 1. Below:

**Graph 1. Shifting the disability paradigm**

<table>
<thead>
<tr>
<th>Institutionalised system</th>
<th>Enabling system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disability paradigm</strong></td>
<td></td>
</tr>
<tr>
<td>• A medical approach</td>
<td></td>
</tr>
<tr>
<td>• The person is viewed as defective and not capable</td>
<td></td>
</tr>
<tr>
<td><strong>Care system</strong></td>
<td></td>
</tr>
<tr>
<td>• Aim = cure protection</td>
<td></td>
</tr>
<tr>
<td>• Services and life-cycle controlled by institutions and experts</td>
<td></td>
</tr>
<tr>
<td>• A system based on a division of beneficiaries into rigid categories</td>
<td></td>
</tr>
<tr>
<td>• Services delivered mainly in special institutions by specialists in disability</td>
<td></td>
</tr>
<tr>
<td>• A rigid system</td>
<td></td>
</tr>
<tr>
<td>• People with disabilities and their representatives are not involved in the planning and evaluation of services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shifting the paradigm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability paradigm</td>
</tr>
<tr>
<td>• A holistic approach</td>
</tr>
<tr>
<td>• Society recognises the potential of all individuals</td>
</tr>
<tr>
<td>System of support services</td>
</tr>
<tr>
<td>• Aim = social participation</td>
</tr>
<tr>
<td>• People have the right to choose services and control their lives</td>
</tr>
<tr>
<td>• A system based on diversity and the right to be different</td>
</tr>
<tr>
<td>• Services mainstreamed within ordinary services at community level</td>
</tr>
<tr>
<td>• A flexible and adaptive system</td>
</tr>
<tr>
<td>• People with disabilities and their representatives are a part of the planning and evaluation of services</td>
</tr>
</tbody>
</table>

**New stakeholder roles**
User involvement in design, implementation and monitoring of service is already a ground-breaking innovation for Western Balkans. It tackles the very essence of a system that is resistant to change, arrogant and centralized. This empowering process builds capacities of PWDs and bonds them together in a strong network that is increasingly perceived - and treated - as a partner by the state.

Beyond the direct service users, CIL mobilizes their associations across Serbia for advocacy on decentralized funding for PA service and for inclusion of CIL-trained DPOs as quality PA service providers. On a practical level, this means that CIL develops local DP organization capacities for local budget process monitoring, familiarizes them with legislative and regulatory framework with regards to local social service provision and strengthens their lobbying and advocacy capacities so that they can effectively win local self-government representatives over for provision of PA service.

Social policy experts and academics are no longer unquestionably driving prioritization of social services to PWDs. Instead, they are getting used to a new role of supporters, often helping behind the scenes, whereas strategic decisions remain with the independent living movement in Serbia, led by CIL. These changed roles and relationships contribute to a new form of governance. DPOs and PA service users are now much more concerned with ways in which their local self-governments spend public monies and they are more interested in local budget monitoring. In the long run, this will contribute to a broader PA service availability/increased user number, greater need for CIL training and service standards.

**New engagement model**
Since "personal assistance", key to independent living, means the user is boss, user-led approach to training and outreach effectively pushes the quality assurance enve-
lope. Key to this approach is CIL’s ‘never let go’ engagement model. Once mobilized stakeholders are effectively employed in further advocacy to close capacity gaps.

CIL’s “engagement model steps away from the traditional pyramid, ladder, or funnel model and looks more like a vortex” described by Julie Dixon and Denis Keyes.34 “At the center of the vortex is the individual. Her/his depth of commitment to the organization is represented by the size of the continuous field around the center. As the person’s commitment deepens, the vortex expands outward. The vortex can be strengthened - and expanded - by the influence of others, but as it grows it also becomes a greater source of influence on others.”35 The graph below is an adaptation from the Dixon & Keyes article, with broader emphasis on stakeholders rather than a focus on donor.

Drivers and Challenges

Direct personal experience in independent living
A small group of People with physical disabilities in Serbia experienced the independent living movement and lived personal assistance service. The group leader actually spent some time in Ireland in early 1990ies where she experienced PA service and took part in Center for Independent Living, Dublin advocacy for mainstreaming of the service.

Decentralization
Way in which statutory responsibilities are changing as a consequence of broader political and socio-economic reforms in Serbia, and specifically the decentralization of the welfare system.

Knowledge
Accumulation of knowledge, capacity and lived experience contributed to changing social roles by increasing CIL’s influence on policy makers, opening up space for dialogue and operationalizing the paradigm shift away from medical model of disability to social model that was proclaimed in the Social Protection Strategy and subsequently the Social Protection Law. Together, these forces resulted in an articulated demand by a disabled person’s organization (DPO) to have a voice in policy articulation, implementation and oversight in response to PWD’s real needs. Other DPOs in Serbia were mobilized around this change platform.

IL-Movement and inequality
Independent living movement36 as an aspiration
Continued inequality of persons with disabilities and changing social roles.
Agents of change
The group leader actually spent some time in Ireland in early 1990ies where she experienced PA service and took part in Center for Independent Living, Dublin advocacy for mainstreaming of the service. Upon return to Serbia, she founded CIL Belgrade. The second one is the way in which statutory responsibilities are changing as a consequence of broader political and socio-economic reforms in Serbia, and specifically the decentralization of the welfare system.

5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Education and Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>1996</td>
</tr>
<tr>
<td>Year of establishment of PA service by CIL</td>
<td>2003</td>
</tr>
<tr>
<td>Year of accreditation of PA training</td>
<td>2011</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Civil society network of 9 CIL offices throughout Serbia</td>
</tr>
<tr>
<td>Financing</td>
<td>Combination of reciprocity resources and public resources, both national and local government funded (initially complemented by donor funding)</td>
</tr>
<tr>
<td>Size of the organization</td>
<td>Number of staff: 27, number of users: 285 PAs trained and 275 service users trained</td>
</tr>
<tr>
<td>Members and participation</td>
<td>Cooperation of actors across different service fields: this model entails cooperation of National Employment Service, Centers for Social Welfare, local self-governments and disabled people’s organizations (DPOs). Network of 10 local self-governments 9 NGOs service-providers, 9 local organizations operating across Serbia, and with regular exchanges within ENIL network and with other disabled people’s organizations in Serbia</td>
</tr>
<tr>
<td>Contact</td>
<td>Center for Independent Living of Persons with Disabilities Serbia Milenka Vesnica 3 Belgrade Serbia</td>
</tr>
<tr>
<td>Name of the innovative example</td>
<td>Phone/fax: +381 11 367-53-17 and +381 11 367-53-18 Email: <a href="mailto:office@cilsrbija.org">office@cilsrbija.org</a></td>
</tr>
<tr>
<td>Homepage</td>
<td><a href="http://www.cilsrbija.org/eng/index.php">http://www.cilsrbija.org/eng/index.php</a></td>
</tr>
</tbody>
</table>

Based on a transformative personal experience with CIL Ireland in early 1990ies, one of CIL founders, Gordana Rajkov talked about independent living philosophy and personal assistance service to a small group of free-minded persons and they started a grass-roots, bottom up innovation - a first of a kind in the entire region. The group gradually grew to 70 PA service users relying on donor support for the service. Together, they ‘evangelized’ and advocated among PWDs for several years and the idea gathered momentum once initial curiosity about the service turned into articulated demand. This emerging demand lacked confidence and faced challenges including financial, policy and regulatory frameworks, enabling cultures, and persistence of traditional roles and relationships. With a growing network of supporters among disabled people’s organizations in Serbia including the National Alliance of Organizations of Persons with Disabilities, CIL advocated for changes in the Social Protection Law. As Social Innovation Fund Program Director noted, “At start, government did not have the absorptive capacity to mainstream CIL’s innovation and CIL contributed to developing that capacity”. With that in mind, CIL developed PA ser-
vice training to help guide new actors in provision of this social service and to make up for absence of a monitoring framework and official service quality standards. From this ideas-generation stage (localized application of IL/PA service), CIL intuitively moved into prototyping (mainstreaming of PA service, user-led development of service standards). This allowed for service innovation - training that is now used to build capacities of PAs and users, DPOs, local authorities, Centers for Social Work and relevant national government employees. Thus it seeks to bridge a gap between the way welfare system used to be and the way social services are supposed to evolve. This connecting force of the service gradually builds an enabling environment, with new municipalities buying into the training and subsequently PA service. Truth be told, local self-governments who are funding PA service in Serbia are still struggling with their new role. However, evidence shows that out of the 10 municipalities trained, 7 continue to provide PA service.

Therefore, the PA service training also equips DPOs to effectively lobby local self-governments for a continuum in service provision. These amounts also indicate that no management, monitoring and evaluation costs are envisioned for service provider organizations, which is a significant vulnerability. Still, scaling of innovation is envisaged by CIL. The organization now advocates for adoption of bylaws that would make the training mandatory, stabilize funding for the training and the PA service and enable users, CIL, other DPOs and other stakeholders to put emphasis on preserving and improving PA service quality. Accredited CIL training for PA service lasts for 5 full days. Depending on a municipality, the training can include local government representatives, service provider organization staff, service users and PAs.

Accredited CIL Training Program Summary is presented below

INTRODUCTION

PART I
1. CONCEPTUAL AND THEORETICAL FRAMEWORK OF THE PROGRAM
2. CONCEPT OF THE SERVICE "SERVICE OF PERSONAL ASSISTANCE FOR PERSONS WITH PHYSICAL DISABILITY"
3. GENERAL AND SPECIFIC COMPETENCIES OF PERSONAL ASSISTANT
4. PRACTICAL EXPERIENCES IMPORTANT FOR THIS EDUCATIONAL PACKAGE
5. COMPETENCIES DEVELOPED THROUGH THIS PROGRAM
6. CONTENT OF THE EDUCATION PROGRAM
7. THE AIMS OF EDUCATION PROGRAM
8. EXPECTED OUTCOMES OF EDUCATION PROGRAM
9. IMPLEMENTATION OF EDUCATION PROGRAM

PART II
INTRODUCTION
MODULE 1 – THE CONCEPTUAL AND THEORETICAL BASE OF THE PROGRAM
MODULE 2 - PERSONAL ASSISTANCE AS A SERVICE
MODULE 3 – PRACTICAL KNOWLEDGE AND SKILLS OF A PERSONAL ASSISTANT
EVALUATION AND FEEDBACK

Any stakeholder can request CIL training and government funding or public works. Hopefully soon, training funding will be stabilized.

After the training, CIL continues to monitor service provision and it conducts assessments of user and direct service provider satisfaction to the extent that its budgets allow it to do so. Thus far, satisfaction rates are very high. This is partly due to an enormous power of positive transformation that this service that may not be as new to some European Union countries but is novel to Western Balkans, presents for service users. It is also due to quality of empirically based training they received from CIL at service start.
6. References


Center for Independent Living of Persons with Disabilities in Serbia, What do you know about budget process? A reminder for civil society organizations in Serbia, 2012

Center for Independent Living of Persons with Disabilities in Serbia, Welfare services for PWDs. Gaps between policy and practice, 2008


Draft Procedures and Standards for provision of PA service, Ministry of Labour, Employment and Social Policy

Draft Procedures and Standards for provision of PA service, Ministry of Labour, Employment and Social Policy


Expert Review conducted by Vladan Jovanović and contracted by the Ministry of Labour, Employment and Social Policy submitted in support of CIL’s application for accreditation with Institute for Social Protection in 2011


Law prohibiting discrimination of persons with disabilities in Serbia, Official Gazette RS No. 33/06

Law on Professional Rehabilitation and Employment of Persons with Disabilities, Official Gazette RS No. 36-09

National Statistics Office, 2011 census

Public procurement Law, Official Gazette RS No. 116/08. Available at: http://www.ujn.gov.rs/sr/propisi/zakon.html and the new law adopted on 29 December 2012 (Date of Access: 11.03.2013)


Ratzka, Adolf D., Independent Living Institute, Stockholm. Available at: http://www.independentliving.org/docs7/ratzka200507.html (Date of Access: 11.03.2013)


Social Protection Strategy, Official Gazette RS No. 108 /05

Strategy for Improved status of PWDs in Serbia, Government of Serbia, 2006
The Disability Monitor Initiative South East Europe, Beyond De-Institutionalisation: The Unsteady Transition towards an Enabling System in South East Europe, 2004

This report is a product of the INNOSERV project (grant agreement nr. 290542) which is funded by the European Union under the 7th Framework Programme.
Data on total welfare expenditure on persons with disabilities in Serbia are not available. According to the Annual Report by Ministry of Labour and Social Policy supported operation and activities of disabled people’s organizations with 4,471,000 Euro. In addition, there are 55,000 beneficiaries of a financial transfer for paid care. Services acquired from the public works are in addition.

For PA training to become mandatory, the state needs to adopt bylaws -- on licensing, service contracting, service cost, etc.

Public works are a measure geared towards employment of persons with disabilities for a period of 6 months. This program is funded by the National Employment Office and a question remains regarding quality standards of PA service funded under this measure. In many cases, funding is discontinued after 6 months. Some service providers under this measure received no training in PA service.

In this way, they indicated their interest in the service but are waiting for bylaws in order to operationalize it. CIL is applying that principle since it started to provide PA service in 2003, because this allowance is a sort of “direct payment scheme”, as money is given to person with disability to “buy a service”. After adoption of bylaws, this will become mandatory.

Part of the problem regarding social services in Serbia lies in a multitude of funding sources: direct transfers, funding for projects of DPOs, other NGOs and from lottery make it almost impossible to establish specific amounts for service funding.

According to 2011 data by Republic Institute for Social Protection http://www.zavodsz.gov.rs/, there are still 3,088 adults with disabilities (aged 18+) in social care institutions in Serbia. Community based services must be developed as institutions close out. The problem is also noted by Regional Center for Minorities http://www.minoritycentre.org/sh/node/1946.

A service provided by a single NGO Iz Kruga www.izkruga.org

Source: CIL research, based on membership in disabled people’s organizations

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With origins in the US civil rights and consumer movement of the late 1960s the Independent Living movement replaces the special education and rehabilitation experts’ concepts of integration, normalization and rehabilitation with a new paradigm developed by disabled people themselves. The first Independent Living ideologists and organizers were people with extensive disabilities. Today the movement’s message is still most easily grasped by people whose everyday lives depend on assistance with the activities of daily living, since they are most exposed to custodial care, paternalistic attitudes and control by professionals. The Independent Living philosophy postulates that disabled people are the best experts on their needs, must take the initiative, individually and collectively, in designing and promoting better solutions and must organize themselves for political power. Besides de-professionalization and self-representation, the Independent Living ideology comprises de-medicalization of disability, de-institutionalization and cross-disability (i.e. inclusion regardless of diagnoses).

Contact information on National organization of persons with disabilities in Serbia (NOOIS) http://www.edf-feph.org/Page.asp?docid=20833&langue=EN

For more details, please see the attached document Accredited CIL program Training outline. A full accredited training program curriculum is also available in Serbian
Theoretically informed case study accompanying the film

Blue Assist and Cloudina – Belgium

Author:
EASPD – The European Association of Service Providers for Persons with Disabilities
Geert Vandewalle, Ann Decorte, Dr. Johan Calu, Jean-Marie Vanhove,
WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/blue-assist

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a Europeanwide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. **Blue Assist and Cloudina: Care innovation for increased autonomy and social inclusion**

**Specific innovative elements of Blue Assist**
Ithaka created the social innovation BlueAssist: An icon with messages on a card, an application for smartphones or a function on an iPhone, which was called Cloudina.

*New form of service delivery*
ICT based care is new in disability care.

*New financial resources*
Funded from Flanders’ Care stimulating social services to collaborate with profit organizations and to commercialize their innovation.

*Cross sectored collaboration*
The Technology is developed with a University College. For the dissemination a collaboration started with public transport and a telecom operator.

**Key characteristics of the service**

*Organisation*
Ithaka, a not for profit organisation, runs a day-care centre for 13 adults with an intellectual disability. Their main objective is to improve their clients’ quality of life. At the moment Cloudina is available as an application for smart phones working in IOS (iPhone) and Android. It will evolve to a platform of different user-friendly functions to support daily life. The cost effectiveness of the Blue Assist innovation is very promising. Hopefully Flemish government will invest in similar projects. As the BlueAssist innovation also is community based, government favors it.

*User groups*
BlueAssist and Cloudina have been developed for people with intellectual disabilities. In a second stage other people with difficulties in understanding will be involved: people with autism spectrum disorders, onset dementia and acquired brain disorders and migrants.

*Peer-principle*
The employees support the clients in achieving increased autonomy, especially those who have had special care for many years. The second principle is full participation in society, which means for Ithaka taking up meaningful roles in society without affecting well-being of the client. These principles are combined with five leverages: Coaching: All professionals are coaches, independent of their function (1), Networking: Creating and supporting networks enable more participation in society (2), Accessibility of communication: All communication must be made accessible through colors, picto’s, voice, explanation,... (3), Technology: Technology supports the communication, the autonomy and remote support (4), Interdependence: Not being able to act independently, does not mean being dependent. The independence is supported by carers, co-citizens: “interdependence” (5).

*Driver(s)*
In the past society has taken care of persons with intellectual disabilities too well. Ithaka strives for empowerment and participation. The manager of the daycare center stimulated his staff to make a shift from institutionalized care to individual coaching in society using ICT, so-called online coaching.
2. BlueAssist and Cloudina
Ithaka, a not for profit organisation, runs a day care centre for 13 adults with intellectual disability. They want to improve their clients’ quality of life focusing on Schalock’s concept (1): emotional wellbeing, interpersonal relationships, personal development, self-determination, social inclusion and rights. Formal and informal carers permanently check the realisation of these indicators with clients, their network and colleagues. If necessary, they search for solutions and improvement in dialogue.

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare – disability care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of organization</td>
<td>Not for profit</td>
</tr>
<tr>
<td>Financing</td>
<td>public</td>
</tr>
<tr>
<td>Size of the organization</td>
<td>15 carers – 19 users</td>
</tr>
<tr>
<td>Contact</td>
<td>v.z.w. Ithaka - <a href="http://www.blueassist.org">www.blueassist.org</a></td>
</tr>
</tbody>
</table>

Table 1: Ithaka overview

Ithaka created BlueAssist: this is an icon with card-messages and an application for smartphones or iPhone, called Cloudina. With the icon people with communication and speech problems are enabled to seek help from co-citizens. Cloudina (Cloud-based inclusion and autonomy) integrates the BlueAssist icon, other supporting functions of the simplified phone, a calendar and photo functions. The BlueAssist and Cloudina innovations deal with novelty aspects of the Innoserv project (2). Care based on Information and Communication Technology (ICT) is a new form of service delivery in disability care. The technology has been developed in cross sectoral collaboration with the University College Ostend-Bruges. The project uses new financial resources as it is 100 % funded by Flemish government on condition that a commercial organisation would make a business model of the innovation.

3. Driving idea: from care-orientation towards support-orientation
In a way, until recent years Flemish society and the service providers on disability care have taken care too well of persons with intellectual disabilities. The care was too heartfelt and often leading towards learned helplessness.

Inspired by the work of Douwe van Houten (3) “To act local and to change by doing”, Ithaka changed this traditional care model into a person centred coaching model striving for empowerment. All carers – formal and informal ones - support the clients in achieving autonomy especially those who have had special care for years. Not all clients and professionals feel comfortable at the beginning; however, they feel better when they experience freedom in a supported environment. Ithaka strives for full participation in society for their clients, i.e. they let them take up meaningful roles in society without affecting their wellbeing. Not being able to act independently does not mean being dependent. Independence, supported by carers and co-citizens is called interdependence.

BlueAssist and Cloudina enable more independency in social life on an equal basis with other citizens. Being able to ask co-citizens for help addresses also disabled people’s aspiration for self determination.
4. Agents of change
The abovementioned shift in care has been initiated by the manager of the daycare center. He stimulated his staff to make a shift from institutionalised care to individual, personalised coaching in society using ICT, so-called online coaching. He also convinced all stakeholders (a.o. the parents) that this way of caring for the clients is more inclusive. Government funds the project as an experimental care delivery project.

![Fig. 1: Factors influencing Social Services Innovation](image)

5. Policy framework for paradigm shift in disability care

5.1 Convention of the United Nations for disabled people (4)
In article 4 (h) member states are invited to provide disabled people with accessible information on assistive technology and on other forms of assistance, assistive devices and facilities. Following article 19 disabled people have the right to live independently and to be included in the community.

5.2. European disability strategy (5)
The new European Disability Strategy 2010 – 2020 wants to promote the transition from institutional to community care for disabled people living in residential settings.
5.3. Flanders
Flemish government holds the authority over person centered issues, including care for people. It delegates this authority to a lot of not for profit private institutes. Contrary to other countries municipalities are not involved. In recent years governmental policies changed priority for social care from residential care to home care. From 2003 to 2009 subsidized capacity in home care has expanded with 52% compared to 17% in residential care. This policy is in accordance with the aspirations of people (6).

<table>
<thead>
<tr>
<th>Year</th>
<th>Home care</th>
<th>Capacity in institutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>25 025</td>
<td>22 191</td>
</tr>
<tr>
<td>2003</td>
<td>57 674</td>
<td>29 386</td>
</tr>
<tr>
<td>2009</td>
<td>87 860</td>
<td>34 584</td>
</tr>
</tbody>
</table>

Table 2: Capacity home care vs. residential care in Flanders

This same policy is not visible as yet in disability care where 80% of budgets is directed towards residential care for disabled people and only 20% to initiatives aiming at independent living. This policy may be based on a long tradition of disability care in Flanders where government subsidizes a whole continuum of care institutes.

<table>
<thead>
<tr>
<th>Residential care</th>
<th>1 000 million EURO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory care</td>
<td>100 million EURO</td>
</tr>
<tr>
<td>Personal assis-tance</td>
<td>65 million EURO</td>
</tr>
<tr>
<td>Supporting technology</td>
<td>36 million EURO</td>
</tr>
</tbody>
</table>

Table 3: Care for disabled people – residential vs. other initiatives 2011

As late as in 2000 Flemish government started with financing personal assistants for disabled people. In 2011, 1 900 disabled people received a personal budget. The budget for supporting technology is minimal.
6. Significant data on capacity and financing of disability care

6.1 Belgian budget for social protection compared to neighbour countries

<table>
<thead>
<tr>
<th></th>
<th>EXPENDITURES ON SOCIAL PROTECTION</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>in PPU (2005)</td>
<td>% of GDP</td>
<td></td>
</tr>
<tr>
<td>Belgium</td>
<td>8 249</td>
<td>29.50%</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>8 529</td>
<td>27.70%</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>8 044</td>
<td>30.50%</td>
<td></td>
</tr>
<tr>
<td>Luxemburg</td>
<td>12 946</td>
<td>19.30%</td>
<td></td>
</tr>
<tr>
<td>The Netherlands</td>
<td>8 305</td>
<td>28.40%</td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>7 176</td>
<td>25.30%</td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Expenditures on social protection

The spending of Belgian government for social protection is comparable to the neighbouring countries with the exception of Luxemburg which spends more and the UK which spends less.
6.2 Belgian budget on disability allowances
Expenditures on disability allowances in Belgium (for daily living and integration) as part of the gross domestic product and as part of social benefits (2005 vs 2007) compared to the neighbouring countries (8).

<table>
<thead>
<tr>
<th>EXPENDITURES ON DISABILITY ALLOWANCES</th>
<th>% of GDP</th>
<th>% of social benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005</td>
<td>2007</td>
</tr>
<tr>
<td>Belgium</td>
<td>2.20 %</td>
<td>1.80 %</td>
</tr>
<tr>
<td>Germany</td>
<td>2.20 %</td>
<td>2.00 %</td>
</tr>
<tr>
<td>France</td>
<td>1.60 %</td>
<td>1.80 %</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>2.80 %</td>
<td>2.30 %</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>2.60 %</td>
<td>2.50 %</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2.40 %</td>
<td>2.40 %</td>
</tr>
</tbody>
</table>

Table 5: Expenditures on disability allowances

The expenditures on disability allowances as part of GDP and of social benefits are decreasing in Belgium as is the case in most neighbouring countries. Exceptions are France and the UK.
6.3 Number of disabled people (25 – 64 years old) entitled to allowances – Belgium

<table>
<thead>
<tr>
<th>Country</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>5,50%</td>
</tr>
<tr>
<td>Germany</td>
<td>4,20%</td>
</tr>
<tr>
<td>France</td>
<td>3,80%</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>6,30%</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>8,90%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>6,20%</td>
</tr>
</tbody>
</table>

Table 6: Allowances

The number of people receiving allowances in Belgium is average compared to the neighbouring countries.

6.4 Care for disabled people – Flemish budgets 2011

As mentioned before, in Belgium federal states are responsible for care for disabled people. Care is divided into residential care and ambulatory care both having a diversified offer of services.

<table>
<thead>
<tr>
<th>RESIDENTIAL</th>
<th>Capacity 2010</th>
<th>Capacity 2011</th>
<th>Subsidy 2011 (Million EURO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential care</td>
<td>4 926</td>
<td>4 928</td>
<td>244</td>
</tr>
<tr>
<td>Observation centers</td>
<td>364</td>
<td>364</td>
<td>20</td>
</tr>
<tr>
<td>Semi-residential area</td>
<td>3 746</td>
<td>3 768</td>
<td>83</td>
</tr>
<tr>
<td>Residents for occupied disabled</td>
<td>1 169</td>
<td>1 169</td>
<td>36</td>
</tr>
<tr>
<td>Residents for unoccupied disabled</td>
<td>9 379</td>
<td>9 469</td>
<td>499</td>
</tr>
<tr>
<td>Residences for short stay</td>
<td>150</td>
<td>150</td>
<td>8</td>
</tr>
<tr>
<td>Daycare centers</td>
<td>3 741</td>
<td>3 769</td>
<td>96</td>
</tr>
<tr>
<td>Living in families</td>
<td>1 036</td>
<td>1 086</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>24 511</td>
<td>24 703</td>
<td>996</td>
</tr>
</tbody>
</table>

Table 7: Types of residential care

Capacities in all residential care institutes are hardly expanded, Government seems to have chosen for a status quo. Ithaka is subsidized as a daycare center (6).
Flemish government expands capacity more in ambulatory care (5%) than in residential care (less than 1%).

6.5 Daycare capacity for disabled people, Flanders

From 2006 to 2009 the capacity of daycare centres expanded with about 4% only. This expansion certainly does not follow the increase of urgent needs which in 2009 tends to approximately one third of capacity (6). Given this need the innovations in Ithaka are efficient as far as capacity is concerned. Ithaka has been recognised by government for 13 persons but nowadays they support 19 persons with intellectual disabilities; this means a capacity increase of nearly 50%. The organisation reaches a capacity utilization degree of 85%, which is much higher than the 60% required by the subsidizing government.

7. Sustainability of innovation

As mentioned above, the cost effectiveness of the BlueAssist innovation is very promising. As the BlueAssist innovation involves community in care, government favours it and has funded it as an experimental care delivery project. It is a tangible realisation of the minister’s „Perspective 2020“, policy plan (5) aiming at maximum integration of disabled people.
INNOSERV - WP 7 Theoretically informed case study accompanying the visualisation

BlueAssist and Cloudina have been developed for people with intellectual disabilities. In a second stage other people with difficulties in understanding will be involved: people with autism spectrum disorders, onset dementia and acquired brain disorders, and migrants. Cloudina is now available as an application for smartphones working in iOS (iPhone) and Android. It will evolve to a platform of different user-friendly functions to support daily life. In a later stage V-pad should be integrated; this is a system to monitor tracks using GPS technology. Instructions and a website for the coach are available in Dutch but can be easily translated. The company ATE (www.skilate.com) became partner of the project in order to distribute Cloudina in Belgium, Europe and North and South America. It guarantees software development where needed. The knowledge center Vilans initiated a demonstration project in the Netherlands. The above mentioned principles have led to other new practices that can be disseminated: De Bezaan (supported living within the community), Pad² (personal assistance in leisure time and the use of cheques), Pict@ (a customized portal providing internet and e-mail access).

7. References

(2) Vanhove, Jean-Marie (2012). Innovative practices in Europe, Innoserv project selection of innovative practices in social services. EASPD.
(4) http://www.diversiteit.be/?action=onderdeel&onderdeel=282&titel=VN-Verdrag+Handicap (Date of Access: 09.03.2013).
(8) European System on integrated Social Protection Statistics (ESSPROS).

This report is a product of the INNOSERV project (grant agreement nr. 290542) which is funded by the European Union under the 7th Framework Programme.
Theoretically informed case study accompanying the film

Mobile health care service - Denmark

Author:
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Hanne Marlene Dahl, Kristian Fahnøe

WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/caht

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a europeawide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Mobile health care service - Health care and social work targeting migrant women in prostitution

Specific innovative elements of the mobile health care service
The target group is both documented and undocumented migrant women in prostitution.

The **main innovative element** is to make contact with possible victims of human trafficking by providing health care services to migrant women in prostitution. For one this is innovative because there has not existed services that reach out to these women working at so-called massage parlours. Furthermore, the practice is innovative in the way the health care service is used as a method to build trust relations that are needed in order to help the women.

**Mobile health care service**
The mobile health care service is a mobile outreach service that provides health care services to migrant women working in prostitution at massage parlours. Working at the massage parlours these women are overlooked and difficult to find. The mobile aspect of the service makes it possible to provide the service where the women are.

**Aim:** to provide access to services and support for the women whose needs are not met otherwise.

**Getting access to victims of human trafficking**
The health care service works as a way to build trust relations between the social workers and the women. This is possible because the women experience that the health care worker can help them with their immediate problem. These trust relations make an advantageous basis for the other team member to build their own relations to the women. Such relations are needed in order to help the women to exit from prostitution. **Aim:** to identify and assists women who are victims of human trafficking.

Key characteristics of the service

**Organisation**
The Centre Against Human Trafficking is a public body under the Ministry for Gender Equality and Ecclesiastical Affairs and is responsible for coordinating different authorities and organizations efforts against human trafficking.

**User groups**
The users are both victims of human trafficking and migrant women working in prostitution in general. These women include both documented and undocumented immigrants.

**Principle**
The core principle is to offer an outreach health care as a response to immediate problems for the women working in prostitution in order to provide a needed harm reduction and to build trust relations between the woman and the social workers and health care worker.

**Driver(s)**
The practice is related to an observed increase the number of migrant women in prostitution in Denmark. Furthermore, the practice is a way to honour the International Conventions on Human Trafficking by which the Danish government has committed itself to fight human trafficking.
2. Policy framework related to human trafficking in Denmark

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Human trafficking and procuring is a punishable offence.</td>
<td>The fight against human trafficking is coordinated and regulated by the government’s action plan for the fight against human trafficking.</td>
<td>Legal milestones:</td>
<td>1. Costs involved in social efforts in the fight against human trafficking:</td>
</tr>
<tr>
<td>2. Migration laws make it impossible to grant undocumented migrants residence permits including persons who have entered Denmark as a victim of trafficking</td>
<td>- The action plan organizes the efforts of various state actors and non-state actors including - Centre against Human Trafficking coordinate the different efforts and runs the mobile health care service</td>
<td>- UN protocol on human trafficking (UN 2000)</td>
<td>€11.5 million € in 2011 to 2014</td>
</tr>
<tr>
<td>3. Prepared repatriation for victims of trafficking. This means that the victims are offered assistance in connection to their repatriation. The assistance aims to help the victim re-establish themselves in the home country and making them self-sufficient</td>
<td>- The Danish Immigration Service (under the Ministry of Justice)</td>
<td>- Council of Europe Convention on action against trafficking in human beings</td>
<td>2. Financing services</td>
</tr>
<tr>
<td>4. Prostitution: Selling sex is neither defined as a criminal act nor included by the labour market regulations. Earnings made from selling sex do not constitute a criminal act as long as the taxes pay and that the sex worker does not at the same time receive social benefits (Spanger forthcoming).</td>
<td>- The Ministry of Foreign Affairs are responsible for international collaborations related to human trafficking.</td>
<td>- The Danish penal code of 2002 that makes human trafficking punishable (Bekendtgørelse af straffeloven § 229 [The Penal code])</td>
<td>The mobile health care service is financed by a state pool earmarked for the most vulnerable groups in society (Satspuljen).</td>
</tr>
</tbody>
</table>

Local actors and operating actors:
- Hospitals provide services to the mobile service team
- Local police districts cooperate with the mobile service in relation to their operations
- NGOs both working in Denmark and abroad, for instances Red Barnet (Save the Children, Denmark).

<table>
<thead>
<tr>
<th>Legal milestones:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- UN protocol on human trafficking (UN 2000)</td>
</tr>
<tr>
<td>- Council of Europe Convention on action against trafficking in human beings</td>
</tr>
<tr>
<td>- The Danish penal code of 2002 that makes human trafficking punishable (Bekendtgørelse af straffeloven § 229 [The Penal code])</td>
</tr>
</tbody>
</table>

Service area characteristics

An estimate from 2007 suggested that approximately 5567 women work in prostitution. Another estimate suggests that 45% of these are migrants.

Due to the nature of trafficking there exists no data on the number of victims of trafficking in Denmark.
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population:</td>
<td>5,534,738</td>
<td>501,104,164</td>
</tr>
<tr>
<td>Population projections 2010-2050</td>
<td>6,037,836</td>
<td>524,052,690</td>
</tr>
<tr>
<td>Expenditure on social protection (% of GDP) 2009</td>
<td>33.44%</td>
<td>29.51%</td>
</tr>
</tbody>
</table>

3.2 Information about the specific welfare state: Denmark
The state has deployed approximately: 11.5 million (85.6 million Danish kroner) from 2011 to 2014 for the national social efforts in relation to human trafficking. In addition to this there have been expenditures in relation to police work and the work abroad in the countries origins. The work abroad is done in collaboration with NGOs.

Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro.

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>1996-2010</td>
<td>Part of benefits 1996-2010</td>
<td></td>
</tr>
<tr>
<td>EU 27</td>
<td>/</td>
<td>/</td>
<td>34.07%</td>
</tr>
<tr>
<td>Denmark</td>
<td>45,334.15</td>
<td>102.60%</td>
<td>34.13%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>262,859.71</td>
<td>124.56%</td>
<td>32.87%</td>
</tr>
<tr>
<td>Germany</td>
<td>565,683.07</td>
<td>52.53%</td>
<td>30.79%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

4. Challenges and Drivers of Innovation

Structural weaknesses of the system:

- The victims of trafficking do not contact the health care system or the social authorities on their own. There are several reasons for this. Some of the primary reasons are that the women are often unaware where they are and that they fear what will happen if the contact the authorities.
- The migration laws make it impossible to offer the undocumented migrant residence permits even if they have entered the Denmark as a victim of trafficking. This makes it difficult to combat the organized crime behind human trafficking as victims might be reluctant to step forward.
- The Danish opt-out from the EU co-operation on Justice and Home affairs. This means that Denmark is not participating in the common police efforts in EU to target the organized crime behind human trafficking.
Innovation: Ideas, criteria, levels and added values
There are two particularly innovative aspects about the service:

Mobile health care:
Mobile health care brings relevant health care services as well as and social services to migrant women in prostitution, who would otherwise not seek such offers. Thus, the practice is innovative as a way to reach a hard to reach group (Innoserv 2012).

Getting access to victims of human trafficking:
by offering help in relation to the here-and-now problems that the women experience, the midwife at the mobile health care team is able to establish contact with the women and this way make it possible to create trusting relations. The trusting relations are a precondition for the social work with the women and for the work to identify and help victims of trafficking.

Drivers and Challenges
A primary drive behind the initiative is the raised awareness of the international human trafficking and the resulting human suffering. At local level experience from similar practices including a drop-in centre for migrant women working in prostitution in Copenhagen inspired the establishing of the mobile health care service. Based on these positive experiences the mobile health care service was an answer to the challenges in regard to reach the target group in a wide geographical area. Another drive was the experienced difficulties in relation get in contact and identify victims of trafficking which has proven to be a very difficult task.

Challenges
Human trafficking is a low-risk criminal enterprise with high returns and severe consequences for the victims.

Agents of Change
The political agreed action plan has paved the way for initiatives like the mobile health service and since the first action plan there has been establish a political good will both in within the Danish Parliament and in the involved ministries. Another important agent outside the political system was the local hospital (Aarhus University Hospital) that supported the initiative right from the begin and thus making the linkage between the mobile team and the established health care services possible.
5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Health and Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>2010</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Public organization (governmental)</td>
</tr>
<tr>
<td>Financing</td>
<td>The service is financed by a state pool earmarked for the most vulnerable groups in society</td>
</tr>
<tr>
<td>Size of organization</td>
<td>Total number of employees at Danish Centre Against Human Trafficking: 12. Employees involved in the practice: One midwife, two social workers and one project manager</td>
</tr>
<tr>
<td>Members and participation</td>
<td>Aarhus University Hospital.</td>
</tr>
<tr>
<td>Agents of change</td>
<td>Danish government has had action plans to combat human trafficking. (2002), Denmark introduced a penal code on human trafficking in 2002</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of the innovative example</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Homepage</td>
</tr>
</tbody>
</table>

There are an estimated number of 250,000 victims of trafficking per year in Europe (United Nation Office on Drug and Crime 2009). As in other EU countries, reported trends point to an increase in the numbers of victims of human trafficking in Denmark (United Nation Office on Drug and Crime 2009).

From the late 1990s and onwards, the Danish state has observed that the number of female migrants working in prostitution has increased considerably (Spanger 2011). Since 2002, the Danish government has had action plans to combat human trafficking. Parallel to this Denmark introduced a penal code on human trafficking in 2002 (Spanger 2011). The Danish Centre against Human Trafficking was established at the same time and is responsible for the coordination of the efforts under the action plans. Similar policy trends can be identified in the other Nordic countries (Holmström & Skilbrei 2008). Moreover, at an international level the awareness of human trafficking has resulted in the development of a ‘rescue industry’ (Kempadoo 2005, Agustín 2007). In particular, a number of studies (Ditmore 2007, Skilbrei & Holmström 2011, Spanger 2011) investigate how the policy fields of human trafficking and prostitution regulate migrants selling sexual services.

The Danish Centre against Human Trafficking is responsible for several services including a drop-in centre in Copenhagen. Inspired by the experiences gained from the drop-in centre, the mobile health care service was established in 2010 in order to reach a less visible target group than women working in street prostitution which had been the target group at the drop-in centre. The mobile health care service covers Central and Northern Jutland and was established in cooperation with Aarhus University Hospital.
By establishing the health care service as a mobile service, it has been possible to reach the migrant women in prostitution that work in massage parlours that are scattered over a geographically large area. Given the fact that the massage parlour often are situated in desolate places the service is able to reach women are isolated and do not contact the health care service or social authorities. In some cases the women have no knowledge about where they are or how to reach a hospital if needed. The massage parlours are identified by the staff members who go through the sex-selling advertisements in the newspaper and on the internet.

The mobile health care team consists of one midwife, two social workers and one project manager and is based in Aarhus. The midwife visits all massage parlours (as the brothels are called) "employing" migrant women in Central and Northern Jutland offering treatment and examination. If the midwife assesses that a woman needs a specific treatment or an examination that she can provide, she will accompany the women to the local hospital where the treatment or examination will be carried out. Besides the actual examinations and treatments, the project has a prophylactic and health promoting aim: to secure an improved life for the woman. This involves counselling, guidance and a focus on the general health of the woman.

The midwife offers a needed service and relief, and this serves as a kind of icebreaker for the women. By meeting the women’s needs, the midwife is able to establish a trustful relationship with the women. This makes it possible for her to establish contact between the women and the social workers working for the mobile health care service. The social worker’s tasks involve informing the women about their options, rights, risks and alternatives. Further, they try to motivate the women to change their situation. This is a long process.

The social workers also act as case managers for women who are identified as victims by the social workers. This involves work in relation to the prepared repatriation that the identified victims are offered. The aim of prepared repatriation is to help the women to re-establish themselves in the country of origin. This includes assisting them in order to make them self-sufficient e.g. by helping them to establish a small business. As an element of the preparations the women are offered skills-training courses, psychological, legal and social support as well as health care service.

Further, the social workers provide assistance to women who are brought in by the police in connection with police operations. The social workers of the mobile health care service offer assistance to the women and are involved in unravelling the women’s cases in order to assess whether they are victims of trafficking. In relation to this the women may be offered an on location the health care service which besides providing immediate relief could facilitate the more trusting relationship.

The effects of the practice
There are at least two valuable effects of the practice; first, the identification of women as victims of trafficking. Second, the mobile health care service is able to deliver harm reduction to the approximately women working at the parlours in the area. So far, the midwife has established contact with almost 190 women and two men.

However, there are a number of challenges for this practice. Firstly, the geographical area that the mobile health care service covers is sizeable and the parlours are dispersed. Secondly, it is difficult to establish and maintain the relations to the women
as the women get moved regularly and even sometimes abroad. In relation to this the landscape of the parlour are constantly changing as new are opening and old ones closing all the time. This highlights the challenges in regards to establishing and maintain the relations to the women.

6. References


Theoretically informed case study accompanying the film

Center for Independent Living of Persons with Disabilities in Serbia
(CIL Serbia)

Author:
Enil
Sanja Nikolin, Jamie Bolling, Gordana Rajkov Mimica Živadinović
WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/cil

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a europeanwide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Center for Independent Living of Persons with Disabilities in Serbia - CIL

Center for Independent Living provides persons with disabilities personal assistance and training for Personal Assistance (PA) service providers from the public, private and non-profit sector. It has evidence on user driven change encompassing legislative, policy, normative and social change, and resulting in an innovative social service of training for PA service. This innovation rests on an active and formalized role for service users and a disabled people’s organization in maintaining service quality and integrity. The service bridges a significant gap between rules on the book and situation in local municipalities in Serbia.

Specific innovative elements of CIL

*Operationalizing normative paradigm shift in service provision to persons with disabilities (PWDs):*

The main idea is to demonstrate that user involvement in every step of service design, implementation and monitoring is both possible and desirable in Serbia as resource constrained environments dealing with deficiency in human and institutional capacity. CIL mobilizes service users to take on the role of service monitors and build pressure on the government to formalize standards. Therefore, CIL is making the new paradigm possible and real for a growing number of PWDs.

*New stakeholder roles*

CIL develops local disabled people’s organization (DPO) capacities for local budget process monitoring, familiarizes them with legislative and regulatory framework with regards to local social service provision and strengthens their lobbying and advocacy capacities so that they can effectively win local self-government representatives over for provision of PA service. DPOs and PA service users are now much more concerned with ways in which their local self-governments spend public monies and they are more interested in local budget monitoring. In the long run, this will contribute to a broader PA service availability/increased user number, greater need for CIL training and service standards.

*New engagement model*

CIL’s engagement model steps away from the traditional pyramid, ladder, or funnel model and looks more like a vortex.

*Key characteristics of the service*

*Organization*

CIL Serbia is a national cross-disability organization established, governed and managed by persons with disabilities with a staff of 27. CIL was founded in 1996.

*Users: Personal assistants and persons with disabilities*

User groups: Persons with disabilities, organizations of persons with disabilities and PA service providers from the public, private and non-profit sector.

Number of users: 285 PAs trained and 275 service users trained.
Factors influencing Social Services Innovation

Agents of change
- people w. physical disability experienced ILM
- Group leader also PA service user
- experienced center for IL in Dublin

CIL

Drivers
- Institutionalised System
  - Disability paradigm:
    - medical approach
    - person viewed as defective
    - not capable
- Enabling system
  - holistic approach
  - society recognises potential of individual

Structural weakness
- discrepancy
- poor targeting
- no user involvement
- no standards
- no appeal procedure
- Funding allocation system as a barrier

Deinstitutionalization strategy with no adequate transition phase

Public sector weakness
- Identifying & opening up space for innovation resulting from:
  - paradigm shift
  - introduction of pluralism
  - decentralisation of social service
  - the fact that PA service was ind. in law

Response: CIL
- Users involvement
- every step of service
- New stakeholder roles
- Development of local DP organization
- local budget process monitoring
- New engagement model:
  - away from traditional models

Decentralization

Knowledge

Inspiration from IL-movement
- Users living alone at home, relying on family support
- assistance without access to support services
## 2. Policy Framework related for Persons with Disabilities in Serbia

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Decentralization:</strong> from highly centralized to municipal level: Social Protection Law foresees local level provision of social services, with PA service as an option recognized in the law but not a mandatory service on offer. No service standards and no monitoring mechanisms in place</td>
<td>Local self-governments provide funding for the service</td>
<td>Legal milestones:</td>
<td>1. Costs involved</td>
</tr>
<tr>
<td></td>
<td>Centres for social welfare conduct beneficiary assessment and refer to service providers. For new services, local government launches a tender to procure a new service NGO, DPOs, private firms and public sector organizations can apply as service providers</td>
<td>Social Protection Law, 1991 and 2011</td>
<td>In 2012, local government units set aside approximately 178,000 Euro for PA service. Central government provided an additional 359,000 Euro through public works</td>
</tr>
<tr>
<td><strong>2. Pluralism of service providers:</strong> Shift away from the state as sole service provider to pluralism in service provision, albeit with acute desire of state institutions to remain sole providers and with significant gaps in public procurement procedures for services</td>
<td>Centre for Independent living of persons with disabilities provides training to service providers and users</td>
<td>Social Protection Strategy, Procedures and Standards for provision of PA service (forthcoming)</td>
<td>PAs receive approximately 200 Euro net salary (gross monthly salary about 360 Euro) plus monthly local transportation cost</td>
</tr>
<tr>
<td></td>
<td><strong>Caveats in the system:</strong> PA service training is accredited by the Institute for Social Protection but it is not mandatory.</td>
<td>Strategy for Improved status of PWDs in Serbia</td>
<td>CIL PA training costs are negotiated on a case by case basis and sometimes provided at no cost or with only partial funding</td>
</tr>
<tr>
<td><strong>3. From institution to community-based social services:</strong> greater responsibility for local self-governments but without adequate financial and/or human capacity.</td>
<td>Issue of quality of social services that are being provided by non-trained actors</td>
<td>Law on Professional Rehabilitation and Employment of Persons with Disabilities</td>
<td>2. Financing of municipal social services</td>
</tr>
<tr>
<td>Welfare system gaps include: Disconnect between policy and practice Lack of bylaws and procedures and law Lack of clarity among experts working on Social Service Procedures on whether and how PA service is to be applied to persons with intellectual disabilities</td>
<td>Monitoring of actual service provision is not clearly defined and CIL fills in a gap in this area for 7 municipalities/cities, but a more permanent solution to funding of monitoring activities and full coverage needs to be developed</td>
<td>Public procurement Law, Labour Code</td>
<td>Some municipalities have a decision to fund PA in their local action plans for social protection. Others fund PA on a short term project basis. Most have not yet considered it seriously.</td>
</tr>
<tr>
<td></td>
<td>CIL PA service training program targets the service for persons with physical disability.</td>
<td>Ratified Convention on the Rights of persons with disabilities, art. 19</td>
<td>Underdeveloped municipalities should receive block grants from central government if they adopt local social protection strategy and identify service provision as a priority but grants are not available yet.</td>
</tr>
<tr>
<td></td>
<td><strong>Service characteristics</strong></td>
<td>300+ PWDs are members of organizations that completed CIL training</td>
<td>Users of PA service provided by CIL pay participation fee for PA service amounting to 20% of their allowance for help by another person</td>
</tr>
<tr>
<td></td>
<td>approximately 100+ PWDs receive services from persons who are not CIL trained service providers and there is no other accredited training provider</td>
<td></td>
<td>Allowance ranges from 100 to 200 Euro/month.</td>
</tr>
</tbody>
</table>

### Notes:
- Social Protection Law, 1991 and 2011
- Social Protection Strategy
- Procedures and Standards for provision of PA service (forthcoming)
- Strategy for Improved status of PWDs in Serbia
- Law on Professional Rehabilitation and Employment of Persons with Disabilities
- Public procurement Law
- Labour Code
- Ratified Convention on the Rights of persons with disabilities, art. 19
- CIL PA service training program targets the service for persons with physical disability.
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th>Table 1 Key statistical data</th>
<th>Serbia</th>
<th>EU27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>7,241,295&lt;sup&gt;15&lt;/sup&gt;</td>
<td>503,824,373&lt;sup&gt;16&lt;/sup&gt;</td>
</tr>
<tr>
<td>GDP per capita in PPS in 2011, EU27 = 100</td>
<td>35&lt;sup&gt;17&lt;/sup&gt;</td>
<td>100</td>
</tr>
<tr>
<td>Estimated proportion of persons with disabilities in total population</td>
<td>15,0 %&lt;sup&gt;18&lt;/sup&gt;</td>
<td>15,0%&lt;sup&gt;18&lt;/sup&gt;</td>
</tr>
<tr>
<td>Membership of persons with physical disabilities in DPOs</td>
<td>6,000</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of PA service users</td>
<td>400&lt;sup&gt;19&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>National government spending on social services</td>
<td>Data unavailable&lt;sup&gt;20&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
<tr>
<td>Local government spending on PA service in 2012</td>
<td>19,800,000 RSD</td>
<td>N/A</td>
</tr>
</tbody>
</table>

3.2 Information about the specific welfare state: Service Orientation Serbia

Serbia’s welfare services infrastructure targeting persons with disabilities evolved around medical approach to disability and with institution as the welfare solution within a socialist state-as-the-service-provider. Over the past 12 years, the country’s legislation gradually shifted to social model of disability. Unfortunately, a requisite shift in funding for and management of social services has not followed suit, or not at the same pace. In 2005, CIL demonstrated that benefits of PA service outweighed costs in an Analysis of Investing In the Organization of Personal Assistant Service Network for Persons with Disabilities in Serbia<sup>21</sup>

Today, social care institutions are eroded and scheduled for closure due to policy emphasis on deinstitutionalization<sup>22</sup>, without real alternatives on offer on the ground for persons with disabilities<sup>23</sup>. The majority of PWDs, however, live at home and rely on family support and assistance. Without access to support services, including PA, even the socially and professionally active persons with disabilities remain dependent on their kin, out of the labour market and - more often than not - in poverty.

In addition to institutional care and allowance for help by another person, the following social services are available to PWDs in Serbia: personal assistance service only in 7 out of 168 municipalities, supported housing, home help, day care centres, respite care and SOS hotline for victims of domestic violence against persons with disabilities<sup>24</sup>.

Table 2 presents CIL target groups for personal assistance service provider training in relation to the full universe in Serbia

<table>
<thead>
<tr>
<th>Target groups</th>
<th>Total trained by CIL by Dec 2012</th>
<th>Total in Serbia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with disabilities</td>
<td>300</td>
<td>6,000&lt;sup&gt;25&lt;/sup&gt;</td>
</tr>
<tr>
<td>Organizations of persons with disabilities</td>
<td>60</td>
<td>Approximately 500&lt;sup&gt;26&lt;/sup&gt;</td>
</tr>
<tr>
<td>PA service providers from the public, private and non-profit sector</td>
<td>10 local self-governments and 9 NGOs service-providers&lt;sup&gt;27&lt;/sup&gt;</td>
<td>168 disabled people’s organizations and X companies providing social services&lt;sup&gt;28&lt;/sup&gt; (number not available)</td>
</tr>
</tbody>
</table>
For a new social service to be launched, a social institution or another service provider organization must obtain license from the Ministry of Labor and Social Policy. Local self-governments wanting to procure a new social service need to launch a public tender for eligible licensed service providers. Once service providers are selected, service users apply with Center for Social Welfare for joint assessment of needs and status. If it is determined in the assessment that a person is eligible for PA service, then s/he is free to choose from available licensed service providers. Criteria are prescribed by the Minister of Labor, Employment and Social Policy. For a new service, potential service users can raise their claim with the local self-government and, pending a favorable funding decision, the tender procedure can be launched – once bylaws are in place.

The goals of Serbia’s new social service orientation are:
- Continuum of service provision
- Community-based services as a priority
- User able to select a service and service provider
- User participates in service design and service delivery
- User as partner in service delivery

A social welfare system that enables users to satisfy various needs

CIL PA service provider training is instrumental to the development of the following relationships:
- licensed service provider organization and service user
- licensed service provider organization and personal assistant
- service user and personal assistant

According to the Ministry of Labor, Employment and Social Policy official, CIL training design is an early bird, a champion of change that sets a path for standardization leading to accreditation of other types of training, assistance and support programs. The training clarifies PA scope of work through two specific groups of tasks: assistance in everyday operation and assistance in performing formal and professional duties. At the level of educational tools and methodologies, the Program contains a variety of interactive, multimedia and multi-technical tools, including interactive presentations, guided discussions, demonstrations, simulations and role plays, film and video materials, stories with illustrations and other tools. The program is relevant, comprehensive, innovative, coherent and of a high quality standard. The CIL training program was accredited by the National Institute for Social Protection in February 2011.

There is a steadily increase of expenditure in benefits in kind of social protection benefits (including social services), that shows the growing meaning in comparison to social protection benefit in cash. The table below presents the social protection expenditure of selected countries.
4. Challenges and Drivers of Innovation

**Structural weaknesses** of the system
- Discrepancy between entitlements *de jure* and *de facto* situation on the ground
- Poor targeting and fragmented entitlements that are not individualized
- No user involvement, no effective monitoring system in place and no feedback loop
- No standards of service provision
- No appeal procedure

**Innovation**: Ideas, criteria, levels and added values
The innovation focuses on public sector weaknesses as opportunities. It identifies and opens up space for service innovation that resulted from: a) paradigm shift; b) introduction of pluralism of service providers; c) decentralisation of social services; and d) a fact that PA service was included in the law as a social service option. CIL managed to connect the dots and fill in for public sector capacity gaps. CIL - PA training and follow up work further make up for lack of adequate guidance and/or monitoring systems.

*Operationalizing normative paradigm shift in service provision to PWDs:*
The main idea is to demonstrate that user involvement in every step of service design, implementation and monitoring is both possible and desirable in Serbia as resource constrained environments dealing with deficiency in human and institutional capacity.

It has been noted above that a normative shift away from medical to social approach to disability is poorly implemented due to a very real gap in capacities, lack of service standards and inexistence of a monitoring function. Accredited CIL training is currently the only quality assurance mechanism available for PA service provision. It is aligned with global disability movement standards for PA service and they guide service users and providers through the process to ensure at least minimum service quality. By involving persons with disabilities in training provision and training participation, CIL mobilizes service users to take on the role of service monitors and build pressure on the government to formalize standards. Therefore, CIL is making the new paradigm possible and real for a growing number of PWDs.
The complexity of a paradigm shift in the context of South East Europe is presented in graph 1. Below:

**Graph1. Shifting the disability paradigm**

<table>
<thead>
<tr>
<th>Institutionalised system</th>
<th>Enabling system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disability paradigm</strong></td>
<td></td>
</tr>
<tr>
<td>• A medical approach</td>
<td></td>
</tr>
<tr>
<td>• The person is viewed as defective and not capable</td>
<td></td>
</tr>
<tr>
<td><strong>Care system</strong></td>
<td></td>
</tr>
<tr>
<td>• Aim = cure protection</td>
<td></td>
</tr>
<tr>
<td>• Services and life-cycle controlled by institutions and experts</td>
<td></td>
</tr>
<tr>
<td>• A system based on a division of beneficiaries into rigid categories</td>
<td></td>
</tr>
<tr>
<td>• Services delivered mainly in special institutions by specialists in disability</td>
<td></td>
</tr>
<tr>
<td>• A rigid system</td>
<td></td>
</tr>
<tr>
<td>• People with disabilities and their representatives are not involved in the planning and evaluation of services</td>
<td></td>
</tr>
<tr>
<td><strong>System of support services</strong></td>
<td></td>
</tr>
<tr>
<td>• Aim = social participation</td>
<td></td>
</tr>
<tr>
<td>• People have the right to choose services and control their lives</td>
<td></td>
</tr>
<tr>
<td>• A system based on diversity and the right to be different</td>
<td></td>
</tr>
<tr>
<td>• Services mainstreamed within ordinary services at community level</td>
<td></td>
</tr>
<tr>
<td>• A flexible and adaptive system</td>
<td></td>
</tr>
<tr>
<td>• People with disabilities and their representatives are a part of the planning and evaluation of services</td>
<td></td>
</tr>
</tbody>
</table>

**New stakeholder roles**
User involvement in design, implementation and monitoring of service is already a ground-breaking innovation for Western Balkans. It tackles the very essence of a system that is resistant to change, arrogant and centralized. This empowering process builds capacities of PWDs and bonds them together in a strong network that is increasingly perceived - and treated - as a partner by the state.

Beyond the direct service users, CIL mobilizes their associations across Serbia for advocacy on decentralized funding for PA service and for inclusion of CIL-trained DPOs as quality PA service providers. On a practical level, this means that CIL develops local DP organization capacities for local budget process monitoring, familiarizes them with legislative and regulatory framework with regards to local social service provision and strengthens their lobbying and advocacy capacities so that they can effectively win local self-government representatives over for provision of PA service.

Social policy experts and academics are no longer unquestionably driving prioritization of social services to PWDs. Instead, they are getting used to a new role of supporters, often helping behind the scenes, whereas strategic decisions remain with the independent living movement in Serbia, led by CIL. These changed roles and relationships contribute to a new form of governance. DPOs and PA service users are now much more concerned with ways in which their local self-governments spend public monies and they are more interested in local budget monitoring. In the long run, this will contribute to a broader PA service availability/increased user number, greater need for CIL training and service standards.

**New engagement model**
Since "personal assistance", key to independent living, means the user is boss, user-led approach to training and outreach effectively pushes the quality assurance enve-
lope. Key to this approach is CIL’s ‘never let go’ engagement model. Once mobilized stakeholders are effectively employed in further advocacy to close capacity gaps.

CIL’s “engagement model steps away from the traditional pyramid, ladder, or funnel model and looks more like a vortex” described by Julie Dixon and Denis Keyes.34 “At the center of the vortex is the individual. Her/his depth of commitment to the organization is represented by the size of the continuous field around the center. As the person’s commitment deepens, the vortex expands outward. The vortex can be strengthened - and expanded - by the influence of others, but as it grows it also becomes a greater source of influence on others.”35 The graph below is an adaptation from the Dixon & Keyes article, with broader emphasis on stakeholders rather than a focus on donor.

![Stakeholder Engagement Diagram](image)

**Drivers and Challenges**

*Direct personal experience in independent living*

A small group of People with physical disabilities in Serbia experienced the independent living movement and lived personal assistance service. The group leader actually spent some time in Ireland in early 1990ies where she experienced PA service and took part in Center for Independent Living, Dublin advocacy for mainstreaming of the service.

*Decentralization*

Way in which statutory responsibilities are changing as a consequence of broader political and socio-economic reforms in Serbia, and specifically the decentralization of the welfare system.

*Knowledge*

Accumulation of knowledge, capacity and lived experience contributed to changing social roles by increasing CIL’s influence on policy makers, opening up space for dialogue and operationalizing the paradigm shift away from medical model of disability to social model that was proclaimed in the Social Protection Strategy and subsequently the Social Protection Law. Together, these forces resulted in an articulated demand by a disabled person’s organization (DPO) to have a voice in policy articulation, implementation and oversight in response to PWD's real needs. Other DPOs in Serbia were mobilized around this change platform.

*IL-Movement and inequality*

Independent living movement36 as an aspiration

Continued inequality of persons with disabilities and changing social roles.
Agents of change
The group leader actually spent some time in Ireland in early 1990ies where she experienced PA service and took part in Center for Independent Living, Dublin advocacy for mainstreaming of the service. Upon return to Serbia, she founded CIL Belgrade. The second one is the way in which statutory responsibilities are changing as a consequence of broader political and socio-economic reforms in Serbia, and specifically the decentralization of the welfare system.

5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Education and Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>1996</td>
</tr>
<tr>
<td>Year of establishment of PA service by CIL</td>
<td>2003</td>
</tr>
<tr>
<td>Year of accreditation of PA training</td>
<td>2011</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Civil society network of 9 CIL offices throughout Serbia</td>
</tr>
<tr>
<td>Financing</td>
<td>Combination of reciprocity resources and public resources, both national and local government funded (initially complemented by donor funding)</td>
</tr>
<tr>
<td>Size of the organization</td>
<td>Number of staff: 27, number of users: 285 PAs trained and 275 service users trained</td>
</tr>
<tr>
<td>Members and participation</td>
<td>Cooperation of actors across different service fields: this model entails cooperation of National Employment Service, Centers for Social Welfare, local self-governments and disabled people’s organizations (DPOs). Network of 10 local self-governments 9 NGOs service-providers, 9 local organizations operating across Serbia, and with regular exchanges within ENIL network and with other disabled people’s organizations in Serbia</td>
</tr>
<tr>
<td>Contact</td>
<td>Center for Independent Living of Persons with Disabilities Serbia Milenka Vesnica 3 Belgrade Serbia Phone/fax: +381 11 367-53-17 and +381 11 367-53-18 Email: <a href="mailto:office@cilsrbija.org">office@cilsrbija.org</a> <a href="http://www.cilsrbija.org/eng/index.php">http://www.cilsrbija.org/eng/index.php</a></td>
</tr>
</tbody>
</table>

Based on a transformative personal experience with CIL Ireland in early 1990ies, one of CIL founders, Gordana Rajkov talked about independent living philosophy and personal assistance service to a small group of free-minded persons and they started a grass-roots, bottom up innovation - a first of a kind in the entire region. The group gradually grew to 70 PA service users relying on donor support for the service. Together, they ‘evangelized’ and advocated among PWDs for several years and the idea gathered momentum once initial curiosity about the service turned into articulated demand. This emerging demand lacked confidence and faced challenges including financial, policy and regulatory frameworks, enabling cultures, and persistence of traditional roles and relationships. With a growing network of supporters among disabled people’s organizations in Serbia including the National Alliance of Organizations of Persons with Disabilities, CIL advocated for changes in the Social Protection Law. As Social Innovation Fund Program Director noted, “At start, government did not have the absorptive capacity to mainstream CIL’s innovation and CIL contributed to developing that capacity”. With that in mind, CIL developed PA ser-
vice training to help guide new actors in provision of this social service and to make up for absence of a monitoring framework and official service quality standards. From this ideas-generation stage (localized application of IL/PA service), CIL intuitively moved into prototyping (mainstreaming of PA service, user-led development of service standards). This allowed for service innovation - training that is now used to build capacities of PAs and users, DPOs, local authorities, Centers for Social Work and relevant national government employees. Thus it seeks to bridge a gap between the way welfare system used to be and the way social services are supposed to evolve. This connecting force of the service gradually builds an enabling environment, with new municipalities buying into the training and subsequently PA service. Truth be told, local self-governments who are funding PA service in Serbia are still struggling with their new role. However, evidence shows that out of the 10 municipalities trained, 7 continue to provide PA service.

Therefore, the PA service training also equips DPOs to effectively lobby local self-governments for a continuum in service provision. These amounts also indicate that no management, monitoring and evaluation costs are envisioned for service provider organizations, which is a significant vulnerability. Still, scaling of innovation is envisaged by CIL. The organization now advocates for adoption of bylaws that would make the training mandatory, stabilize funding for the training and the PA service and enable users, CIL, other DPOs and other stakeholders to put emphasis on preserving and improving PA service quality. Accredited CIL training for PA service lasts for 5 full days. Depending on a municipality, the training can include local government representatives, service provider organization staff, service users and PAs.

Accredited CIL Training Program Summary is presented below

INTRODUCTION
PART I
1. CONCEPTUAL AND THEORETICAL FRAMEWORK OF THE PROGRAM
2. CONCEPT OF THE SERVICE "SERVICE OF PERSONAL ASSISTANCE FOR PERSONS WITH PHYSICAL DISABILITY"
3. GENERAL AND SPECIFIC COMPETENCIES OF PERSONAL ASSISTANT
4. PRACTICAL EXPERIENCES IMPORTANT FOR THIS EDUCATIONAL PACKAGE
5. COMPETENCIES DEVELOPED THROUGH THIS PROGRAM
6. CONTENT OF THE EDUCATION PROGRAM
7. THE AIMS OF EDUCATION PROGRAM
8. EXPECTED OUTCOMES OF EDUCATION PROGRAM
9. IMPLEMENTATION OF EDUCATION PROGRAM

PART II
INTRODUCTION
MODULE 1 – THE CONCEPTUAL AND THEORETICAL BASE OF THE PROGRAM
MODULE 2 - PERSONAL ASSISTANCE AS A SERVICE
MODULE 3 – PRACTICAL KNOWLEDGE AND SKILLS OF A PERSONAL ASSISTANT
EVALUATION AND FEEDBACK

Any stakeholder can request CIL training and government funding or public works. Hopefully soon, training funding will be stabilized.

After the training, CIL continues to monitor service provision and it conducts assessments of user and direct service provider satisfaction to the extent that its budgets allow it to do so. Thus far, satisfaction rates are very high. This is partly due to an enormous power of positive transformation that this service that may not be as new to some European Union countries but is novel to Western Balkans, presents for service users. It is also due to quality of empirically based training they received from CIL at service start.
6. References


Center for Independent Living of Persons with Disabilities in Serbia, What do you know about budget process? A reminder for civil society organizations in Serbia, 2012

Center for Independent Living of Persons with Disabilities in Serbia, Welfare services for PWDs. Gaps between policy and practice, 2008


Draft Procedures and Standards for provision of PA service, Ministry of Labour, Employment and Social Policy


Expert Review conducted by Vladan Jovanović and contracted by the Ministry of Labour, Employment and Social Policy submitted in support of CIL’s application for accreditation with Institute for Social Protection in 2011


Law prohibiting discrimination of persons with disabilities in Serbia, Official Gazette RS No. 33/06

Law on Professional Rehabilitation and Employment of Persons with Disabilities, Official Gazette RS No. 36-09

National Statistics Office, 2011 census

Public procurement Law, Official Gazette RS No. 116/08. Available at: http://www.ujn.gov.rs/sr/propisi/zakon.html and the new law adopted on 29 December 2012 (Date of Access: 11.03.2013)


Ratzka, Adolf D., Independent Living Institute, Stockholm. Available at: http://www.independentliving.org/docs7/ratzka200507.html (Date of Access: 11.03.2013)


Social Protection Strategy, Official Gazette RS No. 108 /05

Strategy for Improved status of PWDs in Serbia, Government of Serbia, 2006
INNOSERV - WP 7 Theoretically informed case study accompanying the visualisation

The Disability Monitor Initiative South East Europe, Beyond De-Institutionalisation: The Unsteady Transition towards an Enabling System in South East Europe, 2004

This report is a product of the INNOSERV project (grant agreement nr. 290542) which is funded by the European Union under the 7th Framework Programme.

2 Data on total welfare expenditure on persons with disabilities in Serbia are not available. According to the Annual Report by Ministry of Labour and Social Policy supported operation and activities of disabled people’s organizations with 4,471,000 Euro. In addition, there are 55,000 beneficiaries of a financial transfer for paid care. Services acquired from the public works are in addition.

3 For PA training to become mandatory, the state needs to adopt bylaws – on licensing, service contracting, service cost, etc.

4 Official Gazette RS No.36/91, 79/91, 53/93, 67/93, 46/94, 48/94, 52/96, 29/01, 84/04, 115/05

5 Official Gazette RS No. 108/05


7 Official Gazette RS No. 33/06

8 Official Gazette RS No. 36-09


12 Public works are a measure geared towards employment of persons with disabilities for a period of 6 months. This program is funded by the National Employment Office and a question remains regarding quality standards of PA service funded under this measure. In many cases, funding is discontinued after 6 months. Some service providers under this measure received no training in PA service.

13 In this way, they indicated their interest in the service but are waiting for bylaws in order to operationalize it. CIL is applying that principle since it started to provide PA service in 2003, because this allowance is a sort of “direct payment scheme”, as money is given to person with disability to “buy a service”. After adoption of bylaws, this will become mandatory

14 Source: 2011 census, National Statistics Office


16 First estimates for 2011 GDP per capita in the Member States ranged from 45% to 274% of the EU27 average in 2011 http://epp.eurostat.ec.europa.eu/cache/ITY_PUBLIC/2-20062012-AP/EN/2-20062012-AP-EN.PDF

17 According to World Health Organization estimates

18 Approximately 300 persons receive PA service from CIL trained service providers. Another 100+ PWDs receive service from other providers.

19 Part of the problem regarding social services in Serbia lies in a multitude of funding sources: direct transfers, funding for projects of DPOs, other NGOs and from lottery make it almost impossible to establish specific amounts for service funding.


21 In line with art. 19 UN CRPD; however, as noted by ENIL, European Coalition for Community Living (ECCL), CIL

22 According to 2011 data by Republic Institute for Social Protection http://www.zavodsz.gov.rs/ , there are still 3,088 adults with disabilities (aged 18+) in social care institutions in Serbia. Community based services must be developed as institutions close out. The problem is also noted by Regional Center for Minorities http://www.minoritycentre.org/sh/node/1946

23 A service provided by a single NGO Iz Kruga www.izkruga.org

24 Ministry of Labour, Employment and Social Policy has approximately 500 DPOs on file throughout Serbia. However, DPO membership includes persons with different types of disabilities and the PA service provider training targets organizations that gather wheelchair users, thus not a full universe.

25 CIL data

26 Private companies and social enterprises are eligible for provision of service under the Law but there is no data on any company actually providing the services as of December 2012

27 According to Expert Reviewer contracted by the Ministry of Labour, Employment and Social Policy, Vladan Jovanović, review submitted in support of CIL’s application for accreditation with Institute for Social Protection in 2011

28 The Disability Monitor Initiative South East Europe, *Beyond De-Institutionalization: The Unsteady Transition towards an Enabling System in South East Europe*, 2004


With origins in the US civil rights and consumer movement of the late 1960s the Independent Living movement replaces the special education and rehabilitation experts’ concepts of integration, normalization and rehabilitation with a new paradigm developed by disabled people themselves. The first Independent Living ideologists and organizers were people with extensive disabilities. Today the movement’s message is still most easily grasped by people whose everyday lives depend on assistance with the activities of daily living, since they are most exposed to custodial care, paternalistic attitudes and control by professionals. The Independent Living philosophy postulates that disabled people are the best experts on their needs, must take the initiative, individually and collectively, in designing and promoting better solutions and must organize themselves for political power. Besides de-professionalization and self-representation, the Independent Living ideology comprises de-medicalization of disability, de-institutionalization and cross-disability (i.e. inclusion regardless of diagnoses).

Contact information on National organization of persons with disabilities in Serbia (NOOIS) http://www.edf-feph.org/Page.asp?docid=20833&langue=EN

For more details, please see the attached document Accredited CIL program Training outline. A full accredited training program curriculum is also available in Serbian.
Theoretically informed case study accompanying the film

Stroke care – Patient led rehabilitation (through “Early Supported Discharge”) - UK

Author:
University of Southampton
Chris Hawker, Jane Frankland
WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/esd

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a European-wide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Stroke care – Patient led rehabilitation (through “Early Supported Discharge” from Hospital based Acute Stroke Care Services)

People who suffer stroke often experience long-lasting cognitive and physical symptoms and require rehabilitation from a team of specialists, including physiotherapists, speech therapists and occupational therapists in order to recover function. This service is an example of the Early Supported Discharge model of stroke care. This type of service represents a new means of achieving clinical and patient directed goals, based on research evidence.

Specific innovative elements

Healthcare at home

Patients receive specialist rehabilitation for stroke at home rather than as a hospital inpatient; this care is of the same level as would have been received in hospital; the service is provided by the specialist stroke team who deliver their care out in the community.

Personalised care

Clinicians and therapists work with patients and carers to help them set their own personalised rehabilitation goals.

Patient and Carer Involvement

Patients and carers (where relevant) share the management of their rehabilitation programme with therapists.

Integration with intermediary care services

The service is very integrated with intermediary care services, and patients are supported in their transition to these services where appropriate.

Key characteristics of the service

Principle

The principle is that stroke patients who are able to have rehabilitation in their own home, but of the same intensity as would have been received if they had remained in hospital, achieve better clinical outcomes than those who are provided with rehabilitation in hospital. Greatest benefits are seen when the services were provided by a specialist multidisciplinary team to a selected group of patients (those with mild to moderate stroke) (Langhorne et al, 2005).

Organisation

The service is provided by the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHFT). The Trust receives approximately 730 acute stroke and 200 transient ischaemic attack (TIA), or ‘mini-stroke’, admissions per year.

User groups

The service is provided to patients who have experienced mild to moderate stroke (and their carers) who are suitable for early supported discharge because they are medically stable, carers can cope and the patient has active rehabilitation goals.

Driver(s)

- Better outcomes and experience for patients
- Cost savings
- Evidence informed national policy
- Patient and carer involvement
Factors influencing Social Services Innovation

Drivers
- Changing disease pattern
- National policy on stroke care
- Improved outcomes for patients

Novelty
- Delivery of rehabilitation at home by specialist healthcare professionals
- Focus on personalised goals
- Patient and caregiver involved in managing their rehabilitation

Response: Stroke care: patient-led rehabilitation

Agents of change
Clinical and Hospital Management teams

Sustainability
- The pilot programme is now being extended across the region

Challenges
- Increasing incidence of stroke
- Pressure to reduce hospital inpatient costs

Quality
- More efficient use of resources
- Improved patient experience and outcomes
- High levels of staff satisfaction
## 2. Policy Framework related to stroke care in the United Kingdom

<table>
<thead>
<tr>
<th>Principles/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move towards long term healthcare provided in community settings,</td>
<td>Health care in the UK is provided by the National Health Service as a universal service funded from taxation</td>
<td>The service model is based on a number of national policy statements in stroke: UK Department of Health National Stroke Strategy, 2007 (Department of Health, 2007) states that people who have had a stroke should receive high quality rehabilitation as soon as possible and for as long as they need it</td>
<td>Direct cost to the UK NHS of stroke care - about £2.8 billion a year (Division of Health and Social Care Research,)</td>
</tr>
<tr>
<td>Personalisation</td>
<td>Department of Health: UK health care policy is promoting and supporting early supported discharge in stroke</td>
<td>UK Royal College of Physicians National Clinical Guidelines for Stroke, 2008 (Intercollegiate Stroke Working Party, 2008) states that early discharge patients should be followed up by a specialist stroke rehabilitation service</td>
<td>Annual costs to the wider economy associated with lost productivity, disability and informal care for stroke - around £4.2 billion. (Division of Health and Social Care Research,)</td>
</tr>
<tr>
<td>Integrated working</td>
<td>The RBCHFT provides acute care services to a population of around 550,000 in the south of England</td>
<td>Collaboration for Leadership in Applied Health Research and Care - Nottinghamshire, Derbyshire and Lincolnshire - A Consensus on Stroke: Early Supported Discharge, 2005 (Fisher et al, 2011) uses a review of literature and expert consultation to make recommendations for ESD service composition</td>
<td>Stroke care is free at point of access for all UK residents (tax based system)</td>
</tr>
<tr>
<td></td>
<td>The RBCHFT has an established, integrated stroke service, including pre-hospital public and paramedic awareness, acute and rehabilitation care and stroke prevention</td>
<td>UK National Health Service -National Stroke Improvement Programme Accelerated Stroke Improvement Measures, 2010. (NHS Improvement Programme, 2008) NHS committed to an accelerated programme of improvement in stroke services, including provision of ESD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RBCHFT Stroke Specialist ESD Team deliver specialist stroke care and rehabilitation in the community</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>On-going long-term support provided by primary care, social care and voluntary sector providers as appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th></th>
<th>UK</th>
<th>EU27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population, (2010)</td>
<td>62.3 million</td>
<td>501.1 million</td>
</tr>
<tr>
<td></td>
<td>(ONS, 2011a)</td>
<td>(Eurostat, 2011a)</td>
</tr>
<tr>
<td>Population projections 2035</td>
<td>73.2 million</td>
<td>525 million</td>
</tr>
<tr>
<td></td>
<td>(ONS, 2011a)</td>
<td>(Eurostat, 2011b)</td>
</tr>
<tr>
<td>Proportion of population aged 65-79 years, (2010):</td>
<td>11.9% (ONSa)</td>
<td>12.7%</td>
</tr>
<tr>
<td>Proportion of population aged 80 years and more (2010):</td>
<td>4.7% (ONSa)</td>
<td>4.7%</td>
</tr>
<tr>
<td>Proportion of population aged 65 and over (2010):</td>
<td>16.6% (ONSa)</td>
<td>17.4%</td>
</tr>
<tr>
<td>Old-age-dependency ratio (2008)</td>
<td>310 (ONSb)</td>
<td></td>
</tr>
<tr>
<td>Projected old-age dependency ratio 2051</td>
<td>495 (ONSb)</td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth in years: male/female</td>
<td>78.1/82.1 (2008-2010) (ONS, 2010b)</td>
<td>76.4/82.4 (2009) (Eurostat c)</td>
</tr>
<tr>
<td>Expenditure on health care (% of GDP, 2009)</td>
<td>9.8</td>
<td>10.2 (EC, 2012)</td>
</tr>
<tr>
<td>Direct NHS care costs for stroke (2003-4)</td>
<td>2.8bn (Division of Health and Social Care Research,)</td>
<td>-</td>
</tr>
<tr>
<td>Number of people having a stroke per annum</td>
<td>150,000 (Stroke Association)</td>
<td>About 1,000,000 (EC, 2007)</td>
</tr>
</tbody>
</table>

3.2 Information about the specific Welfare State: UK

In the UK, the state provides a basic level of social support and social protection. Around half the UK population (approximately 30 million people) receive some social security benefit. These benefits are a mix of taxable/non-taxable; contributory/non-contributory and means/non-means tested benefits. The benefits can be divided into six categories of recipient: families with children, unemployed people, those on low incomes, elderly people, sick and disabled people, and bereaved people. Social security benefits for the period 2011-12 amounted to 13.5% of the GDP of Great Britain, and is the largest single area of government spending (Browne and Hood, 2012).

Social services (social care and social support) are organised at a local level, with some schemes funded nationally but mediated through local government, and some funded locally. Local governments have reduced their role of direct service provider in some areas, with a growing number of independent providers and a growing social enterprise sector becoming involved. The system thus has a plurality of service providers. Social care services in England, Northern Ireland, Scotland and Wales are managed separately, although are similar in most respects (Theil, 2010).

Health care is provided through the National Health Service (NHS) which is funded through taxation and is free at the point of use for anyone living in the UK. Again, NHS services in England, Northern Ireland, Scotland and Wales are managed sepa-
rately, although are similar in most respects. Expenditure on healthcare in the UK in 2009 was £136.4 billion, or 9.8% of GDP (Qaiser, 2011).

In the UK, there is a continuous increase of expenditure in benefits delivered in kind rather than in cash. The table below presents the social protection expenditure of selected countries.

### Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro

<table>
<thead>
<tr>
<th>Time</th>
<th>EU 27</th>
<th>United Kingdom</th>
<th>Germany</th>
<th>France</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expenditure for social protection benefits in Mio. of Euro</td>
<td>Expenditure for social protection benefits in Mio. of Euro</td>
<td>Expenditure for social protection benefits in Mio. of Euro</td>
<td>Expenditure for social protection benefits in Mio. of Euro</td>
</tr>
<tr>
<td></td>
<td>/</td>
<td>3,605,678.95</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>United Kingdom</td>
<td>262,859,71</td>
<td>478,281,18</td>
<td>124,56%</td>
</tr>
<tr>
<td></td>
<td>Germany</td>
<td>565,683,07</td>
<td>765,717,82</td>
<td>52,53%</td>
</tr>
<tr>
<td></td>
<td>France</td>
<td>379,396,42</td>
<td>654,238,65</td>
<td>84,47%</td>
</tr>
<tr>
<td>Source: Own calculations based on EUROSTAT 2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Challenges and Drivers of Innovation

**Structural weaknesses** of the system:
Health services face growing demands on services, from an ageing population, from advances in knowledge, science and technology, and from increasing public expectations. The incidence of stroke and other long term conditions are expected to rise as the population ages. Alternatives to hospital care will be needed to ensure that expensive hospital resources are used to provide for those who need the resources of a hospital setting and cannot be treated in other, usually better, environments. Health services must meet these challenges within a tough financial climate and must work to limit expenditure but also to maintain or improve quality of services.

**Innovation:** Ideas, criteria, levels and added values

*What is new and innovative*
Early Supported Discharge is an evidence-based model of care for certain groups of stroke patients. Traditional models of stroke care are based primarily in hospital, where patients receive both acute care and rehabilitation. The ESD model facilitates an earlier discharge from hospital, with the rehabilitation that would have been provided in hospital being provided in the patient’s home. Rehabilitation at home allows patients to work towards individualised goals which, as they are undertaken at home, are meaningful and functional.

**Outcomes**
An evaluation of the pilot was carried out over a six month period, from August 2011 to January 2012 (Moseley, 2012), in order to test assumptions made in the business case for the service and to evaluate the service impact. The evaluation focussed both
on impact for patients and for the service, and aimed to inform future service provision. The evaluation showed:

Impact for patients:
- A total of 153 patients were discharged from hospital to the ESD service
- The service received positive patient and carer feedback
- The majority of patients showed an improved ‘quality of life’ score on a validated questionnaire based measure compared to those who had previously received hospital based rehabilitation
- All patients maintained or improved their level of functional independence
- All patients demonstrated improvement on their level of personal goal achievement

Impact for stroke service:
- A reduction in the average length of inpatient stay from an average of 21 to 13.28 days
- An estimate of 1642 bed days saved over the 6 month period
- The closure of 22 in-patient stroke beds
- No increase in readmissions (in a period of up to 30 days from discharge) indicating that the identification of patients who could benefit from this approach was appropriate

Agents of Change
The service began as a local pilot in order to develop the model of provision and to assess its outcomes. The Senior Consultant Doctor of the stroke service led the development of the pilot. A factor driving the pilot was the requirement to close one of the Trust’s stroke facilities and thus to reduce bed numbers.

5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>August 2011</td>
</tr>
<tr>
<td>Type of organization</td>
<td>National Health Service, acute stroke service</td>
</tr>
<tr>
<td>Financing</td>
<td>NHS; 6 month pilot in August 2011</td>
</tr>
</tbody>
</table>
| Size of organization | Number of staff: 8 full time, one 0.6 of full time, plus 1 session per week stroke consultant, 3 sessions per week consultant therapist
Number of users: 153 over 6 month pilot period |
| Members and participation | Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHFT). The Trust receives approximately 730 acute stroke and 200 transient ischaemic attack (TIA), or ‘mini-stroke’, admissions per year. |
| Contact | Stroke care – Patient led rehabilitation (through “Early Supported Discharge”) |
| Name of the innovative example | http://wires.wessexhiecpartnership.org.uk/ |
**Background**

Early Supported Discharge (ESD) is a model of accelerating discharge from hospital to home, with provision of specialist rehabilitation in the home setting. The provision of rehabilitative therapy in the community for suitable patients has been shown to improve patient outcomes in those patients with mild to moderate symptoms of stroke, which equates to about 40% of all stroke patients.

Major improvements have been made to Stroke care services in recent years, in response to government policy guidance, but the uptake of an early supported discharge model of service delivery has been slow. The Stroke Early Supported Discharge service at Royal Bournemouth and Christchurch NHS Foundation Trust began as a 6 month pilot in August 2011. The service was started as a local pilot based on evidence from research based practice elsewhere in the UK in order to test the model of service delivery and to evaluate the impact of the service over this period (Moseley, 2012).

The introduction of this service has supported the merger of two stroke units, with a planned reduction of 22 inpatient beds.

**The setting**

The Bournemouth and Christchurch NHS Trust serves a population of 350,000 across Dorset and Hampshire in the south of England. The Trust has around 730 acute stroke and 200 transient ischaemic attack (TIA), or ‘mini-stroke’, admissions per year. Specialist stroke care is delivered by a multidisciplinary team on the stroke unit at the Royal Bournemouth Hospital. The ESD team is situated within the Rehabilitation Department of the hospital. The ESD team work alongside the in-patient team to identify patients for ESD. Patients can be discharged to the ESD service if deemed suitable according to certain eligibility criteria, including medical stability and low likelihood of carer strain.

**Service delivery**

The ESD service is delivered by specialist stroke staff from a variety of disciplines (see box below), and is delivered 7 days per week in the patient’s home.

<table>
<thead>
<tr>
<th>Staffing of RBCHFT ESD service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 clinical leader</td>
</tr>
<tr>
<td>2 Physiotherapists</td>
</tr>
<tr>
<td>2 occupational therapists</td>
</tr>
<tr>
<td>1 speech and language therapist</td>
</tr>
<tr>
<td>0.6 stroke nurse</td>
</tr>
<tr>
<td>2 rehabilitation assistants</td>
</tr>
<tr>
<td>1 session per week stroke consultant</td>
</tr>
<tr>
<td>3 sessions per week consultant therapist</td>
</tr>
</tbody>
</table>

Welcome home visits take place within 24 hours of a patient’s discharge. The ESD team work with the patient and carer to set individualised rehabilitation goals and a programme of rehabilitation. As these goals are actioned within the patients’ own home, they are relevant to the patient’s daily lives. The team is normally involved with a patient for around 2 weeks. Discharge from the ESD service then includes referral to a continuing community support services when appropriate.
Relevance for Europe

ESD in stroke care is an evidence based model of care which provides more appropriate outcomes for stroke care patients and their families, helps support independence and which can address pressures to contain healthcare costs. As such, it is likely to be a model of interest to other countries within the EU.

6. References


Eurostat (c) Available at: http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Mortality_and_life_expectancy_statistics (Date of Access: 09.03.2013)


Office for National Statistics (a). Table A2-1, Principal projection - UK population in age groups, 2010-based. Available at: www.ons.gov.uk (Date of Access: 09.03.2013)


Office for National Statistics (2011a) Summary: UK Population Projected to Reach 70 Million by Mid-2027. Available at: www.ons.gov.uk (Date of Access: 09.03.2013)

Office for National Statistics. (2011b) UK Interim Life Tables, 1980-82 to 2008-10. Available at: www.ons.gov.uk (Date of Access: 09.03.2013)


Stroke Association. Available at: www.stroke.org.uk (Date of Access: 09.03.2013)

Theoretically informed case study accompanying the film

ELTERN-AG – Germany

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Gorgi Krlev, Lukas Nock, Georg Mildenberger

WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a European-wide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. ELTERN-AG Parent education in Germany

ELTERN-AG is a private nonprofit provider that targets parents-to-be and parents with children at a very early age which are ‘hard-to-reach’ or cut off from the regular providers (e.g. single parents, parents with immigrant background etc.). The organization provides coaching to these parents to support them in the upbringing and education of their children. It does so with a ‘low-threshold’ approach, treats parents as experts, empowers them thereby and initiates self-help networks to build sustainable support structures for parents in need.

The project has been initiated on the background of a missing effective connection between the regular public system of assistance and the target group. By creating individualized support the project aims at breaking the circle of continued inequalities. Apart from that the social role of families as places of community instead of solely private interests is strengthened.

Specific innovative elements of ELTERN-AG:

Access to ‘hard-to-reach’ target groups:
Project is realized within the target group’s local communities; participants are acquired directly by disseminators and intermediaries (low-threshold approach).

User focus and empowerment:
Focus on the parents’ perspective; they are seen as the main experts who just have to be activated to use their competencies; empowerment instead of paternalistic advice.

Initiation of self-help network structures:
Participants are encouraged to get more and more involved in the program’s form and content; aim: parents meet each other regularly as a self-organized and locally embedded group after the intervention has ended officially.

Scaling by cooperating with welfare organizations:
Employees of established welfare organizations are offered vocational trainings to become a mentor; aim: spreading the approach widely by using the existing infrastructure of the welfare associations.

Research-based evaluation
Constant scientific evaluation of the program’s effectiveness.

Key characteristics of the service

Organisation:
ELTERN-AG’s provider is a private non-profit organization called MAPP-Empowerment GmbH (located in Magdeburg, Germany). A special cooperation model enables welfare associations and other organizations from the field of social services to offer ELTERN-AGs directly on site. Since September 2012 there are 188 trained mentors in ten German federal states, who have already reached 1,228 parents and 2,908 children.

User groups:
Users are parents-to-be and parents with children at a very early age, who meet at least one of the following criteria: single-parent, underage parent, immigrant background, socially deprived, low educational level.

Principle:
The main idea is that a targeted set of simple educational advice given to parents is sufficient for unleashing and fostering their educational potential. This potential can be developed, strengthened and shared in groups. In spite of the postulates’ simplicity, the method is based on actual scientific expertise with relation to the fields of neurosciences, developmental psychology and social work.
Factors influencing Social Services Innovation

Drivers
- New management styles
  - Program evaluation as proof of effectiveness

Social roles
- Family as new place of community interest
- Enabling of families by becoming part of a community network
- Competence development

Challenges
- Weakness of system
- Cash benefit oriented family and child care policy
- Fragmented and divided services
- Increasing costs in the child and youth welfare sector
- Missing effective connection between regular public system & target group

ETERN AG’s response
- Empowerment for disadvantaged parents as hard to reach users (new form of service)
- User involvement & focus on parents’ abilities (new form of delivery)
- Establishment of community networks (self-help logic) (new form of governance)
- Ongoing evaluation (new way of monitoring)
- Scaling model through cooperation with social service providers (new form of resourcing)

Positive outcomes
- Higher cognitive, emotional and social competency of children
- Less or more constructive conflicts in families
- Avoidance of future conflicts and deficiencies
- Support network for parents

Resulting ambitions
- Individualized support aims to break circle of inequalities
- Reaching out to excluded user groups
- Mixing individual and community support
- Preventative measures
- Strengthening and developing individual self-esteem and competencies
- Extending service reach through collaboration

Agents of change
- Result of a seminar at Magdeburg-Stendal University of Applied Sciences

Continued inequalities
- Missing enablement of learning careers through disadvantaged backgrounds

Individual aspirations
- Need for individualized support

Sustainability
- Parents continue to meet after the formal program has ended

Novelty
- New practice for old needs
- New perspectives on old needs
### 2. Policy Framework related to parent education in Germany

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Education as a basic right:</strong> the care and upbringing of children is the natural right and a duty of parents. The state watches over them in the execution of this duty (cf. Basic Law of the federal Republic of Germany, art. 6, par. 2)</td>
<td>- The state (in this case: municipality) is legally obligated to build up an infrastructure of youth welfare services by running public or subsidising private non-profit organisations (cf. Schröer, Struck &amp; Wolff 2005)</td>
<td><strong>Legal milestones:</strong></td>
<td><strong>1. Public expenditure for the whole area of child and youth welfare in 2010 (cf. StBA 2012):</strong></td>
</tr>
<tr>
<td><strong>2. Families as spheres of ‘informal education’:</strong> Trend to strengthen education beyond the formal educational system (cf. BMBF, 2010, p. VIII-IX)</td>
<td>- Legal foundation of the right of every child to support their individual development and to build a self-dependent and socially natured personality (cf. Social Security Code VIII, §1)</td>
<td><strong>Service characteristics</strong></td>
<td><strong>2. Financing of municipal child and youth welfare is generally granted by the local government</strong></td>
</tr>
<tr>
<td><strong>3. Educational partnership:</strong> Redefining state’s sentinel function from paternalism to partnership based forms of support in the upbringing and education of children. (cf. BMFSFJ 2009)</td>
<td>- Every Family has got the same legal claim to child and youth welfare services, but esp. families in need either cannot be reached by the services, or do not participate at all, or tend to drop out of interventions prematurely</td>
<td><strong>Early interventions are either based on voluntary decisions of parents to participate or mandatory when the child’s wellbeing is endangered. Thus, it is hard to find data on ELTERN-AG’s target groups. The following gives an impression on the issue of single parents:</strong></td>
<td><strong>- Especially in very early child age (2-3 years) there is a support gap. Parents cease to receive parental pay and at the same time children don’t yet have a legal claim to go to Kindergarten. A similar gap prevails in afternoon-care for school children. (Cf. Bellermann 2011)</strong></td>
</tr>
<tr>
<td><strong>4. Shifting the perspective…</strong></td>
<td>- Especially in very early child age (2-3 years) there is a support gap. Parents cease to receive parental pay and at the same time children don’t yet have a legal claim to go to Kindergarten. A similar gap prevails in afternoon-care for school children. (Cf. Bellermann 2011)</td>
<td><strong>- From 1996 until 2010 the number of single parents increased from 1.3mio to 1.6mio</strong></td>
<td><strong>- More than 210.000 single men and women have to take care for a child under the age of three years (cf. BMFSFJ 2012; own calculation)</strong></td>
</tr>
<tr>
<td>… from deficit to resource oriented perspective on families (cf. Wiesner 2012)</td>
<td>- Policy competencies are pillarized and fragmented between different constituents (school and youth welfare; kindergarten and early childhood education; etc.) (Cf. Bellermann 2011)</td>
<td><strong>- about 10% of the single parent families rely on state support in education (cf. StBA 2010)</strong></td>
<td></td>
</tr>
</tbody>
</table>

¹ The official statistics do not include ‘early interventions’ as an independent category; it is usually summed up together with other related forms of assistance into the category called “general promotion of education in families” (cf. Social Security Code VIII §16; StBA 2012). Restructuring in this regard is to be expected, which underlines the peculiarity of the field as an emerging, increasingly important special category of intervention.
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population (2010)</td>
<td>81,751,602</td>
<td>501,104,164</td>
</tr>
<tr>
<td>Population projections 2010-2050</td>
<td>69,412,000</td>
<td>524,052,690</td>
</tr>
<tr>
<td>Proportion of population aged 0-3 years (2010)</td>
<td>2.5%</td>
<td>n/a</td>
</tr>
<tr>
<td>Single parent families (2010)</td>
<td>1,600,000</td>
<td>n/a</td>
</tr>
<tr>
<td>Expenditure on social protection (total) (2009)</td>
<td>254,000,000.000</td>
<td>n/a</td>
</tr>
<tr>
<td>Expenditure on social protection (% of GDP) (2009)</td>
<td>31.1%</td>
<td>29.51%</td>
</tr>
<tr>
<td>Expenditure on child and youth welfare services (2010)</td>
<td>28,900,000.000</td>
<td>n/a</td>
</tr>
<tr>
<td>Expenditure on child and youth welfare services (% of GDP) (2010)</td>
<td>1.16%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Source: StBA 2012

3.2 Information about the specific Welfare State\(^3\): Germany

The German welfare state has a long tradition which goes back to the end of the 19\(^\text{th}\) century and to Bismarck’s social policy (which itself can be seen as a genuine social innovation). It can be illustrated as a ‘two-pillar model’. The first pillar of welfare is focused on shelter and protection. Social insurance and transfers serve as risk buffers in special circumstances (livelihoods, services of general interest) and shall guarantee a minimum of societal participation (*the material problems of life*). The second pillar, the social services, are the institutional version of service arrangements in which the state and society provide interventions that aim at addressing social problems with more or less specialized consulting, mentoring or care offers (*the immaterial problems of life*). Which areas social services should focus on is influenced by several supply- and demand-side factors and is the subject of political debate and compromise formation:

- On the demand side and with regard to the particular service field, it is mainly socio-cultural change that has an effect on raising demand for such services: Pluralization and individualization trends, changes in gender roles and relations, increasing mobility requirements by changing labor markets and structural change in families e.g. demand for a greater density of care services for children and adolescents (child care).
- On the supply side a broadening of services offered comes through the diversification and specialization of social services provided by an increasing variety of different actors. The growing number of welfare professions creates an expansion of the definition of requirements, particularly in the field of education, social work or psychotherapy.

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\(^2\) The variety of national statistical categories makes it hard to clearly identify budgets dedicated to the field on the EU level. That is why most of data is indicated as n/a.

\(^3\) For references and a more fine-grained illustration of the Welfare sector in Germany compare to literature review of INNOSERV WP1 and separate “Reader on the field of Welfare in Germany”.
Recent structural changes in welfare-state arrangements are to be understood primarily in the context of issues relating to the affordability of the welfare state (‘neo-liberal critique’) in relation to social change in modern service economies. Based on the tension between the requirements of increasing social welfare services on the one hand and growing demands for cost saving on the other hand, a restructuring of the architecture and the logic of welfare distribution is in progress in almost all fields of state intervention. This process (also called commodification or economization in the current discourse) refers not only to institutional and legal frameworks, but is also reflected by an increasing business orientation of organizations. This drives the introduction of economic instruments to control social service providers on the background of limited available resources. The economization is accompanied by the paradigm of activation, which comes together with a redefinition of the welfare state’s self-image. The enabling state has to offer a broad range of highly complex, preventative and activating social services in order to increase the capacity for self-help and individual responsibility. Thereby it supports and encourages a stronger interaction between public and private providers as well as a free and active civil society. These still ongoing reconstruction processes relate strongly to the welfare state landscape:

- The social services in the local government areas are being reorganized since the 1990s with regard to structures and processes. The underlying aim has been a radical modernization of the administration (keyword: new public management, lean management, double-entry accounting and privatization of municipal services support).
- In the area of child and youth services market competition has found its way into the provider landscape. While youth services have experienced an infrastructural extension in terms of playing a partial role in preparing adolescents for participation in working life (public investment in early childhood education), other functional areas of the sector (such as educational aids) have suffered from legitimacy pressures in recent years due to their declining power of integration.

There is a steady increase of in-kind benefits as percentage of total social protection benefits (including social services), which underlines the significance of such services against simple cash benefits. The table below illustrates social protection expenditures of Germany in comparison with the EU 27.

**Social protection expenditures: Aggregated benefits and grouped schemes in Mio. of Euro**

<table>
<thead>
<tr>
<th>Time</th>
<th>Total expenditures for social protection (in Mio. Euro)</th>
<th>Increase in in-kind benefits</th>
<th>Proportion of in-kind benefits (of total social protection benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3.605.678,95</td>
<td>/</td>
</tr>
<tr>
<td>Germany</td>
<td>565.683,07</td>
<td>765.717,82</td>
<td>52,53%</td>
</tr>
<tr>
<td>Hungary</td>
<td>/</td>
<td>22287,98</td>
<td>/</td>
</tr>
<tr>
<td>France</td>
<td>379.396,42</td>
<td>654.238,65</td>
<td>84,47%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012
4. Challenges and Drivers of Innovation

**Structural weaknesses** of the system:
- Still mainly cash benefit orientated family- and childcare policy
- Highly 'pillarized' and 'fragmented' services
- Support gaps at very early child age and in school age
- Cost increases in the area of child and youth welfare

**Drivers and Challenges**

Upon the given background the main *challenges* referring to societal and sociopolitical developments which ELTERN-AG has to deal with and its *responses* to it can be summarized under the following topics.

- According to the close connection between social origin and educational opportunities the challenge is to break the circle of *continued inequalities* which families in less-favorable social circumstances often suffer from. The response is the enablement of ‘learning careers’ despite disadvantaged backgrounds by an *individualized support* of the target group – at the same time this aims at enabling *self-help structures* face to restricted budgets.
- The latter aspect plays a role in the issue of *spreading an intervention* (scaling). Given the diversity of service providers, which comes with a multiplicity of ideas but also with the risk of loosing quality, innovative impulses can best be standardized through *collaborative efforts* (between new and established constituents). In terms of quality *continuous* (scientifically guided) *evaluation* and impact measurement can be expected to play a pivotal role.
- The understanding of *social roles* has to be changed. Families are no longer seen as places of solely *private concerns* which are hermetically sealed from *community interests*. So the response is the enablement of families as a part of the community network.

**Innovation**: Ideas, criteria, levels and added values

The need for individualized support of single parents or other parents in difficult life situations in bringing up children under improved circumstances is not going to decrease in the next years. Reasons for this are the ongoing pluralisation of forms of family life, the high divorce rate and the inequality of wealth distribution (specific poverty risk for single parents).

One of the basic principles of child and youth welfare in Germany is the voluntary use of the offered services (when the child’s wellbeing is not endangered acutely) and the obligation of cooperation between parents and public bodies (cf. Social Security Code VIII §27 and §36). These high-level professional requirements make it hard for the public youth welfare to act preventatively and to reach out for the identified target group. Parents can perceive not be obliged to take part in educational programs but have to be convinced constantly motivated to keep up their participation. The latter is beyond the capacity of the public youth welfare. This provision gap is closed by the selected example based on the following innovation criteria (as introduced initially):
Access to hard-to-reach target groups:
Participants are acquired directly by disseminators and intermediaries working in the program and/or other cooperating institutions. There are eligibility criteria directed at including groups that are most in need of the service.

User focus and empowerment:
The participant's perspective is stressed and parents are encouraged in their abilities and competencies. The parents are treated as experts, who simply need a (subtly) guiding hand and especially possibilities for exchange. This strategy of empowerment creates a motivating service situation beyond paternalistic advice which might provoke resistance.

Initiation of self-help network structures:
From the beginning the participants are encouraged to become the essential part of the program. At the end of the guided session program the parents meet up with each other regularly as a self-organized and locally embedded group supported by a mentor if required. This helps to ensure the sustainability of effects and builds an ecosystem of support that contributes to minimizing individual exclusion.

Scaling by cooperating with welfare organizations:
Instead of offering all services themselves, the organization provides vocational training for the staff of well established welfare organizations. Through using the existing infrastructure the service can be spread widely. As a result the idea gets also more and more embedded in the public welfare system, which can be seen as another indicator of sustainability.

Research-based evaluation:
The program is evaluated constantly by an independent research institute to improve quality and measure the effectiveness of the intervention on the cognitive, emotional and social development of the children, whose parents have participated. This is important to underline the programs value towards funders, partners and third parties broadly.

Agents of Change
ELTERN-AG was founded at the Magdeburg-Stendal University of Applied Sciences in 2002/2003 as a reaction to controversies about continued inequalities in educational opportunities for children in Germany. In order to scale up the program, a private non-profit organisation (MAPP-Empowerment GmbH; gemeinnützig) has been established as the new provider of ELTERN-AG in 2007. The connection to academia and science has contributed to the establishment of a continuous evaluation program accompanying the offered services. First, this happened in the form of self-evaluation, later an external evaluator has been commissioned.
5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>2002/2003</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Private non-profit organization; limited liability company with &quot;public benefit&quot; status (gGmbH)</td>
</tr>
</tbody>
</table>
| Financing                        | - Training and cooperation fees of the collaborating welfare organizations, which in turn can receive a full refund by the state  
                                    - Charitable donations and grants from foundations |
| Size of organization             | 188 trained mentors in ten German federal states |
| Members and participation        | 1,228 parents and 2,908 children  
                                    - special cooperation model enables welfare associations and other organizations from the field of social services to apply and spread the program |
| Name of the innovative example   | Programm ELTERN-AG    |
| Contact                          | Klausenerstr. 15      |
| Homepage                         | 39112 Magdeburg       |

In 2000 the PISA study (Program for International Student Assessment) and later on the IGLU study (German for PIRLS – Progress in International Reading Literacy Study) showed that the social backgrounds of children are strongly related to their educational achievements on the one hand and their individual mental and physiological health on the other hand. These connections are especially pronounced in Germany. Therefore these results stimulated debates about reforming the German formal educational system and renewing the educational mandate of nursery schools. Besides, the role of the non-formal education, especially in families became an intensively discussed subject. ELTERN-AG is an approach that focuses on the latter in order to deliver equal educational opportunities for all children irrespective of their social backgrounds. The eligibility criteria for the ELTERN-AG-empowerment are strict and aim at including most vulnerable groups. The organization pro-actively approaches their participants and is thereby most effective in reaching the 'hard-to-reach' target groups that alternative providers have missed to address. This is also due to the fact that there are no costs for the participating parents.

What are the characteristics of ELTERN-AG as a social service and how is this service organized?

ELTERN-AG is organized in a special cooperation model which enables welfare associations and other organizations from the social field to offer ELTERN-AGs directly on site. Employees of the cooperating welfare organizations are offered vocational trainings to become mentors.

ELTERN-AG’s financing occurs by training and cooperation fees of the collaborating welfare organizations, which in turn can receive a full refund by the state. Furthermore, there are charitable donations and grants from foundations.
ELTERN-AG as a social service can be characterised along the following basic themes (cf. Armbruster 2005):

- early childhood: focus on pre-school age
- intuitional educational competency of parents: “parents are the born educators”
- competencies of children: self-regulation under conductive framework conditions
- de-institutionalized assistance – leaving “experts” out: exchange at eye level
- gender orientation: awareness raising for the mother and father role by male and female mentors
- scientific approach: neuroscience, developmental psychology, pedagogic, evidence-based

The intervention happens pre-natal or at a very early child age. Thus, the intervention is highly preventative. It helps avoiding the emergence of family problems before they occur or aggravate. Thereby it ensures a conflict-free upbringing and education of the children. This is important, since early childhood and youth experiences have a high impact on the future development of people.

The coaching program fundamentally builds on the interests, the involvement and the capabilities of the parents, which decide individually and freely on their participation (empowerment). The following basic educational rules parents are sensitized for are sufficient to tap into and enable parents’ with their existing educational competencies (cf. Armbruster 2005):

- respect for the child
- advancement and responsiveness
- setting clear limits and being consequent on decisions
- reinforcement of desirable behaviour and non-observance of undesirable behaviour
- constructive way of dealing with conflicts
- upbringing free from violence

By applying a bottom-up, low-threshold approach the organization succeeds in building trust in participants that enables intense and effective collaboration. Furthermore, the program is conceptualized for small groups in local neighbourhoods. The parents are seen as experts, which is reflected in the following basic group rules that contribute to group cohesion (Armbruster 2005):

- focus on joint issue: our children
- voluntariness
- mutual respect
- mutual assistance
- absolute confidentiality
- equal rights for all
- no pathologization
Thereby it automatically enables the establishment of mutual aid and community networks that mostly continue to exist after the end of the official program.

The effectiveness of the intervention is underlined by two facts: The results of the scientific evaluation and the increasing number of well established, large welfare organizations that make use of the experiences and the special concept of ELTERN-AG and let their staff participate in vocational trainings provided by the organization. ELTERN-AG thereby serves as an innovative lever for the existing welfare landscape.

Similar positive effects as illustrated above could be expected in other European countries, as the ELTERN-AG seems to be an appropriate measure to break the circle of continued inequalities in education, which is a Europe-wide problem. Targeting the close connection of social backgrounds and educational success by a highly preventative early intervention along the criteria and principles of ELTERN-AG concept seems a very promising way to avoid problems before they emerge.

6. References


Eurostat (Statistisches Bundesamt) Hrsg. 2012: Tables by functions, aggregated benefits and grouped schemes - million EUR. Available at:


Statistisches Bundesamt (StBA) (2012): Kinder- und Jugendhilfestatistiken - Ausgaben und Einnahmen der öffentlichen Jugendhilfe 2010. Available at:
https://www.destatis.de/DE/Publikationen/Thematisch/Soziales/KinderJugendhilfe/AusgabenEinnahmenJugendhilfe.html (Date of Access: 09.03.2013)


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Theoretically informed case study accompanying the film

European Care Certificate - Europe

Author:
EASPD
James Churchill, Miriana Giraldi

WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://inno-serv.eu/ecc

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a Europeanwide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. The European Care Certificate (ECC)

The main idea behind the ECC was to create and promote an “award” for entry level staff in the care sector which will be recognised anywhere in the EU and which has a place on the European Qualifications Framework and in the National Qualification Frameworks of Member States.

Specific innovative elements of ECC

Agreement on a shared definition of what basic knowledge is needed:
The representatives of participating countries could agree on the content of the Basic European Social Care Learning Outcomes (BESCLO) and both workers and employers confirmed that its contents were directly relevant to their job.

The creation of a reliable test for that knowledge in a worker/applicant:
The ECC exam has been used in 16 different EU countries with over 3,500 candidates, with an overall pass mark of around 61%. Employers have also used the ECC exam for screening applicants and report that it is a useful and reliable way of separating out apparently similar candidates.

Being able to demonstrate basic knowledge helps workers and employers:
Anecdotal evidence from employers and exam candidates demonstrates that holding the ECC does help get staff into interviews, does improve employment prospects and does help employers to have confidence that the worker/applicant has the basic knowledge to work safely in care and understands fundamental care principles.

Key characteristics of the service

User groups:
Frontline workers providing social care to disabled and elderly people, either in a social care service or as a domestic worker in a family context;
Employers: either larger social care services or a single family;
Trainers and regulators: who need to look at qualifications and ensure that adequately trained staff is employed to provide frontline social care services.

Principle:
The strategy involved agreeing on a shared definition across EU Member States of what care staff on entry into the care profession need to know in order to work safely and then being able to test for that knowledge (via an exam) and offering a Certificate (the European Care Certificate) for those who pass the exam. This creates a common foundation for care services based on the principles of user centred services, human rights and the rights enshrined in the UN Convention on the Rights of Persons with Disabilities and facilitates worker mobility.

Driver(s):
- The driver for this innovative project is the fact that the social care workforce in the EU is “largely female, poorly paid and poorly led”. This is particularly the case at entry level.
- Changing family and societal structures are another driver behind the ECC.
- The new policy drivers exemplified by the principles of the UN Convention on the Rights of Persons with Disabilities are in fundamental conflict with the old approach typified by the ‘medical model’ of long term care for people with disabilities.
Factors influencing Social Services Innovation

Drivers and challenges
- Ageing of the population
- Changing family structures and role of women
- Mobility of workers
- Lack of appropriate/standardised training for entry level care staff across Europe
- UNCRPD
- Deinstitutionalisation

Agents of change
- Social service providers who wanted to tackle the issues of ensuring entry level care staff knowledge on care principles;
- Frontline care workers who have taken the ECC award;
- Trainers providing training on the BESCLO

Response
- Novelty: New way of testing and verifying basic knowledge by frontline staff
- Quality
- Sustainability: Need and satisfaction with the award both by workers and employers
  Award is now recognised in many EU countries
  EASPD central repository at EU level

*These lists are used for illustration only and are discussed more fully in WP2.
2. Policy Framework related to employment in the care sector in Europe

<table>
<thead>
<tr>
<th>Principle/Guideline</th>
<th>Key organisations and actors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ratification of UNCRPD by the EU and two thirds of its Member States:</td>
<td>1. Frontline care staff who take the ECC exam to receive a qualification of their knowledge of care sector work;</td>
</tr>
<tr>
<td>Sanctions the shift form a medical to a social vision of disability and sanctions rights and equal opportunities for disabled people;</td>
<td>2. Employers, who understand the need for a qualification to recruit frontline care staff based on their knowledge of care principles;</td>
</tr>
<tr>
<td>2. Deinstitutionalisation: from institution to community-based settings: implies a radical shift in the way in which care for disabled people is provided towards an individualised, user-centred approach. It necessitates training and re-training of care staff;</td>
<td>3. Trainers, who develop training courses that are ECC compliant and that aim at providing training and qualifications to entry level staff in the care sector, thus increasing and improving their employment prospects.</td>
</tr>
<tr>
<td>3. Mobility: EU legislation promotes a free market for workers which fosters movement of workers across EU Member States.</td>
<td></td>
</tr>
</tbody>
</table>

3. The social, political and institutional context

*Employment in the care sector in Europe*

Employment levels in the EU rose consistently since the beginning of the “Lisbon Strategy” in 2000: overall employment rates reached 65.9% in 2008, a 4% increase on pre-Lisbon figures; employment levels of female and older workers also significantly improved in the same time span, reaching 59.1% and 45.6% respectively.

Similar trends can be observed looking more specifically at the broad care sector, which was the biggest source of job creation in Europe in recent years, with health and social care services being a “particularly dynamic sub-sector” which contributed to the creation of 3.3 million new jobs between 2000 and 2007, i.e. one sixth of the jobs created in the services sector as a whole.

More recent data shows that in 2011, the number of workers in the health and social care sector aged 15 to 64 stood at 22.3 million, i.e. 10.5% of the total in all sectors. This means that the sector has grown by 5 million jobs since 2000, but the growth has been unequal across Member States. It has been highest in countries such as Denmark, the Netherlands, Finland and Sweden and lowest in Cyprus, Romania and Latvia.

The job creation in this sector has been particularly relevant for women and older workers. Considering the demographic trends in the EU, where life expectancy is on the increase in all Member States, it is essential to improve labor market participation of underrepresented groups in order to ensure the financial sustainability of social insurance schemes. This is all the more urgent for the social sector in the context of

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1 European Commission, Biennial report on social services of general interest, Brussels, European Communities 2008, p. 15.
changing family life patterns and of increasing numbers of women joining the labor market, meaning that informal care work traditionally performed within the family will result in growing demands on the formal care sector.

There are strong weaknesses in terms of both labor supply and demand: demand for social services across the EU is higher than the resources available to provide them, especially in terms of labor supply and financial resources. This situation can only worsen considering the current demographic trends described earlier, unless action is taken to make the most of the growth potential of the sector to create new jobs. It is estimated that, at current rates and needs, 2 to 3% extra jobs could be created in the “old” Member States, and 5 to 7% in the new ones.

Employment creation in this field has been driven by 3 key elements: the ageing population in Europe, which brings with it an increase of ill health and dependency, changing societal structures, mainly smaller family units, greater participation of women in the labor market and decreased availability of informal careers, and an expansion of services to better meet quality requirements and rising demands.

Employment in the care sector has some structural weaknesses that can be summarized as follows:

- The workforce is dominated by women (representing 78% of total workers in the sector in the EU);
- The wage difference between women and men is greater in this sector than in other sectors of the economy;
- The workforce in this sector is ageing rapidly;
- Workers in this field have, on average, a medium or high level of education, but large imbalances in skills levels can be observed;
- The prevalence of temporary or part-time work is higher than in other economic sectors;

4. Challenges and Drivers of Innovation

Structural weaknesses of the pre-ECC situation:

- Many frontline care workers in the health and social care sectors had no qualification, and little or no opportunity to access training;
- Those care staff who were capable had no means of having their knowledge and skills recognised at entry level;
- Many countries had no clear entry requirements for staff entering the sector. Whilst most had qualifications / awards ‘higher up’ the awards scale for qualified staff, there was nothing for the very large numbers of hands-on care staff right at the bottom of the scale;
- Large numbers of staff from other countries were being employed as carers in some EU Member States, with no clear method of quality control or means to quantify knowledge or basic attitudes to disability or principles of care. This was especially true for people employed in the “grey economy”, working directly for families or elderly people/people with disabilities;
- There was no clearly accepted view as to the place of people with disabilities in society and the fundamental principles which should govern their care. The medical model of care was the default norm, but this was being challenged by ideas such as ‘inclusion’ and ‘person centred’ services.
Innovation: Ideas, criteria, levels and added values

Innovation: using the ECC to turn large scale policy shifts into facts on the ground

Research has shown that the need for personal health and social care staff has and will continue to increase. Recently adopted changes in the approach to the position of people with disabilities in society, the kind of life they should expect to lead and the level of personalisation of the services they receive (as in the UNCRPD) will produce additional demands for care support staff. The EU has now formally ratified the UNCRPD and Member States are committed to implement it in their health and social care services.

These policy changes will also increase the likelihood of support staff being directly employed by people with disabilities and/or their families. This in turn will require this new tide of ‘direct employers’ to have means of sifting applicants and testing for knowledge and basic attitudes. The EU wide policy of ‘de-institutionalisation’ is taking longer to implement than many would like, but one effect is to increase the numbers of people with disabilities living in the community, needing personalise support services. The UNCRPD is clearly based on the principles of human rights and a social model of disability. The medical model of care is explicitly rejected as inappropriate and backward looking.

The ECC award will provide a shared common basic set of principles underpinning all care services in the EU, and help workers holding the ECC to find employment in any country. It is important to remember that this award is at entry level and defines the **minimum common knowledge** which care staff should have. This makes the ECC unique in that it is the **only** such award offered at this level across the EU. At entry level (where staff numbers are at their highest but qualifications and training opportunities are at their lowest) many countries have no entry requirements at all. Those requirements that do exist are frequently ignored or easily circumvented: the result is that many millions of vulnerable people are receiving direct hands-on care from staff with little or no formal training, recognition or support.

**Given all the above** - how do we re-equip a huge workforce to deliver a different model of care? The ECC has adopted the approach of trying to ensure all new entrants to the sector are provided with basic knowledge and attitudinal training. It has:
1. defined what needs to be known;
2. provided a means to test for that knowledge;
3. shown how to formally certify this when candidates demonstrate they do know the basics;
4. defined the common knowledge in a series of learning outcomes – the BESCLO;
5. started work to provide a shared means of delivering that knowledge via a common training programme.

Further, it will:

6. develop means to ensure that ECC trainers understand and can help candidates understand how the UNCRPD principles should guide the way in which they work and the kind of services which need to be provided;
7. seek EQF and NQF recognition for the ECC award.
Sustainability:
Research shows that there is increasing mobility and migration of workers in the care sector: Many workers move across EU Member States to seek employment in the social (and health) care sectors, and the EU also welcome many heath workers from third countries. In the latter example, there are clear links between the country of origin of migrant workers and that of destination: often times linked to the colonial past of EU Member States. In terms of intra EU movements; this increasing mobility can play an important role in alleviating imbalances between demand and supply of care workers, but it has been increasingly noted, in recent years, that mobility is often linked to the opportunity of earning higher wages elsewhere, and that it doesn’t necessary solve the problem of an overall lack of care workers, it merely “shifts” from a country to another. What is clear is that mobility of health and care sector worker will only grow in years to come, and therefore tools such as the ECC, that make it easy to certify knowledge of basic care principles will be increasingly relevant.

The ECC is currently used in 18 countries, but it hasn’t yet been acknowledged by relevant governmental bodies in all of them; largely because of the different ways in which social care is managed in each of these countries. It has been recognised at municipal level in Romania, and in the Czech Republic the award is on a list of courses approved by the Ministry and is used to get long)term unemployed people back into work. These are only a few examples, more information will be available later this year.

To this date, no “hard data” is available on possible improvements in wages or user satisfaction because of the ECC.

Drivers and Challenges
The driver for this innovative project is the fact that the social care workforce in the EU is “largely female, poorly paid and poorly led“. This is particularly the case at entry level. Social care is a common way for workers to find employment in other countries, but many states have little or no means of recognising (or even requiring) basic knowledge or skills on entry into the care workforce. Even when ‘requirements’ exist, they are often ignored or overlooked by inspectors and can be satisfied at the stroke of a pen by a home or workforce manager certifying that the worker has a satisfactory level of knowledge – with no need to justify that statement with evidence.

Changing family and societal structures are another driver behind the ECC.
In many Member States, families employ carers directly to work in the family (with minimal supervision provided or understanding of what is needed) and care staff have poor access to training and development opportunities.

The new policy drivers exemplified by the principles of the UN Convention on the Rights of Persons with Disabilities are in fundamental conflict with the old approach typified by the ‘medical model’ of long term care for people with disabilities (i.e. – such people need medically based care, supervised by a doctor, delivered by a nurse or healthcare assistant in a hospital or other institutionalised health setting). Changing the ‘mindset’ of staff (and staff trainers) is a necessary first step to changing the way in which services are delivered, so that people with disabilities may be enabled to take their rightful place in society and enjoy their human rights on an equal basis with all other citizens.
Agents of change
Up to 2011, the ECC has been developed through two Leonardo da Vinci projects and a third project (see above) has just begun to deliver training support packages for the ECC.

The idea of developing the European Care Certificate came from England in the UK, and it stemmed from the realisation that great benefits could come from all care workers having standardised induction training in the sector. The next step was working on this at EU level as other countries might have been in the same situation. Anecdotal evidence backed up that in other countries, front line staff received little or no training, something that was confirmed by the first project research. Additionally, there was a clear translational dimension because of the high numbers of foreign workers in the sector. Two organisations, (ARC – and Skills for Care – the sector skills council in England) were instrumental in developing this idea and getting the first project off the ground.

5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>2009</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Non profit</td>
</tr>
<tr>
<td>Financing</td>
<td>Financed by European Funds, through the Leonardo da Vinci programme</td>
</tr>
<tr>
<td>Size of the organization</td>
<td>N/A</td>
</tr>
<tr>
<td>Members and participation</td>
<td>18 lead delivery partners</td>
</tr>
</tbody>
</table>
| Contact            | Name of the innovative example: ECC
|                    | http://www.eccertificate.eu/ |

Delivery, development and organisation: ECC
The ECC was born out of a recognition of the fact that there’s a high demand of care staff to look after elderly or disabled people in Europe, either in their own homes or in care settings. At the same time, there is a lack of a recognised qualifications that would reassure employers of the value of a prospective employee’s qualifications, or enable workers to seek employment in another country.

The ECC is relevant to services for all adult user groups. It was principally developed with adult services in mind, but we know that some people have used it in staff working in services for children. Whilst the BESCLO was in development partner agencies were asked to consult with users in their countries about the content of the BESCLO. All the elements within the ECC were endorsed via a large scale consultative process within the UK involving users, workers and employers when induction standards were being developed within that country. The ECC is aimed at trainers, employers and staff in the sector.

The European Care Certificate was developed through 3 EU funded projects:
LdV project – Not Patients but Citizens with Rights 2012-2014
LdV Project – Creating a Common Foundation in Care 2009-11
LdV Project – European Care Licence 2006-8
EASPD as the European umbrella body for service providers for persons with disabilities in Europe is the appropriate repository for the ECC award. Up to 2011, the ECC has been developed through two Leonardo da Vinci projects and a third project (see above) has just begun to deliver training support packages for the ECC.

With its extensive membership base, EASPD has access to providers in many countries and understands the difficulties staff and employers face. EASPD provides the administrative home for the ECC and support its governing body – the Board of the ECC. The current ECC Board acts as a Special Interest Group (SIG) within EASPD and reports to the EASPD Board on HR and training issues. The ECC Board counts representatives of all the 16 EU countries where the ECC is currently offered and is responsible for its future development and management.

In terms of delivery, we currently have 18 Lead Partner agencies who work with around 20 more Delivery Partner Agencies, all training/delivering or examining for knowledge of the BESCLO in a very diverse user base. EASPD holds a central database of all candidates and results and promotes the award in European institutions (e.g. the EU and the Council of Europe) and in new countries.

6. References

Building a Foundation for Care, European care Certificate – your starter pack

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EU Employment and Social Situation, Quarterly Review, December 2012: Special Supplement on Health and Social Services

Employment in Social Care in Europe, Eszter Neményi and Maria Herczog, Zsuzsanna Kravalik, Martin Jones and Lucy Bekarian, Robert Huggins Eurofound, 2006

Employment in the Care Sector in Europe, Miriana Giraldi; EASPD, October 2010.


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Theoretically informed case study accompanying the film

GPE Gesellschaft für psychosoziale Einrichtungen Mainz GmbH Germany

Author and WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller
Claudia Rustige

QR-Code to the Homepage and video:
Link to the video: http://inno-serv.eu/gpe

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a Europeanwide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. GPE (Gesellschaft für psychosoziale Einrichtungen Mainz GmbH) - Society for psychosocial facilities Mainz Ltd.
Educational and charitable organization in Germany

GPE offers customized assistance to people with disabilities and disorders to facilitate their occupational and social integration into society. This innovation is characterized by its wide local availability, individual opportunities, focus on the subject and their resources, to facilitate participation as well as strong internal networking of all facilities and services.

Specific innovative elements of GPE

**New types of service: Integrative offer for professional, social and medical integration**
One of the main innovative elements is the implementation of a holistic approach to foster people with disabilities.
This holistic approach combines both levels of professional and medical rehabilitation, with the purpose to facilitate integration into the work and everyday life.

**New types of results: Integration and promotion of participation**
Integration into the work place, promotion of social participation and empowerment, opportunities of 'equal' payment for people with disabilities

**New types of processes: Easily accessible and individual resource-oriented assistance single-handedly:**
Measures are provided, planned and facilitated single-handedly. This large range of assistance and accessibility towards integration are assembled individually, with special regards to the clients capabilities and are characterized by its low accessible services. The in-house networking makes it possible to create and utilize synergetic effects.

Key characteristics of the service

**Organization**
At GPE are working disabled and non-disabled people quite together. Employees can be financed by two different ways:
1. Equal payment for disabled and non-disabled employees by an collective wage agreement for psychologists, social worker and disabled people.
2. Payment for disabled employees which are working as an employee in a sheltered workshop.
For all employees apply both: employment rights and works council.

**Users**
Users are people with psychological disorders, people with disabilities and long-term chronic diseases as well as unemployed persons.

**Principle**
Jointed and comprehensive framework to facilitate the promotion of equality, social and occupational participation and discrimination.

**Drivers of innovation**
Desire to lead an independent life. Political and social processes positively contribute to the changing social role of people with disabilities in society.
Factors influencing Social Services Innovation

Challenges
- Structural weakness of system
- Need to reform complex system of financing social security
- Coping with demographic and globalization issues
- Lack of transparency between benefit types and responsibility of institutions
- Massive increase in cost as a problem for municipal budgets

Drivers
- Desire for independent life
- Political & social process contributes to changing social role

Quality
- Overcoming interfaces
- Blurring boundaries

Sustainability
- New forms of service
- Various occupational integration measures
- Measures to promote everyday & independent living and individual psychosocial support

Novelty
- Professional integration
- Promotion of social participation and empowerment

Agent of change
- Politischer Wohlfahrtsordnung and set out to find a solution (framework for psychiatric movement) to avoid evolution large psychiatric institutions

GPE-Mainz response:
- Occupational integration from a single source
- Center for work diagnosis
- Occupational therapy practice
- Rehabilitation and career development support
- Wide range of labor and employment offers in sheltered workshops
- Integration of companies (health, food store, hotel, laundry, food markets, etc., bookbinding)
## 2. Policy Framework related to People with Disabilities in Germany

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
</table>
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th>Total Population: (see Eurostat 2013a)</th>
<th>Germany 2012: 81843743 P:</th>
<th>EU27 2012: 503663601BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical disability (see DESTATIS 2013b)</td>
<td>62%</td>
<td></td>
</tr>
<tr>
<td>Number of beneficiaries of integration assistance (see DESTATIS 2011: 6ff.)</td>
<td>1991: 324000</td>
<td>2009: 725000</td>
</tr>
<tr>
<td>Proportionately gross expenditure of the total social expenditure (see DESTATIS 2011: 6ff.)</td>
<td>1963: 5%</td>
<td>2009:58%</td>
</tr>
<tr>
<td>Number of recipients of integration assistance for disabled people in 2009 (see DESTATIS 2011: 6ff.)</td>
<td>Insgesamt: 725000 people</td>
<td></td>
</tr>
<tr>
<td>Benefits for medical rehabilitation (see DESTATIS 2011: 6ff.)</td>
<td>9916 people</td>
<td></td>
</tr>
<tr>
<td>Benefits for participation in the work life (see DESTATIS 2011: 6ff.)</td>
<td>6824 people</td>
<td></td>
</tr>
<tr>
<td>Benefits in established workshops for disabled people (see DESTATIS 2011: 6ff.)</td>
<td>248643 people</td>
<td></td>
</tr>
<tr>
<td>Benefits for participation in community life (see DESTATIS 2011: 6ff.)</td>
<td>495906 people</td>
<td></td>
</tr>
<tr>
<td>Benefits for ensuring the effect on medical prescription and for secure inclusion of the working life (see DESTATIS 2011: 6ff.)</td>
<td>3702 people</td>
<td></td>
</tr>
<tr>
<td>Other benefits for integration assistance (see DESTATIS 2011: 6ff.)</td>
<td>49975 people</td>
<td></td>
</tr>
<tr>
<td>Integration help benefits in form of an personal budget (see DESTATIS 2011: 6ff.)</td>
<td>3669 people</td>
<td></td>
</tr>
</tbody>
</table>

3.2 Information about the specific welfare state: Germany

Germany's social policy is largely nationalized in international comparison. A great number of national services are provided by private carriers, stakeholders, organizations and other institutions (see Bellermann 2011, 19).

The national social state is a heterogeneous construction. Its primary function is to grant security against the risks that emerge out of wage-related work such as illness, unemployment, accidents at work for people in advanced ages. The social states basic design is to distribute social security laws and social expenditures.

Social security law: Social property rights and the law to participate in the decision-making process through social laws.
Social expenditures Benefits of money-transfers and non-cash or employment services (Real transfer).
Benefits in kind are amongst others prescribed medicine and appliances from the health insurance.
Social services are among others counseling services for children and youth.
The special feature of social services is that it’s not within the framework of social security but included as a category of services in the money, material and legal systems.
According to Weisser (1956) social services are distinguished by principles or specific characteristics.
Tax breaks (e.g. for families, marriages or services from the employer) are considered as indirect social benefits.
Social Insurance is the dominant social security principle (see Bellermann: 83ff.).
There is a steady increase of expenditure in benefits in kind of social protection benefits (including social services), that shows the growing meaning in comparison to social protection benefit in cash. The table below presents the social protection expenditure of selected countries.

### Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro.

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Increasing benefits</th>
<th>Part of benefits of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3.605.678,95</td>
<td>/</td>
</tr>
<tr>
<td>Germany</td>
<td>565.683,07</td>
<td>765.717,82</td>
<td>52,53%</td>
</tr>
<tr>
<td>Denmark</td>
<td>45.334,15</td>
<td>78.367,78</td>
<td>102,60%</td>
</tr>
<tr>
<td>France</td>
<td>379.396,42</td>
<td>654.238,65</td>
<td>84,47%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

The table below presents the german social protection expenditures (benefits in kind and cash benefits) and the expenditure ratio.

<table>
<thead>
<tr>
<th>GDP in PPS (see Eurostat 2013b)</th>
<th>Germany: 30300 2011</th>
<th>EU27: 25100 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social benefits (see Bmas 2012)</td>
<td>767,6 Mrd. Euro</td>
<td></td>
</tr>
<tr>
<td>Social expenditure ration (BIP) (see Bmas 2012)</td>
<td>29,9%</td>
<td></td>
</tr>
<tr>
<td>Cash benefits 2010 (see Eurostat 2012)</td>
<td>61,29%</td>
<td></td>
</tr>
<tr>
<td>Benfits in kind 2010 (Own calculations based on EUROSTAT 2012)</td>
<td>34,69%</td>
<td></td>
</tr>
<tr>
<td>Benfits by function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diseases</td>
<td>9,4% of the GDP</td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social protection benefits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cash benefits 2011</td>
<td>465.752 million</td>
<td></td>
</tr>
<tr>
<td>- Benfits in kind 2011</td>
<td>271.062 million</td>
<td></td>
</tr>
<tr>
<td>- Social protection benefits 2011</td>
<td>28,7% of GDP</td>
<td></td>
</tr>
</tbody>
</table>
4. Challenges and Drivers of Innovation

**Structural weaknesses** of the system:

- The need for reform within the complex framework of funding for social security
- To cope with demographic and globalization problems
- Lack of transparency about the types of social services and jurisdictions of agencies for social security, characterized by ambiguity in legal services and the variety of carriers. Orientation on the social class. Result: Exclusion of low income earners (i.e. People barely- or unable to work, unemployed women and people with part-time jobs) (see Heinze, Hombach, Scherf 1987; Voruba 1990).
- Services funded by different carriers such as the health insurance company, accident insurance fund, pension insurance, employment agency and care insurance.
- Disintegration: People with disabilities often live and work in separate workplaces, agencies and organizations (sheltered work).
- In 2009 59% of eligible people for integration assistance received the service within institutions. Only 32% of the eligible recipients received services individualized outside of institutions (see DESTATIS 2011:8).
- Massive increase in expenditures turns out to be a problem especially for municipalities.
- Average after-tax spendings of integration assistance for disabled people:
  (see DESTATIS 2011:15).

**Innovation:** Ideas, criteria, levels and additional value
This innovative project is characterized especially by its multidimensional diversity to promote social and occupational participation. GPE makes sure that the assistance and measures are intertwined and connected.
These measures can be distinguished by its easily accessible services and future orientation by providing services for occupational rehabilitation, restoration of the basic ability to work, new establishment of perspectives, qualifications and occupational construction of the future.

There are five particularly **innovative aspects** about the service:
Promoting the social inclusion and empowerment of people with disabilities / mental and intellectual disorders through:

1. Labor market integration programs that are tailored to the user
2. Work opportunities in a wide range of businesses (providing low
threshold to higher skilled employment opportunities) which create employment for each other

3. Employment, training and support services that are provided from one source giving full support and facilitating transitions

4. Labor and relationship are placed at the heart of the community to beat stigmatisation and discrimination.

5. GPE promotes payments according a collective wage agreement (tarif classification) for disabled people.

New types of services: Individual offers single-handedly
GPE put forward a diversity of measures in one house.
Center for 'labor-diagnoses, occupational therapy practice, rehabilitation and occupational supervision and a big range of job opportunities in workshops for disabled people and integration businesses (natural food and grocery stores, hotels and inns, Laundromats, book binding-, carpenter-, tailor- and Secondhand shops).
Measures that promote the everyday-life and independent living:
Assisted living and psychosocial individual care, community psychiatric centers, consulting cafés for people with psychological disorders.

New types of results: Promotion of autonomy as well as integration to overcome von Schnittstellenproblematiken
Personal skills are being utilized so that a self-determined life can be facilitated.
All offers are strongly interconnected so that individual help can be carried out.
The measures are long-term and sustainable. Realistic agencies facilitate the promotion of integration and the defeat of stigmatization in society.
The utilization of internal structures and resources are meaningful and contribute so that affected people can feel integrated.

New types of processes: Networked measures of integration within a regional network, occupational integration in society
Big, regional networks from linked measures of integration. Measures that are fitted to the individual and are being facilitated individually without a step-by-step program.
Users do not have to fulfill a specific criteria to be able to work at a company:
Services within society such as natural food shops in a tightly populated neighborhood.
Cooperating systems of services:
Laundromats provide laundry services for hotels, hotel cooks food for the bed and breakfast, natural cost shops makes bakery products for hotels and bed and breakfasts.

Agents of change
The umbrella organization „Der Paritätische Wohlfahrtsverband“ in Germany made it their task to contribute money for the Integration of people with mental disorders in the community within the framework of the psychiatric reform.
Customized services with the goal of occupational and social integration into society; individual services that are adjusted to peoples capabilities to facilitate participation through internal and external networking of all agencies and services.
5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>1992</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Non-Profit-Organisation</td>
</tr>
<tr>
<td>Financing</td>
<td>Carrier for rehabilitation, service providers, integration assistance or personal budgeting</td>
</tr>
<tr>
<td>Size of the organization</td>
<td>205 employees and ca. 800 users</td>
</tr>
<tr>
<td>Members and participation</td>
<td>Paritätische Wohlfahrtsverband, Werkstätten für behinderte Menschen Mainz gGmbH, Mitglied der BAG / LAG der Werkstätten für behinderte Menschen, BAG / LAG Integrationsfirmen, BAG Unterstützte Beschäftigung, Deutsche Gesellschaft für Soziale Psychiatrie, Trägerverbund Mainz, Gemeindepsychiatrischer Verbund Mainz, Netzwerk für seelische Gesundheit Mainz und Mainzer Bündnis gegen Depression.</td>
</tr>
<tr>
<td>Contact</td>
<td>Claudia Rustige, <a href="mailto:info@gpe-mainz.de">info@gpe-mainz.de</a>, Phone: +49 6131 669 40 10</td>
</tr>
<tr>
<td>Name of the innovative example</td>
<td>GPE Mainz</td>
</tr>
</tbody>
</table>

The umbrella organization (der Paritätische Wohlfahrtsverband) in Germany got involved within the framework of a psychiatric movement to help dissolve large establishments to promote community life for people with psychological disorders. Furthermore topics such as work and occupation came up. The charity organization and workplaces for disabled people Mainz Ltd. were incorporated in the GPE. GPE Mainz was established in 1985 as a non-profit organization. Their goal was to integrate people with psychological disorders as well as the establishment of occupational integration.

Currently the GPE offers and provides an extended amount of services for the fields of everyday-life, training, medical and occupational rehabilitation as well as employment that are funded by various service carriers.

The GPA has 205 employees and 800 users as well as members from: BAG / LAG der Werkstätten für behinderte Menschen e.V., BAG / LAG Integrationsfirmen, BAG Unterstützte Beschäftigung, Deutsche Gesellschaft für Soziale Psychiatrie, Trägerverbund Mainz, Gemeindepsychiatrischer Verbund Mainz, Netzwerk für seelische Gesundheit Mainz und dem Mainzer Bündnis gegen Depression.

GPE has already received numerous awards among which they won got in second place for the innovation award for trendsetting in western Germany (1999), the „Janssen-Cilag- futureprize (2002), prime minister prize for participation, equality and self-determination for people with disabilities (2003), 2nd place for the best-practice-competition for community based psychiatric services (2006), the award for the German federal ministry for families, seniors, women and youth (2007), the DGPPN-anti-stigma prize (2011) and „the land of ideas“ price (2012).
The innovative service provides the following possibilities for the users:

1. Work
   ServiceCenter (workshop for people with psychological disorders or disabilities)
   CAP-Lebensmittelmärkte in Mainz-Weisenau und Jugenheim (Integrationsbetriebe), Hotel INNdependence (Integrationsbetrieb), Naturkostladen "natürlich mainz“ (Integrationsbetrieb)

2. Therapy
   Occupational therapy practice

3. Everyday life
   Gemeindepsychiatrisches Zentrum: community psychiatric center
   Tagesstätte: Day Care Center
   Betreutes Wohnen: Assisted Living
   Kontaktstelle: Reception centre
   Einzelbetreuungen: Individual counseling
   Sozialpsychiatrisches Zentrum für junge Menschen: socialpsychiatric center for youth
   Beratungscafé unplugged: Consulting café
   (cf. Basener 2011)

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INNOSERV - WP 7 Theoretically informed case study accompanying the vizualisation

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This report is a product of the INNOSERV project (grant agreement nr. 290542) which is funded by the European Union under the 7th Framework Programme.
Theoretically informed case study accompanying the film

Humanitas Financial Home Administration Programme
Improving people's financial and administrative skills - Netherlands

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Solidar
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WP Leader HAW Hamburg
Andreas Langer, Simon Günther, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/humanitas

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a European wide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Humanitas - Financial Home Administration Programme

Financial Home Administration is a programme carried out by Humanitas to provide support to people not being able to manage independently their financial and administrative work. Through this programme users acquire new financial and administrative skills helping them to manage their finances and preventing problems (such as indebtedness) to become more serious.

Specific innovative elements of Humanitas

The innovative aspect of this service is that volunteers take over an important role in the field of debt relief services. In the Netherlands, this is normally a field for professional service providers. Humanitas volunteers develop close working relations with these professional service providers without interfering with their tasks (their role is additional and preventive). The project is innovative because the support service starts before the classical debt relief services and is tailor-made: volunteers help users at their homes, through an individual approach instead of approach in group.

New service for growing needs

Humanitas offers a broad spectrum of activities such as projects for (former) prisoners, addicts, homeless people, migrants, counselling and group support for people dealing with grief and loss. The Humanitas services are free of charge and available to anyone, irrespective of age, ethnicity, lifestyle and sexual orientation. Humanitas advocates values such as: equality (of volunteer and users), responsibility (for yourself and others in society) and independence (the activities are geared towards ensuring that the users can once more take control of their lives).

Key characteristics of the service

Organisation

Humanitas is a non-profit association, which involves more than 11,000 volunteers across the Netherlands to support people in need of social and (health) -care services.

User groups

Users are people who are not able to independently manage their financial and administrative work and often face, as a result of that, debts or arrears. In particular, the following categories of users have been identified:

- People experiencing financial troubles (i.e. as a consequence of bankruptcy, indebtedness, displacement);
- Young adults having difficulties with financial management (i.e. as consequence of illiteracy or a low level of education);
- Ex-prisoners who need administrative support to be reintegrated into society;
- Others

Principle

Humanitas’ approach aims to enable users to grow in their confidence, which they need to change their personal situation. Based on the value of solidarity and independence, the support offered by volunteers is more than merely ‘administrative’ and contributes to the empowerment of the user and her/his (re)integration in society.

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Factors influencing Social Services Innovation

Drivers
- managerial development
- aspiration
- changed social rules

Challenges
- fills gap in service provision
- providing support that starts before classic debt relief
- addressing new need in society
- consequence of economic crisis

Agents of change
Humanitas identified need:
- to support
- and empower people
In increasing necessity in liberalised economy (pension/insurance)

Sustainability
Support of volunteers
- additional
- preventive

Novelty
Innovation aspect:
Volunteers play important role in debt relief
(usually field for public service provider)

Quality
Evidence based evaluation of impact
- creation of social & human relations
- empowerment of user
- social cohesion
- active inclusion
2. Policy Framework related to debt help and relief services in the Netherlands

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dutch social security and support systems put responsibilities on the individuals and move towards enabling and empowerments of individuals. Increasing privatisation of social services and social protection schemes. Government is responsible of the promotion of citizens’ well-being and can intervene to solve poverty and inequality problems when market solutions do not work.</td>
<td>Government (setting debt problems and balancing income is a governmental task) National credit bank (providing a series of services of debt counselling and coaching services) Municipal credit banks (active cooperation with local municipalities to implement debt relief programmes) Local municipalities (key players in the organisation of social services, also in the field of debt counselling and rehabilitation) Volunteering organisations (as shown by Humanitas’ project, volunteers can play an additional and preventive role working in cooperation with the municipalities).</td>
<td>National credit bank (‘Volkskredietbanken’) providing services such as: - educational and training programmes at schools, in companies or to individuals; - the analysing of underlying problems and solving the most critical elements (e.g. housing); - the provision of information about the ongoing process (debt solving and balancing income) and advise for the follow up; - coaching; - the provision of a bank card and a special account with no overdraft and amicable debt settlement between clients and debtors following a strong formalised method. Debt-relief programmes implemented by local municipalities in cooperation with volunteering organisation and/or private institutions.</td>
<td>As settling debt problems and balancing income is seen as a governmental task, finances mostly come from the local governments who are owners of the municipal banks. For some of the services the customers themselves also have to pay a fee.</td>
</tr>
</tbody>
</table>
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th></th>
<th>Netherlands</th>
<th>EU27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>16574989</td>
<td>501120157</td>
</tr>
<tr>
<td>Population projections 2010-2050 (2010)</td>
<td>17357798</td>
<td>524052690</td>
</tr>
<tr>
<td>Expenditure on social protection (% of GDP)(^2) (2010)</td>
<td>32.06</td>
<td>29.37</td>
</tr>
<tr>
<td>People at risk of poverty or social exclusion (% of population) (2011)</td>
<td>15.7</td>
<td>24.2</td>
</tr>
<tr>
<td>Unemployment rate, monthly average (November 2012)</td>
<td>5.6</td>
<td>10.7</td>
</tr>
</tbody>
</table>

Source: EUROSTAT 2010

3.2 Information’s about the specific Welfare State: Netherlands

The Dutch welfare state has been largely founded in the post-war period when many social expenditure programmes were introduced. Welfare state expenditures expanded rapidly during the sixties and seventies. Starting from the eighties, the Government started a programme of cuts in social benefits that was completed by institutional reforms in the nineties. Since the beginning of the nineties, the government also started to reduce the tax burden and to privatise social protection schemes such as the sickness insurances and parts of the pension system. Increasingly Dutch social security and support systems put responsibilities on the individuals and move towards enabling and empowerment of individuals.

Social policies for debt help and relief services in the Netherlands

The Dutch government has the responsibility to promote social well-being and to provide responsible credit and debt solving when the market does not take its responsibility. Tackling certain issues can be achieved by restrictive laws on lending, a maximisation of interest rates and similar measures or by facilitating organisations that help solving the problems of over-indebtedness as well as by organising insolvency structures at local level.

Until 1992, debt counselling was provided by social workers working for local authorities and by private organisations. At that time, national organisations worked in cooperation with local authorities. Furthermore, people could ask for advice at regional not-for-profit organisation providing of legal support.

In 1992, a proposal was made to extend the Bankruptcy Act by a law on debt rehabilitation which finally came into force in 1998. It stipulated compulsory direct cooperation between local authorities, private and semi-private debt advice agencies of the 50 municipal credit banks. Additionally, the Dutch credit institution also did some amicable settlements in the Netherlands, as well as e.g. the municipal social services. If no amicable settlement is achieved a judge can still appoint an administrator who will set up a rescue plan. Debtors have to follow the rescue plan for three years after which they will be released from the remaining debts.

\(^2\) Expenditure on social protection contain: social benefits, which consist of transfers, in cash or in kind, to households and individuals to relieve them of the burden of a defined set of risks or needs; administration costs, which represent the costs charged to the scheme for its management and administration; other expenditure, which consists of miscellaneous expenditure by social protection schemes (payment of property income and other). It is calculated in current prices (EUROSTAT)
The Dutch approach to debt reduction can be seen as a combination of three strategies:
1. Consumer laws protect clients from predatory lending and high interest rates.
2. Banking laws restrict the ways financial service providers can act.
3. A local organised structure of municipal banks bridges the world of financing and debt solving. Where the amicable or pre-law phase of debt solving doesn't succeed a final solution can be granted through a three year statutory debt settlement procedure.

The office dealing with natural persons is managed by the Council for legal support. Each of these offices cooperates closely with other social services in the country. All institutions that have been working in the context of debt counseling and rehabilitation are mentioned on publicly available websites. Debtors receive exact information on what they can do and how they can do it. They can apply for debt advice via computer and can download the questionnaire.

The Dutch system offers a large range of products and services that are provided by the national credit bank (‘Volkskredietbanken’) in dealing with financial problems. This includes preventive educational and training programmes at schools, in companies or to individuals; the analysing of underlying problems and solving the most critical elements (e.g. housing); the provision of information about the ongoing process (debt solving and balancing income) and advise for the follow up; coaching; the provision of a bank card and a special account with no overdraft and amicable debt settlement between clients and debtors following a strong formalised method.

Against this background, volunteers play an important role in many fields of social services: usually when a person gets in serious financial troubles such as indebtedness and bankruptcy, he/she asks help to the municipality or to other public services. Nevertheless, it can happen that those services, in order to provide the adequate support, ask to the person to put his/her finance in order and give a clear overview of the situation. The service provided by Humanitas helps people to fulfil this precondition: volunteers support users in putting their finances in order and in having a clear overview of their financial situation. For this reason, the service provided by volunteers is additional and preventive to the classical debt-help services. The positive results of the programme show that volunteers can play an important role in many fields of social services and support people on an individual, self-empowering basis at an early stage.

There is a steady increase of expenditure in benefits in kind of social protection benefits (including social services), that shows the growing meaning in comparison to social protection benefit in cash. The table below presents the social protection expenditure of selected countries.

---

Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro.

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>/</td>
<td>/</td>
<td>34,07%</td>
</tr>
<tr>
<td>EU 27</td>
<td>3.605.678,95</td>
<td>/</td>
<td>34,07%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>94.052,49</td>
<td>188.731,00</td>
<td>36,80%</td>
</tr>
<tr>
<td>France</td>
<td>379.396,42</td>
<td>654.238,65</td>
<td>34,17%</td>
</tr>
<tr>
<td>Denmark</td>
<td>45.334,15</td>
<td>78.367,78</td>
<td>40,00%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

4. Challenges and Drivers of Innovation

Structural weaknesses of the system
This project represents a social innovation as it fills a gap in the service provision by providing a preventive support that starts before the classic debt relief services that are foreseen in the Netherlands and concretely addressing a new need emerged in society as consequence of the economic crisis (and of the increasing necessity of making choices in a liberalised economy: pensions, insurances, utilities etc). It also is less stigmatising since people don’t have identify themselves as needy and show up in public institutions. The volunteers visit them at home and give tailored support.

Drivers and Challenges⁴
‘Changed social roles’
The inability to do the home administration can be the result of many factors (i.e. illiteracy, low level of education, consequences of the economic crisis) but is mostly enforced by the absence of any social network to fall back on for support

Increasing aspiration
People for self determination and independence: this project helps users to concretely acquire new skills to manage independently their finance and, as an indirect results, it contributes to the improvement of their self-confidence.

Evaluation
The impact of the service through an in-depth research has been driven by the increasing trend in the social service sector to provide evidence-based policies (managerial developments): the findings of the analysis made by the University of Tilburg provide concrete evidences of the added value of the project as well as of its social impact.

⁴ Hawker, C. and Frankland, J. (2012) Theoretical trends and criteria for ‘innovative service practices’ in social services within the EU. INNOSERV Work Package 2 report
**Innovation:** Ideas, criteria, levels and added values

The service is innovative because it is able to meet unmet needs in society for a short-term period as well as to empower users improving their abilities and promote their active inclusion in society. The main reason why this programme was designed is to help and empower users to do their home administration themselves again. It is conceived as a temporary support to improve people’s self-determination and autonomy.

There are three particularly innovative aspects about the service:

*New form of service:*
The innovative aspect of this service is that volunteers play an important role in the field of debt relief services, which is normally a field for public service providers. Humanitas volunteers develop close working relations with these service providers without interfering with their tasks (their role is additional and preventive).

*New form of service delivery:*
The project is innovative because the support service is an early intervention that is less stigmatising and tailor-made: volunteers help users at their homes, through an individual approach, they help them helping themselves. Through the creation of personal relations, users improve their empowerment and self-confidence.

*New way of evaluation:*
In order to evaluate the effectiveness of this service and its impact on people’s life, Humanitas commissioned an in-depth research to the University of Tilburg. This innovative method of evaluation represents a source of evidence-based information which can be used to better allocate resources in the future development and implementation of Humanitas projects.

Positive externalities of the project are the empowerment of users and social inclusion: being part of this programme, users not only acquire new financial and administrative skills but they also improve their self-confidence and self-determination.

**Agents of Change**

Humanitas identified the need to support and empower people on the increasing necessity to make choices in a liberalised economy (pension, insurances, utilities...).
5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>2001</td>
</tr>
<tr>
<td>Type of the organization</td>
<td>nonprofit association</td>
</tr>
<tr>
<td>Financing</td>
<td>The local projects have several sources: local authorities, banks, social housing companies, energize-suppliers, charities, churches etc.</td>
</tr>
<tr>
<td>Size of organization</td>
<td>More than 300 professional staff, more than 10,000 volunteers, more than 40,000 users</td>
</tr>
<tr>
<td>Members and Participation</td>
<td>University of Tilburg, AUSER Association is a member of SOLIDAR, a European network of 59 NGOs active in over 90 countries working to advance social justice in Europe and worldwide.</td>
</tr>
<tr>
<td>Contact</td>
<td>Name of the innovative example</td>
</tr>
<tr>
<td></td>
<td>Homepage</td>
</tr>
</tbody>
</table>

**Organisation**

*Humanitas* is a non-profit association which involves more than 11,000 volunteers across the Netherlands to support people in need of social and (health) care services. Humanitas offers a broad spectrum of activities such as projects for (former) prisoners, addicts, homeless people, migrants, counselling and group support for people dealing with grief and loss. The Humanitas services are free of charge and available to anyone, irrespective of age, ethnicity, lifestyle and sexual orientation. Humanitas advocates values such as: equality (of volunteer and users), responsibility (for yourself and others in society) and independence (the activities are geared towards ensuring that the users can once more take control of their lives). Commissioning an in-depth research to the University of Tilburg, Humanitas used a new form of investigation to assess the impact and the added value of the service.

This project represents a social innovation as it fills a gap in the service provision by starting before the classic debt relief services foreseen in the Netherlands and concretely addressing a new need emerged in society as consequence of the economic crisis (and of the increasing necessity of making choices in a liberalised economy: pensions, insurances, utilities etc). The project aims at preventing social poverty and social exclusion. In addition, it contributes to the empowerment of users improving their skills and abilities as well as promoting their active inclusion and (re)integration in society.

Being part of this programme, users acquire new financial skills and abilities and learn (step by step) how to independently manage their administrative work. This programme offers them a concrete help to overcome existing financial troubles and to prevent problems to become more serious. Learning new skills and acquiring new abilities as well as establishing a personal relation with the volunteer, users improve their self-confidence and independency. It also is less stigmatising since people don’t have identify themselves as needy and show up in public institutions. The volunteers visit them at home and give tailored support.

In order to evaluate the effectiveness of this service and its impact on people’s life, Humanitas commissioned an in-depth research to the University of Tilburg. This innovative method of evaluation represents a source of evidence-based information...
which can be used to better allocate resources in the future development and implementation of Humanitas projects.
The projects and activities from Humanitas are organized by local departments across the Netherlands. Each year more than 10,000 Humanitas volunteers give support to 36,000 users.
The Financial Home Administration programme involves more than 300 people representing the Humanitas Professional staff and more than 10,000 volunteers who have helped more than 40,000 people in need of support to independently manage their home finance.
In order to evaluate the effectiveness of the Home Financial Programme and its impact on people’s life, Humanitas decided to commission an in-depth research to the University of Tilburg. The aim of this study is to investigate the effects of the project as experienced by users and to assess whether or not they acquired skills to independently manage their administrative work after they have had the support by volunteers. This is done by performing both quantitative (88 surveys) and qualitative (interviews with two clients and two volunteers) research. From this view, the following research question was formulated: “To what extent has the administrative assistance of volunteers an effect on clients?”
The findings generated within this research represent evidence-based information about the project which can be used to better allocate resources in the future development and implementation of Humanitas projects.
This new form of collaboration between Humanitas and the University of Tilburg is to be considered as an innovative instrument used by the organisation to evaluate the effectiveness of services provided and assess the added value of its impact in order to optimize its provision.
Main results of the research carried out by the University of Tilburg:
- The findings show that the high quality of support received is one of the most important sources of satisfaction of the users of this programme. Users indicate to have experienced activating incentives and a safe space to exercise with new/renewed skills.
- The quality of the support has been proven to be much more effective on the empowerment of users than the amount of time spent by volunteers: increasing the frequency of the support does not lead to higher satisfaction of the user.
- On the other hand, the skills and capabilities of volunteers can make a significant difference on the level of satisfaction of users: users improve their self-confidence and self-determination thanks to the ‘transfer of skills’, which is defined as the extent to which the volunteer is capable of transferring skills and abilities to the user.
These findings imply that, in order to improve the quality and effectiveness of the service and maintain the users satisfaction, Humanitas needs to invest on the training of volunteers, providing them with the appropriate competencies and knowledge to be able to transfer the adequate skills to the users of the project.
Two of the important challenges that Humanitas is going to address in the future are:
- How to position the work of volunteers in the area of social services, without exceeding the limitations of volunteering?
- How to find enough funding for the work to be done?

6. References


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Theoretically informed case study accompanying the film

Irre menschlich e.V. Hamburg – Trialog - Germany

Author and WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller
Thomas Bock, Gyöngyvér Sielaff

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/irremenschlich

This report is part of the research project „Social Platform on innovative Social Services” (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a European-wide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Irre menschlich e.V. Hamburg (registered association):
Trialogue Principle in Psychiatry (ex-users of psychiatry, relatives, therapists, citizens with and without psychological illness/psychiatry experiences)

- Public Relations about all aspects of mental health,
- Information-, encounter-, prevention and training-projects are offered
- Teaching the basic idea of the Trialogue as an 'equal meeting of experts' on all levels of psychosocial and psychiatric care
- Effort for more tolerance in dealing with others and more sensitivity with one self as a requirement for prevention and inclusion
- Effort for a psychiatric institution without prejudice, with equal chances, more flexibility, continuity, respect and participation.
- Implementation of peer counselling (ex-users of psychiatry become instructors and employees of psychosocial services through a two semester training and 60-hour internships

Specific innovative elements of irre menschlich e.V.
Trialogue here means the equal face-to-face encounter of ex-users of psychiatry, relatives, and therapists that is characterized by mutual learning and respect. This idea has its origin in Germany in the so called 'psychosis seminars'. This idea has also already a meaning for experiences with illnesses and other levels of encounters (for example: psychiatric practice, anti-stigmatization work, Beschwerdestellen, psychiatry organisation, quality management as well as teachings, conferences and trainings for empirical research).

- Equal collaboration at the Trialogue. Ex-users of psychiatry are the expert of their own crisis experience, relatives are experts because they were witnesses of the ex-users experiences and professionals are occupational experts who develop an understanding of mental crises and health.
- A change of definition for psychological illness, of its diagnosis and treatment. Promotion of equality, empowerment, destigmatization and non-discrimination.
- Participation, involvement, empowerment and the focus on capabilities of ex-users of psychiatry, relatives and professionals. New methods of collaboration at eye-level.

Key characteristics of the service

Users
Users are people from the community especially pupils of all types of schools, the police, businesses, churches, actors are ex-users of psychiatry, relatives and professionals are equal partners on a team.

Principle
The suspense of stigma, self-stigmatisation and discrimination. This is where rehabilitation and self-rehabilitation overlap. Through these projects the theoretical input complements the practical experiences.

Drivers
Incubator was the first 'psychosis-seminar' in Hamburg which developed out of the involvement of ex-users of psychiatry, relatives and professionals:
- Professionals were requested to abdicate their decision-making power.
- Ex-users of psychiatry want to be taken seriously by their relatives
2. Policy Framework related to the Psychiatric Reform in Germany - Participation as a chance

Principle/ Guidelines

The situation of psychological ill people in society in the social policy system of Germany is shaped by reform efforts that stopped half-way: The previous situation of psychological ill people was characterised by exclusion of society and admission to institutions with big rooms with no privacy. Today the problems are the outpatient „ghetto“ or the acute ward with the clinical atmosphere. The core of psychological illness has not changed sufficiently over the years. The needs of psychologically ill people are currently unmet in the following.

In the systematic integration of the social network, meaningful responsibilities, biographic classification of acute crises with its significant momentum and somatic factors. Some are hopeful with the concept of „Integrated Health Care“, which gives the health insurance the freedom of closing a contract that tests new financial and health care types. But it is most importantly necessary to keep and open mind and have a different 'trialogical' attitude.

Key Organisations and Actors

The health care system was characterised by inhumane conditions in psychiatric institutions for a long time. They were alternatively replaced by social-psychiatric institutions such as outpatient clinics and departments. The next step was the paradigm-shift from institutional to personal assistance with the goal to prioritise outpatient assisted living before stationary living arrangements. As well as the expansion of this shift into other areas of life such as participation at the work place. These services will be financed and coordinated by the public sector and carried out by authorised service providers (mostly non-profit organisations).

Services provided by the Government

The current psychiatric reform is characterised by structural problems for the psychiatric health care and its financing that also limit the extent of societal participation (Bock 2011):

- Duplications and divisions in the health care and financial system (between psychiatry and psychosomatic, providers of social and health care, in- and outpatient services and so on) connect resources, hinder continuity and penalise the critically ill.
- Predominance of large institutions (i.e. orphanages, clinics, institutions) which financing is focused on stationary assistance.
- Problems in the supply of housing and job; the reform is reliant on (national)political support.
- Ongoing societal stigmatisation from psychological ill people, the thematic discussions are determined by reductionary understanding of illness.
- Boundaries within the service spectrum: psychotherapeutic assistance, patients with specific diagnosis (schizophrenic psychosis and bipolar disorder) are hardly accessible (Melchinger 2008).
- Psychosocial assistance are threatened to be triturated by market mechanisms and struggle to retain functions.
3. The social, political and institutional context

3.1 Population/ Government

The necessary balance between pathological and anthropological aspects of mental illness

Specific information about the targeted group of the mentally/psychologically ill are difficult to maintain for the one reason that the user group is situated in various social assistance systems and additionally because no standardised unity in data collection are available.

The health care system of people with psychological illness in Germany is faced with massive challenges. Irre menschlich addresses the question to the system whether humanity is getting more ill or the illness is becoming more human? Worst-case scenario of this is that soon 30 or 50% of people are declared psychologically ill.

'Irre menschlich' will push a paradigm-shift with the goal to recognise profound humanity in serious psychological illnesses. The challenge for the public understanding lies in the task to see functionality despite the disorder and meaning and significance despite the search for causality.

The medical system of health care for psychologically ill people and the public is being challenged by the projects of ‘Irre menschlich’. This is about an open minded point of view as a prerequisite for a mobile integrative psychiatric institution that is no longer tied to inpatient accommodations but instead promotes outpatient crises intervention. ‘Irre menschlich’ is trying to stress the anthropological aspect of a variety of the specific disorder condition as part of their destigmatisation work.

One main challenge for the social psychiatry and furthermore societies perception of psychological illnesses is its need for significance. It is profoundly human. Especially people with psychiatric experiences do not simply want to be acknowledged as well-behaved beneficiaries but instead as people who long for significance. That includes the desire to work and for meaningful occupation.

3.2 Information about the specific welfare state: Germany

Germany’s social policy is largely nationalised in international comparison. A great number of national services are provided by private carriers, stakeholders, organisations and other institutions (see Bellermann 19). Its primary function is to grant security against the risks that emerge out of wage-related work such as illness, unemployment, accidents at work for people in advanced ages (see Bellermann:83). A characteristic of social services is that they do not make up their own system but are merely included as a category of services in the money, material and legal systems (see Bellermann: 87).

In 1900 the health care system for psychologically ill was strongly characterised by medical treatment and institutional care. Psychologically ill had to suffer through excommunication, physical exclusion, forced sterilisation and death. Neurologists and nurses shaped the environment according to the medical model.

Social psychiatry and community-based psychiatry was established through sensitivity for processes of individualism and the occurrence of expansion for psychological understanding.
In the 20th century psychiatry is characterised by the demand to provide help for people to help themselves, preventive services and aftercare as well as the integration of psychologically ill people, families, neighborhoods, residential districts, communities, organisations and psychiatric agencies (see Dörner et al: 501ff.).

### Economic Indicators

- **Gross domestic product (GDP) European Union 2013**
  - 2011: 32721 USD curr. PPPs (see OECD 2013)
  - 2004: 25707 USD curr. PPPs (see OECD 2013)

- **BiP in KKS (see Eurostat 2013)**
  - Germany: 30300 in 2011
  - EU27: 25100 in 2011

- **Total number of social services (see Bmas 2012)**
  - 2011: 767,6 Mrd
  - 1991: 397,3 Mrd

- **Rate of social services (BiP) (see Bmas 2012)**
  - 2011: 29.9%
  - 1991: 25.9%

### Health Care Expenditure

- **Expenditures for psychological health as a proportion from the health care expenditure (KOM 2005) Germany**
  - 2011: 29.9%
  - 1991: 25.9%

### Costs of Mental Illness

- **Expenditure for psychological illness 2006**
  - 26.7 Mrd. Euro

### Future Projections

- **Prediction of the cost increase until 2030 (DESTATIS 2010:35)**
  - 2002-2006: 3.3 Mrd. Euro
  - 2006: 32 Mrd. Euro (+20%)

### Social Protection Benefits

- **Benefits by function**
  - Illness (see Bmas 2012)
  - Health care expenditure as a proportion of the GDP in Germany (see DESTATIS 2012)
  - Expenditures for psychological health as a proportion from the health care expenditure (KOM 2005) Germany
  - Cost increase for psychological illness
  - Expenditure for psychological illness 2006
  - Prediction of the cost increase until 2030 (DESTATIS 2010:35)
  - Expenditures of psychological illness in the EU % of GDP (KOM 2005)
  - France: Total health expenditure as % of gross domestic product (GDP), WHO estimates (HFA-DB 2012a)
  - Norway: Total health expenditure as % of gross domestic product (GDP), WHO estimates (HFA-DB 2012b)

### Social Protection Expenditure: Aggregated benefits and grouped schemes in Mio. of Euro.

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Increasing benefits</th>
<th>Part of benefits of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3.605.678,95</td>
<td>/</td>
</tr>
<tr>
<td>Germany</td>
<td>565.683,07</td>
<td>765.717,82</td>
<td>52,53%</td>
</tr>
<tr>
<td>Denmark</td>
<td>45.334,15</td>
<td>78.367,78</td>
<td>102,60%</td>
</tr>
<tr>
<td>France</td>
<td>379.396,42</td>
<td>654.238,65</td>
<td>84,47%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

There is a steadily increase of expenditure in benefits in kind of social protection benefits (including social services), that shows the growing meaning in comparison to social protection benefit in cash. The table below presents the social protection expenditure of selected countries.
4. Challenges and Drivers of Innovation

Structural Weaknesses of the System:

1) Large Increase of Case Numbers in Germany:
   Reasons for the Rising Diagnosis:
   · A rise in psychological disorders and illnesses can be associated to age
   · Expanding number of practicing medical specialists for psychiatry and psychotherapists
   · General practitioners more frequently make psychiatric diagnoses (see Stolz 2007:7f.). According to Dörner et al (2002) this is the somatic and psychological claim to absoluteness: every _____ is psychologised.

2) Dominant medical access (see Dörner et al 501ff.)

3) The need for reform within the complex system of social security:
   · To tackle demographic and globalisation issues
   · Lack of transparency about the types of social services and jurisdictions of agencies for social security, characterised by ambiguity in legal services and the variety of carriers. Orientation on the social class. Result: Exclusion of low income earners (i.e. People barely- or unable to work, unemployed women and people with part-time jobs) (see Lampert; Althammer: 346ff.).

Additional Impending Factors:
   · Social-psychiatric claim of absoluteness: All causes lie in social preconditions of the individual.
   · Institutional claim of absoluteness: Institutions - Orphanages
   · Modern technocratic claim of absoluteness: multi-conditional approach: several preconditions lead to mental illness.
   · Serviceadministration: Every group of illness has its own health care system (see Dörner et al: 501ff.)

Innovation: Ideas, criteria, levels and added values

Ten Assumptions About the Triologue

Following the elements of the 'psychosic seminar' strengthens it to an appropriate psychotherapy and implements user rights for valuable relationships: radical changes to personalization, interactions at eye level and discourses free of dominations.” (Bock, Priebe 2005).

1) "Unintentional Psychotherapy' appears to have a strong and lasting effect: The psychosis experience is being reflected, without pressure for change, independently, in a friendly context. Fresh perspectives can be revealed through the cooperation with relatives. This professional experience with this specific form of communication can teach complete perception and serenity which are both important requirements for psychosis psychotherapy.

2) Change in the point of view of ex-users of psychiatry as well as the type of treatment towards more respect, self-determination and independence. In practice through the facilitation of the Trialogue on various levels (clinical practice, teachings, trainings, public relations, planning, quality management, research u.a. Bock 2012b).
3) Basic Principles of the Psychiatry Seminar: a) Empowerment is more important than compliance, b) the variety of experiences outweighs the standard treatment, c) to not make the access to subjective point of views more difficult through narrow definitions of illness, d) the inclusion of relatives in a flexible and natural manner.

4) Coping with the First Experiences of Psychosis: open dialogues, open understanding, most importantly treatment in an anxiety-free space. The method of the „open dialogue“ is an empirically proven intervention that is used in family therapy and also happens to be a practical implementation of the Trialogue (Aderhold et al 2003).

5) The change of definition for psychosis from a pathological to an anthropological view could have a strengthening effect on the self-determination of the patient. The less anxiety is caused by the diagnosis, the braver the client will be to take on psychotherapy - this applies to experienced people, relatives and (!) therapists.

6) The connection from the psychosis-experience to one’s own life is crucial. This also applies to subjective, positive psychosis-experiences and possible constructive twists during the period the patient copes with the illness.

7) The more the patient adopts the clearer is their point of view on the present psychosis-experience which can lead to an optimistic outlook towards the future. Hamburgs research project SuSi offers empirical evidence for the relevance of a biographically oriented psychosis-psychotherapy (Bock et al 2010, Klapheck et al 2011).

8) Psychosis and self-will are related to each other in more than one context: The search for meaning is (physically) existential for people; the search for the meaning behind the symptoms is the guiding principle for therapy and recovery. A new treatment approach is created by understanding that the psychosis could be a retreat to the safe haven of one’s individuality: Empirical studies show that adaptation and compliance - demanded at whatever cost- are often followed by depression and suicidal tendencies. People with headstrong concepts of illness however have a higher quality of life (Roessler 1999).

9) New impulses of psychosis-psychotherapy: The orientation on recovery instead of a symptom reduction setting, respect for the subjective perception of the client, explanation and meaningfulness, the flexible inclusion of relatives as well as the integration of peer-counselling.

10) The Trialogue promotes empowerment. ‘Psychosis seminars’ can encourage a constructive way of coping with the illness effectively. They can also promote and strengthen the attendance in psychotherapy, support and secure the process and have a lasting effect afterwards (Knuf 2010).
### Different Levels of the Trialogue

| **PsychoseSeminar** | Started: 1989, expansion to date  
[www.trialog-psychoseseminar.de](http://www.trialog-psychoseseminar.de) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trialog in der Praxis</strong></td>
<td>For example treatment agreement (Dietz 2009), open dialog, trialogical method for those who have been ill for the first time (Aderhold et al 2003)</td>
</tr>
<tr>
<td><strong>Trialog in Lehre und Fortbildung</strong></td>
<td>A variety of colleges and associations such as DGSP</td>
</tr>
<tr>
<td><strong>Inhalte des Trialgos</strong></td>
<td>Anthropological understanding as a supplement for the pathological order (Bock 2011/2012)</td>
</tr>
<tr>
<td><strong>Öffentlichkeits-, Antistigmaarbeit</strong></td>
<td>For example Irremenschlich Hamburg, <a href="http://www.irremenschlich.de">www.irremenschlich.de</a></td>
</tr>
<tr>
<td><strong>Trialogische Tagungen</strong></td>
<td>For example: World congress for social-psychiatry, „Abschied von Babylon“, 1994 in Hamburg</td>
</tr>
<tr>
<td><strong>Trialog der Verbände</strong></td>
<td>For example between the federal association (FA) of ex-users of psychiatry, FA of relatives, German Act of Social-psychiatry (DGSP)</td>
</tr>
<tr>
<td><strong>Trialogische Organisationen</strong></td>
<td>Network „Stimmenhören“, German Act of bipolar disorders (DGBS)</td>
</tr>
<tr>
<td><strong>Ausweitung auf andere Diagnosen</strong></td>
<td>For example: Borderline-Trialog, obsessive-compulsive disorder (OCD)</td>
</tr>
<tr>
<td><strong>Psychiatriepolitik</strong></td>
<td>Including ex-users of psychiatry and relatives in psycho-social working groups/committees, advisory councils</td>
</tr>
<tr>
<td><strong>Beschwerdestellen, Qualitätssicherung</strong></td>
<td>Various regional examples: (Uebele 2009, Bombosch 2009)</td>
</tr>
<tr>
<td><strong>Trialog/Partizipation in der Forschung</strong></td>
<td>z.B. Hamburgs Research project SuSi „A more personalised meaning“(Bock 2010)</td>
</tr>
</tbody>
</table>

### Agents of change

„Incubator“ was the first ‘psychosis-seminar’ in Hamburg which developed out of the involvement of ex-users of psychiatry, relatives and professionals:

- Professionals were requested to abdicate their decision-making power.
- Ex-users of psychiatry want to be taken seriously by their relatives

### 5. Key innovative elements of this example

<table>
<thead>
<tr>
<th><strong>Field of service</strong></th>
<th>Health, Welfare, Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year of establishment</strong></td>
<td>1998</td>
</tr>
<tr>
<td><strong>Form of organization</strong></td>
<td>Nonprofit Organisation: association</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td>Fundraising, Donations, Mitgliedsbeiträge</td>
</tr>
<tr>
<td><strong>Size of the organization</strong></td>
<td>Staff: 0,5 Position for Coordination; Ehrenamtliche Ärzte, Psychologen, ex-users of psychiatry and relatives</td>
</tr>
<tr>
<td><strong>Members and participation</strong></td>
<td>Number of Members: 50, aktive Members about 25</td>
</tr>
<tr>
<td><strong>Contact</strong></td>
<td>Irremenschlich Hamburg e.V., Martinistr. 52, 20246 Hamburg, Tel.: 040-7410-59259, <a href="mailto:info@irremenschlich.de">info@irremenschlich.de</a></td>
</tr>
<tr>
<td><strong>Name of the innovative example</strong></td>
<td>Irremenschlich Hamburg e.V., Martinistr. 52, 20246 Hamburg, Tel.: 040-7410-59259, <a href="mailto:info@irremenschlich.de">info@irremenschlich.de</a></td>
</tr>
</tbody>
</table>

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9
How the Trialogue Began

Both ‘Irre menschlich Hamburg’ and ‘Irrsinnig menschlich Leipzig’ are a part of the anti-stigma projects of the first hour. It is a non-profit organisation of ex-users of psychiatry, relatives and professionals from the psycho-social field. This initiative emerged out of hamburgs 'psychosis seminar'. The main focus are all aspects of ‘being different’, mental health and psychological illness. This is where barriers are supposed to be penetrated by meetings from pupils and crises experienced people and their relatives. This promotes sensitivity in dealing with others and oneself. The widely spread prejudice against psychological illnesses is makes the actual cases of those who are suffering from it considerably tremendous. This results in anxiety and social withdrawal. Prejudice puts the individual therapeutic progress, the resources of the affected families and the structural development of the psychiatry at risk. Especially affected are the patients diagnosed with schizophrenic and affective psychosis and among those especially the one’s with a manic-depression. The involvement of the relatives puts 5 million people in Germany in direct and indirect contact with the stigma illness. One-sided reports and early misinterpretations from psychiatry keep prejudices alive even though they have been proven wrong empirically to name a few these clichés include assumptions such as: the patients are 'dangerous, incurable, unpredictable'; their personality is 'split', 'the illness is the parents fault'. Science needs the alliance with patients and their relatives to counteract to these prejudices in a believable and convincing way because prejudices can only be cleared out by individual stories and personal encounters. Anti-stigma work helps reduce prejudice, to maintain, create or retrieve social space to therefore guarantee therapeutic success. The beneficiaries of this are mentally impaired, relatives and professionals. The actual work serves the purpose of personal reinforcement and recovery: empowerment. It is already evident that the involved experienced / patients are taking leaps forward through the anti-stigma work that nobody thought ever possible beforehand. Prejudice against people with psychological illnesses is so common among youth that potential at risk candidates are stigmatised and excluded before a specific disease forms or exclude themselves as a result out of the fear to be excluded. Such prejudices are however not yet strengthened and learning processes are still possible. 'Irre menschlich Hamburg’ wants to promote tolerance and sensitivity in dealing with others and with one’s own psyche. Both are important prerequisites for mental health. Anti-stigma work also has an immediate, preventive benefit. This applies especially when youth is directly or indirectly affected by the experiences to relieve them in a gentle way. They make the experience there is a whole lot to talk about in this topic without getting the impression that they themselves are the topic of discussion. The presentation from experienced public speakers reduces anxiety and open up new possibilities of assistance. This project has a direct and indirect use for psychiatry. For the mentally ill and their families in general as well as those directly involved public speakers and also for inquiring institutions such as schools, police, and health facilities.

The culture of a society measures itself on how they deal with vulnerable populations. But psychologically ill people are not only vulnerable, a chance that presents itself is to learn from them. It has become a big challenge to preserve, strengthen and retrieve mental health. Considerable requirements are tolerance ad sensitivity in dealing with one self and others. The goal from Hamburgs 'Irre menschlich' is to promote both. This goal can be reached through authentic information but most importantly meetings. Ex-users of psychiatry and people with crises experiences be-
come public speakers, peer-counsellors and life-teachers. In a context that counteracts common prejudices. In schools, businesses, in cultural and religious contexts. For joint training for health professionals, teachers, police officers, pastors, legal workers, youth services. The association consists of 50 members (approximately half of them which are active) and other supporters. The members are ex-users of psychiatry, relatives and doctors from the universities clinic are mostly active volunteers. Ex-users of psychiatry and relatives will be rewarded with an hourly wage of 15,00€ for their help in the project. The project requires a ½ full-time position to be filled for the coordination and organisation which is funded externally. Members of 'Irre menschlich' include people with psychological illnesses (long-term or short-term patients and relatives), actors of the health care system (doctors and psychologists) and volunteers. Hamburgs 'Irre menschlich' is a registered association is a member of the 'Paritätischen Wohlfahrtsverband' (non-profit association). The association if funded by donations, fundraising and contributions of its members.

Network of 'Irre menschlich Hamburg'

- Universitätsklinik Hamb.-Eppendorf UKE
- Psychoseminar Hamburg
- Arbeitsintegrations-Netzwerk ARINET
- Hilfe u. Orientierung Für ps.erkrankte Stud. HopeS
- Landespolizeischule
- Landesverband der Angehörigen
- Landesverband der Erfahrenen
- Akademie für sozialpäd. Fachkräfte
- Irre menschlich Hamburg
- Hamburg Institut für Lehrerfortbildung
- EU-Projekt EX-IN EXperienced-INvolvement
- Stadtteil-, Berufs-, Gesamtschulen, Gymnasien

- Mitglied im DPWV,
- Förderung durch Start Social,
- Spendenparlament,
- Deutsche Behindertenhilfe,
- Hamb. Ges. für Gesundheitsförderung,
- Mitverantwortlich für Hamburg als „Gesundheitsmetropole der Zukunft“ (Ausschreibung BMG)

- Kreis der ideelle UnterstützerInnen („Paten“):
  Persönlichkeiten aus Kultur, Medien, Politik und Wissenschaft
The services of this trialogical non-profit organisation include information-, meeting- and prevention projects as well as trialogical trainings:

- Frequent information-, meeting and prevention projects for Hamburgs school of all ages and different subjects
- Regularly occurring „Open Houses“ among other things especially for pupils „Psychiatry at school“
- Education and information projects in Hamburgs businesses
- Frequent trainings and further education events for journalists, health occupations, youth services, police officers, teachers and lecturers, pastors, housing industries and work projects
- Public activities in cooperation with representatives of people with disabilities among others
- A variety of cultural events (exhibitions, movies, theater)
- Conception, testing and execution of a curriculum as a preparation for ex-users psychiatry to fulfil tasks in anti-stigma work independently and psycho-social care.

There are public speakers for all types of disorders, a great supply of authentic materials, which are provided free of charge (media box), a detailed teacher's guide 'Irrel!', the successful trialogical booklet 'It's normal to be different' - Treatment and understanding of psychosis' and the award-winning photo exhibition (with its own brochure) 'experience' created to portray the experienced that have transformed their illness experience in activities for the benefit of others. All projects fulfil the goal of 'more tolerance and sensitivity in dealing with others and themselves' - as a prerequisite for mental health for everyone that is participating. (www.irremenschlich.de)

The projects are increasingly prevention-oriented: The meeting projects aim for more sensitivity and to become more confident with crises in dealing with one self as well as greater awareness and tolerance in dealing with others - with pupils as well as co-workers and neighbours.

The trialogical trainings want to counteract against other understandings and perceptions as well as conflicts and selective mechanisms to promote inclusion. This is possible for two reasons - through the natural and direct involvement of the ex-users of psychiatry and their relatives as well as their impact on different targeted groups, most occupational groups, that do not exclusively or often, though increasingly more common, deal with people with psychological illnesses.

6. References

Aderhold V. et al 2003: Psychotherapie der Psychosen – Integrative Behandlungsansätze aus Skandinavien, psychosozial-Verlag


Bmas (Bundesministerium für Arbeit und Soziales) Hrsg. 2012: Sozialbudget 2011. Bonn. Available at:
INNOSERV - WP 7 Theoretically informed case study accompanying the visualisation


Bock, T., Priebe, S. (2005): Psychosis-seminars, an unconventional approach for how users, carers and professionals can learn from each other, psychiatric Services, Vol. 56, No. 11, 1441-1443


DESTATIS 2012 (Statistisches Bundesamt) Hrsg.: Entwicklung der Gesundheitsausgaben; Anteil im Bruttoinlandsprodukt (BIP). Wiesbaden. Available at: https://www.destatis.de/DE/ZahlenFakten/GesellschaftStaat/Gesundheit/_Grafik/AnteilBIP.html (Date of Access: 12.03.2013)


Eurostat 2013b (Statistisches Bundesamt) Hrsg. 2013b: Bruttoinlandprodukt zu Marktpreisen. Kaufkraftstandard je Einwohner. Available at:
INNOSERV - WP 7 Theoretically informed case study accompanying the visualisation


Quellen fehlen:
INNOSERV - WP 7 Theoretically informed case study accompanying the vizualisation

Knut 2010
Dietz 2009
Klinische Praxis Bock 2012b u.a.

An welcher Stelle im Text wurden dieser Nachweis aufgeführt/ zitiert?

This report is a product of the INNOSERV project (grant agreement nr. 290542) which is funded by the European Union under the 7th Framework Programme.
Theoretically informed case study accompanying the film

BIZTOS KEZDET SZIVÁRVÁNY SZIGET GYEREKHÁZ
(SURE START RAINBOW ISLAND CHILD CENTRE) IN KATYMÁR, HUNGARY

Author:
Budapest Institute for Policy Analysis
Dorottya Szikra, Adrienn Győry, Adrienn Kiss

WP Leader HAW Hamburg:
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://inno-serv.eu/katymar

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a europeanwide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. ‘Szivárvány Sziget Gyerekház’ (Sure Start Rainbow Island Child Centre, hereinafter the Child Centre) in Katymár: help for families in need, especially the most disadvantaged Roma to cope with poverty and unemployment

**Specific innovative elements** of the Child Centre
Focused targeting on families with small children: Well-structured services attract disadvantaged families with children. The Centre provides early childhood education, care for families and it gets involved in community building activities.

Interconnectedness of different projects: The projects run by the municipality were actively supported by the Child Centre devoted to increase employability, create new employment opportunities and to enhance a self-sustaining community. The Centre provides assistance and serves as an open space where families gather, discuss and share their problems and experiences.

Multiculturalism: The presence of three (more or less equally represented) ethnic groups (Croatian, German and Roma) as well as the deep-rooted cohabitation practices and openness facilitate an unbiased approach to the multiply disadvantaged Roma people.

**Key characteristics of the service**

**Organisation:**
The Child Centre functions as a non-profit institution financed primarily by municipal subsidies and EU Funds. It employs 9 people including a pedagogue, a qualified child-care nurse, a qualified child-welfare expert, a care-taker, directors and deputy director, financial and project assistant.

**User groups:**
Families with children under 5 years. The aim is to reduce child poverty and promote the intellectual, physical and social development of infants and small children by providing early childhood education and care. Parents can receive training and education on child-raising, cooking, child health related issues and continuous consultancy that helps them to cope with child-raising and family-related problems.

**Principle:**
The local government and the Social Ministry/Ministry of Social Affairs provided the launching of the Centre and Social Land Programme as intertwined programmes. The Child Center approach all families regardless their economic situation, social or ethnic background. Attendance is voluntary. There is a weekly schedule set in compliance with the interests of the children as well as their parents, which helps members of families to get used to regularity. The Social Land Programme aimed to involve families in agricultural activities.

**Driver(s):**
Unemployment, increasing number of people living in deep poverty and the phenomenon of aging society. The aim of involving and integrating the newly-arrived Roma families living under extremely disadvantaged circumstances.

The settlement faced lack of financial tools and adequate social service provisions at that time. As a result of the successful negotiations between the local government and the Social Ministry/Ministry of Social Affairs, the latter one provided the launching of the Centre and Social Land Programme as intertwined programmes.
2. BASIC DATA ON HUNGARY

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Total Population:</td>
<td>10,014,324</td>
<td>501,120,157</td>
</tr>
<tr>
<td>Proportion of population aged 0-5 years:</td>
<td>5.84%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Percentage of population at risk of poverty or social exclusion</td>
<td>29.9%</td>
<td>23.4%</td>
</tr>
<tr>
<td>Percentage of population under 6 years at risk of poverty or social exclusion</td>
<td>37.1%</td>
<td>25.2%</td>
</tr>
<tr>
<td>Expenditure on social protection (% of GDP)</td>
<td>23.1%</td>
<td>29.36%</td>
</tr>
</tbody>
</table>

3. SERVICE ORIENTATION. INFORMATION ABOUT THE HUNGARIAN WELFARE STATE

After the fall of the state socialist regime serious economic decline hit Hungary. The risk of permanent poverty increased especially for unskilled people, those living in disadvantaged areas, people living in small-size municipalities. The political elites expected that economic development and increase in national income would diminish the high rate of poverty. Therefore in the early 1990s they tried to hide the phenomenon with specific cash-transfers in forms of early-retirement, long parental leaves, etc. However the rate of population facing economic deprivation kept being relatively high and no real progress has been achieved. According the data of Central Statistical Office approximately one-fifth of the population at the age of 20-59 was long-term unemployed in 2010 and 3% of the population lived in poverty (Medgyesi and Scharle, 2012).

One of the main sources of reproduction of poverty is education. In absence of special tools for integration of disadvantaged children the schools fail to provide the necessary support for the disadvantaged children to catch up, to acquire equal opportunities when entering the labour market.

Although there are various active labour market policies adopted in order to enhance integration of disadvantaged people into the labour market, emphasis has been put on public works programmes recently. The role of training and consultation as well as empowering social work methods have been gradually ceased/limited Public works programs, however, have not proved to be effective in raising employability of participants in the free labour market (Köllő and Scharle 2011). These programs do not correspond to the realities of the labour market, what decreases their efficacy (Medgyesi and Scharle, 2012).
Hungary maintains a relatively generous family policy system. Expenditure on family policy support has almost reached 3% of GDP\(^1\) in 2010 (Eurostat, 2012). However at current conditions it tends to benefit more the better-off families (especially through tax allowances), while it does not offer appropriate support for families at lower social status. Prior the financial crisis cash transfers had impact on reducing poverty (Gábos, 2008). Since 2008 cash benefits has been kept at the same amount, while its value has decreased (Ferge, Darvas, 2012). For a family in one of the most disadvantaged regions of Hungary it meant a considerable 10% decrease in monthly family income in nominal terms, and 17% decrease in its real value (Ferge, Darvas, 2012). The table below presents the social protection expenditure of selected countries.

### Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro.

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996-2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EU 27</td>
<td>/</td>
<td>/</td>
<td>34,07%</td>
</tr>
<tr>
<td>Hungary</td>
<td>/</td>
<td>/</td>
<td>32,19%</td>
</tr>
<tr>
<td>France</td>
<td>379,396,42</td>
<td>654,238,65</td>
<td>34,17%</td>
</tr>
<tr>
<td>Germany</td>
<td>565,683,07</td>
<td>65,717,82</td>
<td>34,69%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

Access to nurseries and family child-care centres for children under 3 years is highly limited, the share of children attending such services has been around 10% in 2010s (Central Statistical Office, Stadat). Coverage of daycare services exceeds 20% in Budapest and in county seats, while on the other side of the spectrum, in small villages the rate of children accessing the services tends to be under 0.5% (Central Statistical Office – Stadat). Regional differences are quite extensive in Hungary, reifying the existent territorial and social inequalities. In the least developed regions (Northern Hungary\(^2\), Northern Great Plain\(^3\)) the rates are the lowest ones. In terms of household income, children of better-off families are over-represented: Families of the two highest income groups use services of nurseries the most, while the families in lower income groups are under-represented (Tokaji, 2011). The demand for services by far exceeds the

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\(^1\) 2.34% was spent on cash benefits and 0.59% on services

\(^2\) In 2009 it was the 9\(^{th}\) NUTS2 region with lowest regional GDP per capita in the EU (http://epp.eurostat.ec.europa.eu/cache/ITY_PUBLIC/1-13032012-AP/EN/1-13032012-AP-EN.PDF )

\(^3\) In 2009 13\(^{th}\) NUTS2 region with the lowest regional GDP per capita in the EU
capacities of existing facilities and the development of the network is very slow, what is especially unfavourable for disadvantaged children who could benefit the most of early childhood education and care.

In contrast to nurseries, the network of kindergarten is relatively well-developed covering 85% of children of the age cohort (Transmonee). In Hungary the attendance of children is compulsory from the age of 5 (from 2014 age limit is decreased to 3 years). In 2009 the so called kindergarten allowance was introduced to encourage parents of disadvantaged children to attend kindergarten at an early age. Kézdi and Kertesi (2012) found that 2 in 3 children attend kindergarten at the age of 3, while in case of children of mothers with primary education it is only 1 in 3 children. They argue this is partially reasoned by lack of capacities in kindergarten, by limited parental intentions or other reasons on the demand side. Lack of capacity is especially characteristic for municipalities with high rate of unemployment and poverty, and where the Roma minority is represented in higher percentages (Kertesi and Kézdi, 2012).

20.3% of children and youth under the age of 17 lived under the poverty threshold in 2010 (Central Statistical Office, 2012). This rate duplicates in the least developed regions (Ferge, Darvas, 2012). According to the PISA data the impact of social background of families on the educational performance of the child is the strongest in Hungary among all countries examined, which highly underlines the need for early childhood education for disadvantaged children (Danis, 2011).

The Programme against Child Poverty was launched in 2005 and a detailed long-term strategy has been issued in order to deal with these challenges. The main purposes were to ensure healthy life conditions, to make children acquire the necessary skills enhancing their social integration, to reduce the considerable regional differences and ethnic inequalities. One of the main principles advocated was the role of early childhood education and care in reducing the social disadvantages. Within the confines of the Programme as a pilot programme a network of Sure Start Child Centres was developed targeting families in municipalities with high rate of low-income families especially in rural, remote areas. Initially the Child Centres were financed by public funds. However the political and financial support tended to gradually decrease requiring more contribution from the municipalities. In 2009 the financing was shifted under EU financing. Recently the Programme against Child Poverty has been considerably disempowered. Therefore its continuation depends on the political will.

4. INNOVATIVE IDEA OF THE SOCIAL SERVICE
‘Szivárvány Sziget Gyerekház’ (Sure Start Rainbow Island Child Centre, hereinafter the Child Centre) in Katymár takes a leading role in helping families in need, especially the most disadvantaged Roma to cope with poverty and unemployment.
4.1. Micro-context
The municipality of Katymár is situated in Bács-Kiskun county in Southern Hungary, in one of the least developed micro-regions. The number of inhabitants slightly exceeds 2000. The community is composed of four nationalities – Hungarian, German, Croatian and Roma. The three ethnic minorities established their own Minority Local Governments and they aim at preserving their culture while also cooperating and encouraging each other’s activities. 4% of the population is constituted by children under 6 years, 14% by youth at age of 6-17. People aged 18-59 represent 56%, and the remaining 26% are elderly people over 60 years.

Being a municipality with an agricultural profile Katymár was hit by severe economic decline after the democratic transition. Demand for low-skilled workers decreased, the main employers gradually terminated their activities and left the municipality in critical situation. Due to the continuous emigration a lot of houses stood empty inducing considerable inflow of poor, Roma families in the early 2000s, what increased the magnitude of the problems present in the village.

The biggest challenges the municipality faces are unemployment, increasing number of people living in deep poverty and the phenomenon of aging society. Government decree No. 240/2006 declared Katymár a “disadvantaged municipality” from the aspect of social-economic and infrastructural development. Unemployment rate was 14%, 1.78 time higher than the national rate in 2011 (Central Statistical Office – T-star data). Most of the workless are under-educated, which makes their labor market integration difficult especially in a region, where industry and services are underdeveloped branches of economy.

There is a general practitioner working in the village, while there is no paediatrician. Social service is offered in the home of elderly people. The municipality runs a kindergarten and a primary school. Both of them are “ethnic minority specific” institutions with German and Croatian teaching languages. As a negative affect of long-term deprivation, psychiatric problems like depression, hopelessness, feelings of aimlessness characterise many of the unemployed people in the village. In order to overcome these problems and break the poverty trap they would need a range of social services. However, due to the small size of municipality, the difficulty to reach the nearest town and also the lack of information and distrust in public institutions, they are the ones who do not have access to services dealing with mental health problems, labor market activation and family-related problems.

As families with children have a higher incident of poverty than other social groups the municipality – particularly the mayor Endre Pál, the vice-mayor Andrea Zelityné Vas and their supportive colleagues – consciously directed its efforts to support them since the mid-2000s. Thus families with small children, especially single-parent families are the primary beneficiaries of the newly created services.

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4 7% of them have not completed primary education, 43% have primary education, 29% with vocational training (Central Statistical Office, T-Star)
In absence of employment opportunities usually none of the parents work and thus they depend on social benefits. As social assistance levels are extremely low (and even decreased during the crisis) families who have been the target group of the newly created Child Center, cannot afford appropriate nutrition, clothing, heating or even the use of electricity. They live in very poor health conditions. Lack of education tends to further decrease their chances for catch-up. As a pilot project Sure Start Child Club was established in 2005, which later on extended its services and transformed to Sure Start Child Centre. One of the key drivers of creating the Centre was the aim of involving and integrating the newly-arrived Roma families living under extremely disadvantaged circumstances.

The settlement faced lack of financial tools and adequate social service provisions at that time. As a result of the successful negotiations between the local government and the Social Ministry/Ministry of Social Affairs, the latter one provided the launching of the Centre and Social Land Programme as intertwined programmes.

Later on further projects were started to enhance employment opportunities and self-sustainability of the community. Examples include the establishment of producer’s cooperative in the most disadvantaged Bácsalmás sub-region, and programs for people living in extreme poverty. Most of the projects focus on easily utilisable activities relating to agriculture and food production. One of the major innovation of the municipality is the integration of these projects. For example, a good relationship is developed between parents and the Child Centre and this way families with small children enjoyed priority in joining the various employment-related programmes.

**Agents of change**

The leadership of the municipality very well captured the potential of integration of several projects. Relying on the good relations with the parents developed by the Child Centre, these families are channelled in further activating programmes and community building.

### 4.2. Social services provided by the Child Centre

<table>
<thead>
<tr>
<th>Field of Service</th>
<th>Welfare and Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of establishment</td>
<td>2005</td>
</tr>
<tr>
<td>Form of organization</td>
<td>Non-profit</td>
</tr>
<tr>
<td>Financing</td>
<td>Municipal subsidies, EU Funds</td>
</tr>
<tr>
<td>Size of the organization</td>
<td>9</td>
</tr>
<tr>
<td>Members and participation</td>
<td>69 children, approximately 40 families</td>
</tr>
</tbody>
</table>

The Child Centre functions as a non-profit institution financed primarily by municipal subsidies and EU Funds. It employs 9 people including a pedagogue,
a qualified child-care nurse, a qualified child-welfare expert, a care-taker, directors and deputy director, financial and project assistant.

So far there has been no special quality control or impact assessment conducted, however the activities of the Child Center are widely respected among the experts on social services. The members of the staff participate at conferences and further trainings. Often they are the ones sharing their best practices.

69 children have attended the Child Center as of 2012, which means a regular contact with approximately 40 families. The services provided by the Child Center concerned 10% of the population of Katymár directly. As the Child Center succeeded to engage the wider community, promote intergenerational cooperation, approximately 30-40% of inhabitants indirectly benefit from the activities organized by them.

The primary intention of the Child Centre has been to reduce child poverty and promote the intellectual, physical and social development of infants and small children by providing early childhood education and care. Their parents, meanwhile, have received training and education on child-raising, cooking, child health related issues and continuous consultancy that helps them to cope with child-raising and family-related problems. The Social Land Programme aimed to involve families in agricultural activities as well as to encourage people to attain competences to become (at least partly) self-sufficient and to maximally utilize all available resources.

The services have gone through several stages of development. Initially, participant families of the Social Land Programme were offered with seeds and livestock, but without a formal way of social work and expert consultancy. The Sure Start Club had run a few, fragmented activities, but without a strong conception and capacities, so their service-users started to drop-out. In 2006, in the second round of governmental tenders, the vice-mayor, Andrea Zelityné Vas asked for help from early development experts. Next year they started to employ two pedagogues as club leaders whose salaries were financed by the local municipality. In 2009 they applied for EU funds and the building of the Sure Start Centre was reconstructed.

Today they offer a coherent early childhood development program including wide-ranging services such as parent-child playing sessions, child development workshops, baby massage and consultancy. Daily activities involve gymnastics, craft workshops, nursery rhythm clubs in Hungarian, German and Croatian languages. In order to strengthen parental skills and empower them with useful competencies they offer informal forums involving professionals from the local child care service and family help centre. Lecture and consultancy with the local nurse, a psychologist and an early childhood specialist are organized on a monthly basis. Thus health checks, monitoring of children’s development, screening of disorders, special medical examinations are also ensured. Importantly, the Child Centre provides two meals daily ensuring children’s healthy nutrition day-by-day.

The Child Centre is open for all families with children under 5 years. They approach all families regardless their economic situation, social or ethnic background. Attendance is voluntary. The Child Centre succeeded to attract
families and made them committed. There is no need to urge families to come and participate by now. There is a weekly schedule set in compliance with the interests of the children as well as their parents, which helps members of families to get used to regularity.

Although the Child Centre cannot afford to financially support families in need, their services are offered free of charge, and the center organizes collection of used clothes, fundraise to provide washing powder and diapers for families in need.

4.3. Core innovative ideas

- **Focused targeting on families with small children** – The well-structured services of the Child Centre attract disadvantaged families with children. Besides providing early childhood education and care families get involved in community building activities.

- **Interconnectedness of different projects** – The Child Centre actively supports the projects run by the municipality devoted to increase employability, create new employment opportunities and to enhance a self-sustaining community. The Child Centre provides assistance and serves as an open space where families gather, discuss and share their problems and experiences.

- **Multiculturalism** – The presence of three – more or less equally represented - ethnic groups (Croatian, German and Roma) as well as the deep-rooted cohabitation practices and openness facilitate an unbiased approach to the multiply disadvantaged Roma people.

5. CHALLENGES

- **Lack of access to ECEC in remote areas**: Access to early childhood education and care is highly fragmented and unequal. In small municipalities nursery services usually are not available at all, while kindergarten tend to lack capacities. In most cases children of working parents are prioritised during the admission decreasing the chances of socially disadvantaged families and children of unemployed parents to take advantage of these services.

- **Lack of multidisciplinary approach to poverty**: Most of the programmes and projects devoted to tackle poverty are not complex enough to deal with the different aspects of the persisting problem such as education, health, nutrition, housing and lack of economic activity simultaneously.

- **Low level of coordination of relevant public policies (both at central and local level)**: The weakness of the current system is the lack of cooperation between policies like employment, child care, housing, tax and social policies. Furthermore certain fields lack long-term action plans, or even if they do exist they are changed according to the alternation in governments.
6. SUMMARY OF INNOVATION

- Early childhood education and care is considered an effective preventive tool. Services offered by the Sure Start Child Centres target not only children, but their parents as well influencing their childrearing practices, developing interpersonal relations, and building community. Besides these benefits the Child Centre in Katymár succeeded to launch concrete activities. By connecting various municipal projects they prompted families’ engagement in land cultivation, growing vegetables, preservation of vegetables, household management, etc.

- In the last years the Child Centre has become a kind of a safety net for the participating families – offering continuous consultancy, close cooperation with the Family Support Service, Child Social Services as well as with the healthcare facilities it helps the parents in fulfilling their duties and deal with bureaucratic challenges.

- The positive and encouraging attitude and honest good will of all employees of the centre makes the facility well-functioning. Despite of the limited financial resources they attempt to find solutions and compromises for different sorts of troubles.

- Last but not least the Child Centre enhances social learning among the participating families. They acquire valuable knowledge by learning from each other, what may help them to improve their live conditions.

7. REFERENCES

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INNOSERV - WP 7 Theoretically informed case study accompanying the visualisation


Interviews conducted in Katymár.


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This report is a product of the INNOSERV project (grant agreement nr. 290542) which is funded by the European Union under the 7th Framework Programme.
Theoretically informed case study accompanying the film
Môm’artre - Network for after school childcare - France

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QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/momartre

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a Europeanwide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Network for after school childcare

The Môm'artre network creates new spaces for after-school childcare, helping children to develop mainly through art. It is a network of associations with seven childcare centres, in Paris and French cities such as Arles and Nimes. To ensure a social mix, these centres adapt to the incomes and work schedules of single parent families.

The services are aimed at schoolchildren aged 6 to 11 years. The places are open for children after school, during school holidays, and each Wednesday. Schedules are adapted to single parent’s working agenda and fares to family’s resources. Art workshops led by experienced artists are provided to children. The artists are employees of the network.

The ideas underlying the philosophy of the Môm’artre network are

- Participating in the development of children by providing them with an artistic space that enhances the expression of each outside the school and family
- Promoting equality and employability of women;
- Employing struggling artists to create jobs and provide access to art and culture;
- Fostering bustling neighbourhood life by involving the inhabitants.

Specific innovative elements of Mom’artre are:

*Response to new needs*

Mom’artre is particularly attentive to respond to: 1- Opening childcare centres with schedules adapted to urban environments (open until 8 pm, for instance), primarily to accommodate low-income families and single parents; 2 - Offering a variable fee structure depending on the family's income (from 10cts/h to a maximum of 8€/h); 3 - Proposing a full-service offer focused on children's fulfillment after school (Organization of after-school snacks, homework and artistic activities, neighbourhood events and gatherings on weekends).

*Mix of different objectives*

The overall objective is to provide a high quality service with relevant adaptation to the needs of children after school time, interesting artistic contents, and adapted costs and timetables. Further objectives are enhancing the employability of artists and fostering of bustling neighbourhood life.

*Network approach and proximity:*

Each centre strongly interacts with Mom’artre headquarters and also builds partnerships at the local level with other associations, public authorities as well as private companies.

*Resource hybridization*

The viability of the business model is based on a mix of monetary (sale of services and public funding) and non-monetary contributions (donations, sponsorships, volunteering, free provision of staff « gratis personnel »).

*Key characteristics of the service*

*User groups*

The provided services aim at children (between 6 and 11 years) and their single parents with staggered working hours. This service is also an opportunity for artists to find a job and to attend training sessions to improve their skills

*Principle*

The main idea is to create a welcoming service for children awakening to art and culture. Targeted children are those who otherwise could not access this type of activity because of their family situation.
Factors influencing Social Services Innovation

Challenges
- School and learning support
- Assistance for Parents
- Assistance in social integration of artist
- Core mission based on art and educational objectives. Mixed with support for parents in difficulty
- Inadequacy and unmet needs of single parent families in terms of after school care

Drivers
- Meet social & cultural needs of single parents
- Participating in the development of children
- Promoting equality and employability of women

Response:
- Key characteristics of the service
  - Resource hybridization

Quality
- It is a global service with threejoint objectives
- Development of educational and artistic interest
- Increased employability for artists and single parents
- A more attractive life in the neighborhood

Sustainability
- Project leaders are supported by the MonArt network
- Novelty:
  - Children enjoy arts after school time
  - Artists are trained to improve their professional integration
  - The lively activity of the centre makes the district more attractive

Agent of change
- A single mom created MonArt looking for extracurricular service for her child.
## 2. Policy Framework related to extracurricular childcare in France

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The provision of childcare services has to be adapted to:</td>
<td>The childcare services are provided by municipality and by private actors (mostly associations):</td>
<td>There are two types of legal milestones for childcare services in France.</td>
<td>1. There is no statistics at the national level showing the annual cost of the extracurricular childcare centres.</td>
</tr>
<tr>
<td>- <strong>School time</strong>: length of the school week: 24 hours of instruction (4 days a week except Wednesday. Vacations: around Christmas, February and spring</td>
<td>- <strong>Extracurricular childcare</strong>: Service offered to families in connection with the school, (homework, or care for children whose parents work late);</td>
<td>- For regulating the childcare services at the national level, lawyers can refer to:</td>
<td>2. Municipalities are responsible for the funding of childcare centres</td>
</tr>
<tr>
<td>- <strong>Professional constraints of parents</strong>: half the children of working parents do not meet their parents after school and 4 out of 10 children do not see them on Wednesday. (INSEE, 2011);</td>
<td>- <strong>Collective childcare</strong> (nurseries and leisure centres);</td>
<td>- Law n° 89-486 of July 10, 1989</td>
<td></td>
</tr>
<tr>
<td>- <strong>Atypical work patterns</strong>: Schedules of most collective childcare centres are not compatible with long working hours</td>
<td>- <strong>Extracurricular childcare</strong> belongs to the sociocultural animation domain because it allows the social monitoring of children (prevention), while proposing leisure activities;</td>
<td>- Code for social action and families</td>
<td></td>
</tr>
<tr>
<td>2. The goal is to address the issues of:</td>
<td>- <strong>Authorisations</strong> are required by childcare centres to get public funding. issued by:</td>
<td>- Decree n°2002-509 of April 8, 2002 on the control of community facilities for minors.</td>
<td></td>
</tr>
<tr>
<td>- <strong>Single Parent families</strong>: children of single parent families attend more after-school childcare centres. ¼ of women working 35 hours a week are looking for collective childcare;</td>
<td>- the Family allowance fund (Caisse d’allocation familiale),</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- <strong>Unemployed artists</strong>: young artists are looking for jobs and training sessions. In France, the artists depend on a specific regulation (intermittent du spectacle).</td>
<td>- the departmental social cohesion directorates (Les directions départementales de la cohésion sociale).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- and the Directorates of Youth and Sport (Les directions jeunesse et sport);</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- <strong>A diploma is required</strong>: Bachelor or a Master degree.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. The social, political and institutional context

3.1 Population/ Government

### Households and family patterns

<table>
<thead>
<tr>
<th>Types of households</th>
<th>Number of households</th>
<th>1999</th>
<th>%</th>
<th>2009</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household only composed of a...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single man</td>
<td></td>
<td>2 964.0</td>
<td>12.4</td>
<td>3 767.1</td>
<td>14.0</td>
</tr>
<tr>
<td>Single women</td>
<td></td>
<td>4 416.1</td>
<td>18.5</td>
<td>5 295.3</td>
<td>19.7</td>
</tr>
<tr>
<td>Couple without a child</td>
<td></td>
<td>5 904.3</td>
<td>24.8</td>
<td>7 032.8</td>
<td>26.2</td>
</tr>
<tr>
<td>Couple with one (or several) child(ren)</td>
<td></td>
<td>7 502.5</td>
<td>31.5</td>
<td>7 274.5</td>
<td>27.1</td>
</tr>
<tr>
<td>… With one (or several) child(ren) less than 18 years</td>
<td>5 919.5</td>
<td>24.9</td>
<td>5 908.5</td>
<td>22.0</td>
<td></td>
</tr>
<tr>
<td>A single parent family</td>
<td></td>
<td>1 753.6</td>
<td>7.4</td>
<td>2 132.3</td>
<td>7.9</td>
</tr>
<tr>
<td>… With one (or several) child(ren) less than 18 years</td>
<td>1 043.4</td>
<td>4.4</td>
<td>1 374.7</td>
<td>5.1</td>
<td></td>
</tr>
<tr>
<td>Complex households</td>
<td></td>
<td>1 267.6</td>
<td>5.3</td>
<td>1 364.0</td>
<td>5.1</td>
</tr>
<tr>
<td>… With one (or several) child(ren) less than 18 years</td>
<td>378.8</td>
<td>1.6</td>
<td>331.8</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>23 808.1</td>
<td>100.0</td>
<td>26 866.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

3.2 Information about the specific Welfare State: France

The analysis of the national context underlines the growth of single parent families. With this growth the need for extracurricular activities has improved. That is why a legal framework for childcare services has been created in France;

**Extracurricular activities**, introduced by Law on education n° 89-486 of July 10, 1989 and codified in the Article L. 551-1 of the Education Code, extend the perimeter of public services in education. This law aims to promote equal access for all children to sports practices, cultural activities, and to new technologies of information and communication literacy. Under current law, extracurricular activities are not mandatory and rely on local partners (such as local public institutions, local authorities, associations and foundations) for their design and implementation (The Circular No. 98-144 of July 9, 1998 is relative to the schedule of child activities). The Education Code recognizes in the Article L. 216-1 that the municipalities and the local authorities are allowed to organize extracurricular educational activities in schools. Furthermore, the education code allows the mayor to decide on the use of school facilities and equipment during after-school hours for providing cultural activities, social activities, and sports (Article L. 212-15). The local contract for children education, which has been signed between the state, the local authorities and the associations, aims to normalize the provision of extracurricular activities and indicate the legal framework in which they are organized.
It specifies the location of activities (school or outside) and those who are responsible for these activities (local authorities, associations) as well as the modes of financing. The childcare centres are supervised by the Youth and Family state department (Ministry of Youth, Family Allowance Fund, Maternal and Child Health). In France, there is a steady increase of expenditure in benefits delivered in kind rather than in cash. The table below presents the social protection expenditure of selected countries.

### Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro.

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3.605.678,95</td>
<td>/</td>
</tr>
<tr>
<td>France</td>
<td>379.396,42</td>
<td>654.238,65</td>
<td>84,47%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>262.859,71</td>
<td>478.281,18</td>
<td>124,56%</td>
</tr>
<tr>
<td>Norway</td>
<td>32.512,53</td>
<td>80.833,67</td>
<td>152,74%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

### 4. Challenges and Drivers of Innovation

**Structural weaknesses** of the system:

- Single parent families are increasing in number and are the most affected by the crisis in terms of insecurity and low income;
- The schedule of childcare facilities are not compatible with long working hours and atypical working patterns;
- The inclusion of artists is more and more difficult and is a source of insecurity for them.

**Drivers and Challenges**

The initial mission of Mom’artre is to meet the social and cultural needs that single parents cannot afford to their children. The development of this mission over time has allowed the organization to expand the range of provided services to children.

**Innovation**: Ideas, criteria, levels and added values

The innovation of the network is to provide an active response to a social need either not provided or badly met. The overall approach is based on five priorities:
Initiation to art
The core mission of Mom’artre is based on its art and educational objective. This objective is to encourage the child to lead a project in its entirety, from conception to completion. At the end, the child’s work is shown and shared with family, friends and the neighbourhood.

School and learning support
The actions and activities provide effective answers to the lack of affordable and appropriate after-school care, especially for low-income and/or single parent families living in the city. The scholastic and social integration of children is also closely related to poor after-school frameworks, and to the lack of cultural exposure for children of families in difficulty.

Support for parents in difficulty
In its search for social and cultural diversity, Môm’artre makes of each centre a venue open to all. It aims at families who do not have childcare solutions tailored to their schedules, their budgets and their needs – mainly single parents with late working time or long transport time, families on low income or in need to return to employment. And more broadly, families participate who are anxious to bring home secure and cultural openness to their children. It is essential that parents understand and adhere to the project so that children thrive in the project. The presence of Mom’artre in the area allows its beneficiaries (children and parents) to meet artists, to discover their work and to open their mind to different worlds. It is also a means to socialize with other children and adults.

Assistance in social integration of artist
The Mom’artre network provides workshop support tools and trainings for the artists who are involved in the childcare centres.

Making the neighbourhood more attractive
Mom’artre is not just a professional solution for babysitting. In addition to their artistic dimension, the purpose of each centre is to provide, where it is located, a meeting place for the whole family and the neighbourhood. This is an opportunity for parents to share a moment with their child, to meet the artists and the adult supervisors. It is also a chance to get acquainted with other children and other families in the neighbourhood. Each centre is open in the evenings and on weekends to the district inhabitants. They can attend courses (visual arts, performing arts, gym) and practice a hobby.

Agents of Change
At the beginning, Mom’artre project was created by a single mother who was looking for extracurricular services for her children. This mother has been able to combine her own need with her particular skills in marketing and with her passion for arts. Then other people and volunteers have joined this project to allow its development.
5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>Mom’artre 2007, Mom’Pelleport 2011</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Civil society network</td>
</tr>
<tr>
<td>Financing</td>
<td>Hybridization of various resources such as monetary resources (sale of services and public funding) and non-monetary contributions (donations, sponsorships, volunteering, free provision of staff « gratis personnel ») Mix of public subsidies (state, region and department) and donations from foundations and private funders.</td>
</tr>
<tr>
<td>Size of the organization</td>
<td>Mom’artre network supports and rallies 7 centres, 30 employees (27 job equivalent full time), 12 young people doing a civic service in the association, and 85 volunteers.</td>
</tr>
<tr>
<td>Members and participation</td>
<td>Heterogeneous team of employees, permanent, volunteers, apprenticeship students, and artists. Beneficiaries are amounted to 600 families and 680 children.</td>
</tr>
<tr>
<td>Contact</td>
<td><a href="mailto:hanchclaire@momartre.com">hanchclaire@momartre.com</a></td>
</tr>
<tr>
<td>Name of the innovative example</td>
<td>Mom’artre</td>
</tr>
<tr>
<td>Homepage</td>
<td><a href="http://www.momartre.com/">http://www.momartre.com/</a></td>
</tr>
</tbody>
</table>

Mom’artre network was created in 2007. Since its origins, the by-laws of Mom’artre are compliant with the French law of 1901. The Mom’artre network supports and rallies 7 centres. Mom’Pelleport was created in 2011 in the 20th district of Paris. The network was created at the initiative of a woman who raised her children alone in Paris. To address the issues related to her loneliness, she decided to create her own childcare centre on extracurricular time for the children of single parent families with staggered schedules. A marketing study with 110 families has been conducted in Paris by this single mother. This study was a means to be sure that her project was addressing a real social need. Then the results of this study have been used to convince the municipality to provide a free place to welcome the children. The first activities were handled by volunteers. Then, the municipality gave subsidies to finance part of the cost of services. The specificity of this project was to be related to artistic and cultural contents for promoting the development of the child.

Over the time, the original project has been enriched with other inputs. Mom’artre has developed its ability to support the inclusion of the artists and to work with the neighbourhood. A training session has been proposed to the artist to help them to get the skills they miss. Thanks to openings, performances and exhibitions, Mom’artre has been able to promote various forms of conviviality at the district level between the inhabitants, the children, the parents, and the artists.

According to the Mom’artre business model, the beneficiaries pay a bill related to their income. The financial resources of Mom’artre are a mix of public subsidies (state, region and department) and donations from foundations and private funders. This hybridization of resources is complemented by the non-monetary contribution of volunteers in the activities and in the board of directors. The average annual budget of a centre is 190 000 €. This model is based on a heterogeneous team of employees, permanent, volunteers, apprenticeship students, and artists. In this way, they provide a modern,
solidarity-based social service. Each stakeholder has a defined role and responsibilities clearly identified.

The opening of a centre is a long-term process that can last more than one year. Thus, it is very costly in terms of planning, blueprint, and feasibility study. It requires an important intangible investment. That is why the network is helping and supporting the local managers. Before the opening of their centre, the local managers are accountable for the financial viability of it. They are expecting to make a market analysis, to negotiate local partnerships, to find facilities, to hire a team of at least 4 people. It is only when all conditions are met, that the project developer may proceed with the opening of a new centre.

The success of such an initiative is leaning on a strong local network in conjunction with other associations, schools and public institutions. Thanks to short or long period partnerships, the workshops can be enriched. The support of the network is also important because it provides the pooling of several services (accounting tools, communication kit, legal kit, Human resources kit), and it creates a common ground for managers and staff, as well as exchanges among artists involved in different centres.

Each childcare centre that belongs to the Mom’artre network, offers the same extracurricular program. At 4:30 pm each day of the week, the Mom’artre team meet the children at the school entrance of the neighbouring schools. When the children reach the centre, a snack is waiting for them. Children do their homework with the help of volunteers. Then, they join the art workshop they have chosen (2 or 3 different workshop are mostly available). The workshop is supervised by an artist and last about 1:30 until the arrival of parents (between 6:30 pm and 8:00 pm). The workshop is usually conducted over a period of six to eight weeks. The artwork is presented eventually to the parents and the district residents at openings. Arts courses are taught every first week of school holidays and on Wednesdays. Each centre welcomes from 8:30 am to 7:00 pm the children living in the district (regardless of their school) for a day (or half a day) and provides 3 to 5 different workshops.

As of 1 January 2013 Mom’artre has 7 childcare centres, 30 employees (27 job equivalent full time), 12 young people doing a civic service in the association, and 85 volunteers. The beneficiaries are amounted to 600 families and 680 children during the school year 2012/2013. The growth of the network is impressive: by 2016, 20 centres are planned, half of them in urban areas that are classified as “sensitive” and show high levels of social exclusion; 10 centres will be outside Paris and 10 in Paris and its suburbs. Each centre has the same logo but adapts its offer to the local needs based on a market investigation. This survey covers the demands of the residents and the request of local authorities. Thus, this model is potentially transferable.
6. References


Eurostat (Statistisches Bundesamt) Hrsg. 2012: Tables by functions, aggregated benefits and grouped schemes - million EUR. Available at : 


Theoretically informed case study accompanying the film

nueva – Austria

Author:
University of Heidelberg
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Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/nueva

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a European-wide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. nueva - Evaluation of services in Austria
	nueva addresses people with learning difficulties and mental disabilities, who live in residential facilities or work in work integration organizations. Target groups are being expanded to include elderly people, youth and similar areas of support services. The organization has developed a method that allows for involving and empowering these target groups in letting them effectively articulate their needs and assess the services they use. The assessments are performed in a discursive way based on interviews, which are being conducted by specially trained evaluators. Another particularity in this regard is that the evaluators are peers of the target groups, who themselves have a disability. The service also represents an effective work integration effort for the evaluators.

Specific innovative elements of nueva

*Evaluation and quality development from a user perspective:*

Users receive a say in evaluating the services that are offered to them. Thereby they contribute to service improvement.

*Peer-principle:*

The evaluators are themselves people with a disability. This circumstance increases mutual trust, gives them a feel for the situation and avoids hierarchical situations in which users might feel to be patronized.

*Benchmarking and quality development:*

By establishing evaluation as a core variable in service fields, the initiative contributes to encouraging quality development.

*Replicability in other fields:*

The aspects of evaluation, the emphasis on the user as well as the peer principle can be transferred to a large set of new fields, which further increases the initiative’s value for the field of diverse social services.

Key characteristics of the service

*Organisation:*

*nueva* is a private for-profit organization (based in Graz, Austria). The service is currently being expanded to other European countries. A pilot project has been realized in Berlin, Germany. Up to now (September 2012) the organization has performed more than 2,600 evaluations.

*User groups:*

Evaluation services (Evaluation von Dienstleistungen) are offered in the area of housing for people with mental handicaps, job coaching and work integration as well as housing for the elderly. nueva has subsequently extended its expertise along these areas and aims at including new user groups (e.g. in youth services).

*Principle:*

The particularity of the evaluation is that it happens from the perspective of the target groups. At the same time evaluators themselves have a disability and are therefore better capable of receiving truthful feedback.

*Driver(s):*

The project has been initiated on the background of two aspects: (a) a low degree of effective evaluations of services for people with disabilities, (b) the missing inclusion of user groups in such evaluations. By involving users, these can express their needs and organisations can respond to them in a more targeted way, which is promoted by the agenda of “inclusion”. 
Factors influencing Social Services Innovation

**Agents of change**
- Civic initiative (registered society) “atempo” – For the equal treatment of all people

**Drivers**
- Continued inequalities
  - Quality as an aspect of participation
  - Application of the principle of inclusion in practice
- Social roles
  - Need for individualized support (background: current political agenda)
  - Target group as enablers of solutions
  - Use of user particular abilities
- Independent living (and UN convention)
  - User input is seen as increasingly important

**Challenges**
- Responding to societal and socio-political development in service provision
  - Organizational changes:
    - Orientation towards quality
    - Evaluation and continuous improvement
- Novelty
  - New practice for old needs
  - New perspectives on old needs

**nueva: response**
- Evaluation from user perspective (new service)
- Close collaboration of organization providing the standard guidelines for the evaluation and the people (peers) execute the evaluation (new form of delivery)
- Avoiding hierarchical situations; disability as a talent (new form of resourcing)
- Increasing quality orientation in general (across fields) and establishing benchmarks (new way of monitoring)

**Positive outcomes**
- Improvement of services
- Empowerment of users
- Work integration as side effect (peer counsellors)
- Transferability of the principle to other fields

**Sustainability**
- Transfer to other service fields possible and tested
2. Policy Framework related to care for people with disabilities in Germany

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-determination: People with disabilities are to be granted care that is appropriate to their individual needs. They have a right to personal assistance for a self-determined lifestyle independent of their income situation (cf. Social Security Code IX, §1)</td>
<td>Different funding agencies (public and quasi-public) on federal, state or municipal level</td>
<td>Legal milestones:</td>
<td>1. Public expenditure(^1) for the whole area of child and youth welfare in 2010 (cf. BAR 2010):</td>
</tr>
<tr>
<td>2. Participation: Legal entitlement to participation in community life is given equal importance as participation in work and medical rehabilitation</td>
<td>Responsibilities for the rehabilitation of disabled people:</td>
<td>- Establishment of Security Code IX in 2001</td>
<td>- about 28.8bn €</td>
</tr>
<tr>
<td>3. &quot;Outpatient rather than in-patient&quot; care: Aims at enabling people to stay in the customary surroundings as far as possible (cf. BMFSFJ 2006)</td>
<td>- Statutory health insurance and accident insurance</td>
<td>- Individual entitlement to participation benefits (personal budgets) for every person with a disability in need</td>
<td></td>
</tr>
<tr>
<td>4. Quality assurance: Service providers have to build up a quality management system that ensures and constantly improves the quality of their services (cf. Social Security Code IX, §20)</td>
<td>- Old age insurance</td>
<td>- Ratification of the UN Convention on the Rights of Persons with Disabilities in 2009</td>
<td></td>
</tr>
<tr>
<td>5. Discrepancies and doublings in the care system and its financing: Division of the social law into four independent areas:</td>
<td>- German Federal Labor Market Authority</td>
<td>Service characteristics</td>
<td>2. Financing of participation benefits depends on the legal basis the particular accountability arises from</td>
</tr>
<tr>
<td>1. Social insurance</td>
<td>- Social welfare aid</td>
<td>In dependence of the individual needs, the following participation benefits are delivered:</td>
<td>- either municipal financing (Social Security Code VIII and XII)</td>
</tr>
<tr>
<td>2. Social compensation</td>
<td>- Providers of public youth welfare</td>
<td>Participation in community-life:</td>
<td>- or financing by the social security agencies (Social Security Code III, V, VII, XI)</td>
</tr>
<tr>
<td>3. Social promotion</td>
<td>2. Diverse service providers on regional and municipal level</td>
<td>- support to take part in community life (e.g. personal assistance, hearing/communication aids; prostheses)</td>
<td></td>
</tr>
<tr>
<td>Problem: Complex and overarching provisioning results in diverse claims towards different funding agencies</td>
<td></td>
<td>- assistance in finding appropriate housing</td>
<td></td>
</tr>
</tbody>
</table>

---

\(^1\) The indicated amount represents the overall sum of social service providers’ individual expenditures on rehabilitation and participation of people with disabilities (for a clustered overview cf. BAR 2010).
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th>Measure</th>
<th>Germany</th>
<th>EU27²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled persons (2009)</td>
<td>7.101.682</td>
<td>80.000.000</td>
</tr>
<tr>
<td>Proportion of population with handicaps (2009)</td>
<td>8.7%</td>
<td>16%</td>
</tr>
<tr>
<td>Expenditure on social protection (total) (2010)</td>
<td>765.717,82 Mio. €</td>
<td>3.605.678,95</td>
</tr>
<tr>
<td>Expenditure on social protection (% of GDP) (2009)</td>
<td>31.1%</td>
<td>29.51%</td>
</tr>
<tr>
<td>Expenditure on rehabilitation and participation of handicapped persons (2010)</td>
<td>28.850.000.000</td>
<td>n/a</td>
</tr>
<tr>
<td>Expenditure on rehabilitation and participation of handicapped persons (% of GDP) (2010)</td>
<td>1.2%</td>
<td>n/a</td>
</tr>
<tr>
<td>Anteilige Bruttoausgaben der gesamten Sozialhilfeausgaben:</td>
<td>1963: 5%</td>
<td>2009: 58%</td>
</tr>
</tbody>
</table>

Source: StBA 2010/2012; BAR 2010; EC 2010

3.2 Information about the specific Welfare State: Germany⁶

The rehabilitation sector in Germany has been reformed in 1974 and 1975. Since then the implementation and the coordination of the complex system that has been built up became more and more difficult. The main reason for this is that rehabilitation was placed in a system characterized by intersections of a variety of institutional arrangement with different legal roots. In 2001 a new legal basis of the care for people with disabilities (the SGB IX) has been established. Within the German social insurance system the SGB IX has an intermediate and linking function between the general social law, the special laws of the social security system and the cooperation of the different welfare associations. The SGB IX can be seen as a new effort of a general rehabilitation law (cf. Welti 2002). Although there are still some open questions (e.g. with regard to the relation between rehabilitation and sickness treatment, long term care, aspects of prevention and especially issues of disability and age) the amendment brought a paradigm shift to the field of disability. Crucial are the new definitions and understandings of participation (“Teilhabe”) and disability (“Behindernung”), which were connected directly to the constitutional law and to actual standards from the health sciences:

- According to the legal definition of SGB IX people are disabled if their “physical functioning, mental capacity or mental health differ longer than six months from the typical condition of the respective age, and therefore their

² The variety of national statistical categories makes it hard to clearly identify budgets dedicated to the field on the EU level. That is why most of data is indicated as n/a.
³ The significant difference between the values of Germany and the EU is due to the narrow definition of disability used for the German statistics (see footnote below).
⁴ People with a degree of disability of at least 50% are treated as severely disabled; only these are included in the figure (definition valid for Germany).
⁵ Valuation by the European Commission (cf. EC 2010)
⁶ For references and a more fine-grained illustration of the Welfare sector in Germany compare to literature review of INNOSERV WP1 and separate “Reader on the field of Welfare in Germany”.
participation in social life is impaired. They are threatened by disability if the impairment is to be expected” (Social Security Code IX § 2 par. 1). So the understanding of disability it is no longer merely oriented on labour-market directed criteria. Rather, the SGB IX explicitly refers back to a holistic understanding of disability.

- With regard to participation welfare-state efforts now focus on the integration of people with disabilities in community life and not merely on aspects of medical rehabilitation and labour market integration. The emphasis on self-help and self-organization in the selection and design of support – not least through the introduction of personal budgets – illustrates the increasing importance of self-determination of people with disabilities and consequently the emancipation as experts.

These developments – from a reductionist, deficit-oriented and pathogenic to a holistic, resource-oriented, salutogenic perspective on disability – became stronger on the national and international level and led to a shift away from the concept of ‘integration’ to a turn towards the concept of ‘inclusion’. This is linked to an understanding of disability as an element of human / social norm that is not only accepted, but welcomed as a source of cultural enrichment in terms of diversity.

The aspect of inclusion is furthermore an integral part of the UN Convention on the Rights of Persons with Disabilities which was passed in 2006 and formally confirmed by the EU in 2010. The particular innovation potential of the Disability Convention results from its specific accentuation: Empowerment to overcome the deficit-oriented approach, social inclusion as well as humanization of society as a whole (Bielefeldt 2009) form target categories and are starting points for action plans of the government and private organizations. Moreover, the German Convention derives its innovative power from the explicitly required participation of civil society (BMAS 2011d).

Studies of actual practice do however illustrate that still 60% of services for people with disabilities are delivered in stationary setups and that 90% of rehabilitation expenses are spent in this context.

There is a steady increase of in-kind benefits as percentage of total social protection benefits (including social services), which underlines the significance of such services against simple cash benefits. The table below illustrates social protection expenditures of Germany in comparison with the EU 27.

| Social protection expenditures: Aggregated benefits and grouped schemes in Mio. of Euro |
|---------------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Time | Total expenditures for social protection (in Mio. Euro) | Increase in in-kind benefits | Proportion of in-kind benefits (of total social protection benefits) | | |
| EU 27 | / | 3.605.678,95 | / | / | 34,07% |
| Germany | 565.683,07 | 765.717,82 | 52,53% | 30,79% | 34,69% |
| Italy | 241.249,28 | 463.992,0 | 127,52% | 21,86% | 25,86% |
| Belgium | 60592,78 | 106492,16 | 110,88% | 24,18% | 29,01% |

Source: Own calculations based on EUROSTAT 2012
4. Challenges and Drivers of Innovation

Drivers and Challenges
On the given background the main challenges referring to societal and sociopolitical developments which nueva has to deal with and its responses to it can be summarized under the following topics.

- **Independent Living** has become a key variable of life with a disability, the more so as it harmonizes with the UN convention on the rights of persons with disabilities. Both therefore represent new influences on services in the field. User input can consequently increase the convenience and quality of services offered in this area (and also in others).
- This is linked to the issue of continued inequalities with a particular stress on effective responds to the needs and demands of users. Only broad and inclusive initiatives in this area can serve as driver for increase the suitability of services to individual needs across a variety of fields (however, this does not solve the critical issue of access to services).
- The promotion of independent living is connected to the challenge of realizing the ambition that disability becomes an integral part of society and everyday life. This includes a shift from interpreting disability as a deficiency to respecting the individual life situation and treating it as a talent (both as users and as employees).
- From an organizational perspective it becomes ever more important to ensure and develop quality and find valid as well as effective ways to capture, monitor and manage it. Evaluations and an orientation towards continuous improvement consequently can represent vital pillars of professional social services.

Innovation: Ideas, criteria, levels and added values

The need for individualized support in the area of disability is going to increase significantly on the background of the current political agenda and resulting legal frameworks. This shift is connected to similar trends in related service fields that aim at providing personalized and individually crafted support services.

The diversity of service providers simultaneously makes it hard to assess such services with a legally imposed standard model. Tools will rather have to be shaped according to the needs of the target groups and eventually also according to the ones of the applying organization. It is important for the sustainability of such initiatives that a mutual benefit arises, which grants commitment on the organizational and the user side.

Finally, it is to be considered that the agenda of “inclusion” should be reflected in work integration efforts for people with disabilities. These are often neglecting the particular talents individual persons have. It is not unusual to find repeated standard models of work integration, instead of new service arrangements, where people with disabilities are regarded as experts and can achieve things that others cannot.
There are four particularly innovative aspects about the service:

**Evaluation and quality development from a user perspective:**
Nueva has succeeded in developing evaluation tools that enable clients to rate interventions effectively. Combined with the assessment and knowhow of nueva as the responsible analyst, organizations in the listed fields are able to enhance the quality of their services significantly. Indeed, there are standard methods that nueva developed, but it always includes the recipient perspective in a way that makes every performed assessment unique and context specific.

**Peer-principle:**
Evaluations are not being performed along simple rating schemes, but on the basis of peer-to-peer interviews. The organization has furthermore realized a strategy that allows for including and illustrating the perspective even of people that have difficulties in communicating their opinion (due to their age or physical or mental impairments). The quality evaluation is thus highly inclusive and empowers users and clients in unprecedented degrees.

**Benchmarking and quality development:**
The organization offers a service that complements potentially existing internal quality management systems. Overall it increases both, a general quality orientation in the social sector and a user oriented evaluation for tailored service improvement. Abstracting from the organizational perspective nueva supports the establishment of general benchmarks in the social sector. Organizations become aware of and can develop their quality profiles.

**Reliability in other fields:**
As the subsequent development of spheres of application has shown, there is the possibility of extending the method’s application across fields. User involvement and the peer principle can be highly beneficial, also in other contexts. The most intuitive case is the one of care for the elderly, but also seemingly unrelated fields like youth services etc. might profit from the introduction of such principles.

**Agents of Change**
The missing involvement of people with disabilities and other target groups has been recognized and addressed by “atempo”, a registered society and thus a civic initiative that works towards the equal treatment of all people. Based on this current challenge nueva has been founded as a commercial evaluation provider to improve the situation.
5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>2004 by atempo e.V.</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Private for-profit organization; limited liability company (GmbH)</td>
</tr>
<tr>
<td>Financing</td>
<td>Service providers pay for the evaluation service offered by nueva</td>
</tr>
<tr>
<td>Size of organization</td>
<td>To date 2 branches in Austria (Steiermark and Oberoesterreich), 1 in Berlin</td>
</tr>
<tr>
<td>Members and participation</td>
<td>More than 5000 performed interviews</td>
</tr>
<tr>
<td>Name of the innovative example</td>
<td>nueva Betriebsgesellschaft mbH</td>
</tr>
<tr>
<td>Contact</td>
<td>Heinrichstraße 145</td>
</tr>
<tr>
<td>Homepage</td>
<td>8010 Graz</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.nueva-network.eu/">http://www.nueva-network.eu/</a></td>
</tr>
</tbody>
</table>

nueva has been established in Graz, Austria by the registered society “atempo” – for the equal treatment of all people. It has now been transferred to other regions in Austria as well as Berlin as its first German target area. This underlines that the viability of the services is not bound to specific regional or national institutional structures and legislation but can be applied across borders, which is of high relevance for Europe. Transfers to other European countries have already been tested. The scaling and spreading of the intervention works in collaboration with network partners and thereby follows a social franchising logic where training contents for evaluators, tools and models are shared over a period of two years before the evaluations can be performed by the partner organizations.

nueva is not the same as simple satisfaction surveys, since the questionnaire contains concretely formulated criteria that are the result of a discursive and iterative process in which service providers, evaluators and users are involved and have an equal say. The criteria are constantly developed further in so called “quality circles”. If users cannot be interviewed directly, observation instruments are used. These are being developed in a similar manner. The evaluations are executed by specially trained staff, who are peers of the target group and affected by similar life situations.

A key variable in the interviews as the key part of the evaluation process is a feeling of mutual trust and a comfortable atmosphere that is created through the felt “close

ness” of evaluators and users. Usually no other persons are involved, be it other staff from nueva or someone from the service provider, so as not to disrupt this situation or evoke perceived hierarchies.

This is how the evaluation process is usually structured:

5. Collective discussion of quality criteria in quality circle
6. Setting of target profiles (which quality profile fits the organization?)
   - For instance: In the category “self-determination” the organization might choose that it wants to offer a lot of support or rather leave a lot of free space for users. This depends on organizational targets as well as the preferences of users.
7. Discussion of organizational particularities before the evaluation (e. g. accessibility, inclusion of people with visual or auditive impairment)
8. Evaluators and users get to know each other
9. Individual one-to-one interviews with users (sometimes linked to observations performed by evaluators)
10. Data analysis
11. Presentation and discussion of results; setting of targets for improvement (adaptation and further development to meet the target profile, which was set in the initial stage and to close gaps; if necessary and desired the offered (target) quality profile can undergo changes).
12. Publication of selected results on the website for users

In the evaluation questionnaires and quality profiles, nueva uses pictograms to simplify the reception of the categories that are to be assessed by the users in the conversation. By establishing a data base of quality profiles the organization enables (future) users to select service according to their individual preferences and needs. Thereby it does not only contribute to improving the status quo, but also enhances future planning and individual user choice.

6. References


INNOSERV - WP 7 Theoretically informed case study accompanying the visualization


Statistisches Bundesamt (StBA) (2010): Behinderte. Schwerbehinderte Menschen am Jahresende. Available at: https://www.destatis.de/DE/ZahlenFakten/GesellschaftStaat/Gesundheit/Behinderte/Tabellen/GeschlechtBehinderung.html (Date of Access: 08.01.13)

Theoretically informed case study accompanying the film

Place de Bleu – Denmark

Author:
University of Roskilde
Hanne Marlene Dahl, Kristian Fahnøe

WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/place-de-bleu

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a European discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Place de Bleu - Social enterprise employing marginalised ethnic minority women

Specific innovative elements of Place de Bleu
The target group is social marginalised ethnic minority women.

The main innovative element is to run a social enterprise that integrates marginalised ethnic minority women into the labour market by providing a flexible workplace with in-service-training. As a social enterprise Place de Bleu is based on the commercialization of the products produced by the employed women. But at the same time the workplace serves as a way to train the women and offering them a personalized and flexible support beyond the mere training.

Social enterprise training and employing marginalized ethnic minority women
Place de Bleu is a social enterprise sewing room that trains and employs marginalized ethnic minority women. Place de Bleu is innovative as a result of the combination of training and employing marginalized ethnic minority women on terms that allows the women to be a part of the regular labour market.
Aim: to integrate women who are not otherwise integrated into the labour market and society as a whole.

In service training
The women start in the sewing room in job training or as trainees. They are trained in hand craft skills and language skills and taught about Danish society. Over time, the women are offered a regular job. Place de Bleu has developed a new model which allows the women to progress in accordance with their skills and needs.
Aim: to qualify the women for a regular job at Place de Bleu or elsewhere.

Key characteristics of the service
Organisation
Place de Bleu is run by the association Qaravane whose aim is to promote employment among marginalized ethnic minority women. Place de Bleu is the French translation of the name of the Square in Copenhagen where the workplace is located.

Target group
The target group is ethnic minority women who have few Danish language skills, have no or little experience from the Danish labour market. Further, many of the women suffer from health problems as well.

Principle
The core principle is Place de Bleu’s induction programme which is an individualized programme that takes the single woman’s competences as point of departure and works towards upgrading her skills in a safe and supportive environment.

Driver(s)
The immediate trigger was the introduction of a new legislation that put many in the target group at risk of losing their social security benefits. Further, the development of the social economy approach as a way to address social need made it possible to establish a workplace like Place de Bleu where profit and non-profit elements are combined.
Factors influencing Social Services Innovation

Drivers
- Employment policies
  - Job training, wage subsidies, employment on flexible terms
- New business organisation: Social enterprise
- New forms of service for old needs
  - Combining education, training, and employment
  - Individualised training (language skills as well as professional skills)
  - Flexible workplace
  - Qualifying women for jobs in the open labour market
- Labour market exclusion
  - Limited prospects of finding a job for target group (old needs)

Agents of change
- New form of organisation: NGOs
- Management style between social and business

Place de bleu: response
- New forms of service: combining training and employment
- New forms of delivery: service to labour market by upskilling ability of user
- Blurring approach: boundary blurred

Quality
- New forms of delivery: Service to the labour market offering higher skilled workers with better language skills

Sustainability
- Blurring approach:
  - Education, Welfare, Employment improvement of the target group minority ethnic woman and
  - Long-term integration of target group into Danish labour market

INNOSERV - WP 7 Theoretically informed case study accompanying the visualisation
2. Policy framework related to the labour market in Denmark

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
</table>
| **1. Flexicurity** which includes flexibility for employer in relation to hire and lay off staff, security for employees due to high unemployment benefits and active employment policies. | **The National Labour Market Authority** under the Ministry of Employment is responsible for supporting and monitoring the municipalities’ service and for the specific efforts targeting unemployed migrants and their descendants.  
**The municipalities**: are responsible for the services in relation to the employment policies  
**Private partners** under contract with the municipality provide the actual services. | Legal milestones:  
- Law on active employment policy  
- Law on active social policy  
**Service area characteristics**  
The active employment that aim to re-introduce unemployed people in to the labour market and to foster a qualified work force: This covers services both to those with unemployment insurance and those without.  
The services provided include job training, activation, positions as trainee, wage subsidies and employment on flexible terms. | 1. **Costs of the employment policies**.  
The public expenditures on employment policies amounted to 1.2 % of the GDP in 2009 (Eurostat 20012). |

| 2. **Activation policies** as part of the active employment policies entail that unemployed are required to participate in activation programs and job training. |  
**Private partners** under contract with the municipality provide the actual services. |  
**Service area characteristics**  
The active employment that aim to re-introduce unemployed people in to the labour market and to foster a qualified work force: This covers services both to those with unemployment insurance and those without.  
The services provided include job training, activation, positions as trainee, wage subsidies and employment on flexible terms. | 2. **Financing services at Place de Bleu**  
Place de Bleu is financed by its sales income, private donations, public funding and income from their services to the municipal employment agency. |

---

1 In Eurostat the employment policies is termed labour market policies. This data covers “activation measures for the unemployed and other target groups including the categories of training, job rotation and job sharing, employment incentives, supported employment and rehabilitation, direct job creation, and start-up incentives” (Eurostat 2012).
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th></th>
<th>Denmark (2011)</th>
<th>EU 27 (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population projections 2010-2050</td>
<td>6,037,836</td>
<td>524,052,690</td>
</tr>
<tr>
<td>Percentage of migrants and descendants of total population (2012)</td>
<td>10.4 %</td>
<td>N/A</td>
</tr>
<tr>
<td>Projected percentage of migrants and descendants of total population (2050)</td>
<td>16.4 %</td>
<td>N/A</td>
</tr>
<tr>
<td>Employment rate of the total population</td>
<td>75.7 %</td>
<td>68.6 %</td>
</tr>
<tr>
<td>Employment rate among women</td>
<td>72.4 %</td>
<td>62.3 %</td>
</tr>
<tr>
<td>Employment rate among women migrants from non-western countries*</td>
<td>43.0 %</td>
<td>N/A</td>
</tr>
<tr>
<td>Employment rate among women descendants of migrants from non-western countries*</td>
<td>53.8 %</td>
<td>N/A</td>
</tr>
<tr>
<td>Expenditure on social protection (% of GDP) (2009)</td>
<td>33.44%</td>
<td>29.51%</td>
</tr>
</tbody>
</table>

* The statistical data regarding migrants and descendants of migrants from non-western countries is provided by Statistics Denmark and is not available at the European level.

3.2 Information about the specific welfare state: Denmark

As an element of the Danish flexicurity model Denmark leads active employment policies that aim to increase the employment rate and to re-introduce unemployed people in the labour market (Barbieri 2009). These active employment policies entail that Denmark spends a relatively high share of its GDP on public expenditure on employment policies. In 2009 it was 1.2 % of the GDP compared to 0.54 % in EU 27 (Eurostat 2012).

The social services including the services regulated by employment policies are financed through national and local taxes. The municipalities are responsible for providing the services to the labour market at the local level and provide the majority of services. The municipalities receive block grants from the national government as well as activity based funding through reimbursements.

There is a continuous increase of expenditure in benefits in kind (including social services) as compared to benefits in cash. This shows the growing importance of social services within the social protection system. The table below presents the social protection expenditure of selected countries.
Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro.

<table>
<thead>
<tr>
<th>Time</th>
<th>EU 27</th>
<th>Denmark</th>
<th>France</th>
<th>Netherlands</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>/</td>
<td>3.605,678,95</td>
<td>/</td>
<td>/</td>
</tr>
<tr>
<td>2010</td>
<td>78,367,78</td>
<td>/</td>
<td>102,60%</td>
<td>34,13%</td>
</tr>
<tr>
<td>1996-2010</td>
<td>84,47%</td>
<td>31,94%</td>
<td>34,17%</td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>94,052,49</td>
<td>188,731,00</td>
<td>186,74%</td>
<td>25,74%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

4. Challenges and Drivers of Innovation

Structural weaknesses of the system:

- The Danish flexicurity model has been acknowledged as a contributing factor to the low level of unemployment (Madsen 2004). However, critics argued that the model is less suitable for inclusion of people who have been outside the labour market for a longer period and those who are disadvantaged due to health and social problems as well as people with low education (Lindsay and Mailand 2009; Andersen & Etherington 2005). Among these are ethnic minorities who have little or no work experience (Andersen & Etherington 2005).
- The complex regulation of employment services makes it difficult for small businesses to navigate in relation to rules on different forms of employment and training. This poses specific challenges to social enterprises like Place de Bleu that employ unemployed persons.
- The lack of a legal framework for social enterprises makes it difficult to establish and run social enterprises due to the lack of transparency and clear guidelines.

Innovation: Ideas, criteria, levels and added values
Against these challenges, Place de Bleu provides an innovative service that can fill the structural gaps for its participants:

Social enterprise training and employing marginalized ethnic minority women
Place de Bleu is established as a sewing room social enterprise that employs and trains ethnic minority women. As a social enterprise, Place de Bleu is a hybrid organisation that embraces both profit and non-profit aspects (Innoserv 2012:59). This implies that Place de Bleu on one hand offers a flexible workplace that is capable of attending to the specific needs of each of the women. On the other hand, it is a business that operates on the market which means that the needlework is sold at various retailers.
In-service-training
The in-service-training revolves around the induction programme where the women start at Place de Bleu as trainees or in job training and where they are taught the professional skills and Danish language skills during the everyday practices. The in-service-training is individualized in order to meet each woman’s needs. Over time, the women are offered regular jobs at Place de Bleu while the training continues.

Agents of change
The legislation put many ethnic minority women at risk of losing their only income since they had very limited prospects of finding jobs. This inspired the three NGOs to try to establish jobs for the women by creating a flexible workplace.

5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare, education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>2010</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Hybrid organization that embraces both profit and non-profit aspects.</td>
</tr>
<tr>
<td>Financing</td>
<td>A two year project funded by the municipality of Copenhagen and the Ministry of Integration, mix of public funds, private funds, self-earnings, voluntariness and CSR</td>
</tr>
<tr>
<td>Size of the organization</td>
<td>Nine women employed as dressmaker</td>
</tr>
<tr>
<td></td>
<td>Four to six freelance dressmakers</td>
</tr>
<tr>
<td></td>
<td>One designer</td>
</tr>
<tr>
<td></td>
<td>One production manager and one manager</td>
</tr>
<tr>
<td></td>
<td>Three affiliated volunteers</td>
</tr>
<tr>
<td>Members and participation</td>
<td>3 NGOs (Indvandrer Kvindecentret, Integrationshuset Kringlebakken, and FAKTI), voluntariness, private business partners.</td>
</tr>
</tbody>
</table>

Research has shown that there is a lack of labour market integration among migrants from non-western countries and especially among female migrant (Deding & Jakobsen 2007). The association Qaravane that runs Place de Bleu works to promote the employment of ethnic minority women. The aim is to support women towards better integration into the Danish labour market and inclusion in the Danish society. This implies assisting the women and thus also their families. The association works towards this aim both by running the social enterprise Place de Bleu and through political means such as lobbying. The lobbying is done in order to raise awareness of the obstacles they meet in their everyday practice.

The establishing of Qaravane and Place de Bleu was initiated in 2010 by three NGOs (Indvandrer Kvindecentret, Integrationshuset Kringlebakken, and FAKTI) that run guidance and drop-in centers targeting ethnic minority women in Copenhagen. The direct trigger was the introduction of a new legislation that meant that a citizen had to work 300 hours per two years on regular terms in order to receive social security benefits (Bekendtgørelse af lov om aktiv socialpolitik, LBK nr 1460 af 12/12/2007[Law
on active social policy]). The legislation put many ethnic minority women at risk of losing their only income since they had very limited prospects of finding jobs. This inspired the three NGOs to try to establish jobs for the women by creating a flexible workplace. (This legislation law has since been repealed by the new government led by the Social Democratic Party).

Place de Bleu was established as a two year project funded by the municipality of Copenhagen and the Ministry of Integration (now the Ministry of Social Affairs and Integration). The funding from the Ministry made it possible to develop and test the business model of a social enterprise that employs marginalised ethnic minority women.

Place de Bleu is a social enterprise that produces interior design and accessories that are sold on the market like any other ordinary businesses. Presently, there are nine women employed as dressmakers, four to six freelance dressmakers, one designer, one production manager and one manager. On top of that there are three affiliated volunteers.

The women are referred to Place de Bleu by public and private employment agencies or they learn about Place de Bleu through their personal network such as friends and family. Place de Bleu selects the women based on the criteria that they have to be migrant women who has experienced difficulties with gain access to the Danish labour market and that they are motivated to be a part of Place de Bleu as a workplace and an in-service-training programme.

The commercialization makes Place de Bleu innovative and sets it aside from the number of activation project in Denmark where migrant women do needlework. Further, Place de Bleu has developed its own induction programme where the women go from job trainee to be employment with wage subsidies and in positions on flexible terms. And later they are employed on ordinary terms but with a needed flexibility in the everyday. This is a programme that is adjusted to each of the women’s individual situation e.g. their health or family situation.

In practice, Place de Bleu offers assistance to women faced with personal challenges or crises while at the same time provides services to the labour market by up-skilling the employees. This is made possible by organizing the workplace in a flexible manner that allows the women to work to their capabilities and giving them the possibilities of taking the time they need to do the work. And if needed, they may take time off. The assistance to the women also includes assisting them in their dealings with the authorities whether it is the hospital or employment agencies.

Besides providing employment for the women the evaluation of the initial project showed that both the day-to-day management and the participating women experienced an increased self-esteem among the women. The women reported that they had changed and that their work made them proud.

The primary challenge for a social enterprise like Place de Bleu is to embrace both profit and non-profit aspects. This means that Place de Bleu has to navigate between making profit and social value, and between market conditions and public subsidy. This is an on-going challenge and is apparent in relation to the quality assurance process that is need when operating on the market. The quality assurance makes it
necessary to place demands on the employed women in order to satisfy the customers, while on the other hand it has to be acknowledged that some of the employees have difficulties making ends meet in relation to their economy and family life and that they might not be as productive as other workers. In connection to this it is uncertain whether or not it is possible to run a social enterprise like Place de Bleu solely on market terms. At the moment Place de Bleu is not economically self-sufficient and is thus dependent on economic support. Financially, Place de Bleu relies on a mix of public funds, private funds, self-earnings, voluntariness and CSR. Besides the direct economic support Place de Bleu also depended on the employment policies which among other things make it possible to have trainees, wage subsidy work, and persons in work ability testing programmes.

In the case of Place de Bleu, the way to embrace both profit and non-profit aspects is to produce products that allow the price to be set at a level that makes it possible to making a profit while employing persons who might not have the same level of productivity as others. If this innovation is to be transferred to other national contexts it will be a challenge to find other products that warrants a price level that is sufficiently high.

6. References

Andersen, John & David Etherington (2005):”Flexicurity, workfare or inclusion? The Politics of Welfare and Activation in the UK and Denmark”, Working paper no. 8, Centre for Labour Market Research (CARMA), Aalborg University.


Bekendtgørelse af lov om aktiv socialpolitik, LBK nr 1460 af 12/12/2007[Law on active social policy].


INNOSERV - WP 7 Theoretically informed case study accompanying the visualisation


Theoretically informed case study accompanying the film

REAL PEARL BASIC ART-EDUCATIONAL FOUNDATION, HUNGARY

Author:
Budapest Institute for Policy Analysis
Dorottya Szikra, Zsófia Kőműves, Adrienn Kiss

WP Leader HAW Hamburg:
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:

Link to the video: http://inno-serv.eu/realpearl

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a europe-wide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Real Pearl: Basic Art Education Foundation
It provides art-education (including fine and applied art, dance, graphics, painting, ceramics) to foster the psycho-social development of children. The Foundation involves parents in various economic and community activities, including an on-line art shop where handicrafts, based on the works of children are sold.

Specific innovative elements of nueva
Child-centered art education for disadvantaged children, fostering cognitive skills and personality development.
Artistic activities with children are linked to social work, community building and income generating activities with parents (embroidery work sold through social webshop).
Tackling fuel-poverty through the production of bio-bricket.
Filling a gap left by the state in providing complex solutions in the most deprived and segregated rural settlements

Key characteristics of the service

Organisation:
The Real Pearl Foundation, funded in 2000, consists of a core staff with about 14 people, most of whom are art-pedagogues. They are supported by a number of volunteers and other promoters. The Foundation’s work is the effective usage of media.

User groups:
Users of the service include about 600 children and their parents.

Principle:
Stopping the reproduction of poverty will reduce it in the next generation. The difficult task is to break this vicious circle. There is a great need to help the locals in their basic needs but also to rebuild their positive attitude and motivation and to empower them. The cooperation between the local government and the local poor people, especially the Roma, seems to be very weak thus civil and informal initiatives like Real Pearl Foundation play a crucial role. Real Pearl apply an integrated and child-centered educative methodology to build up children’s self-esteem. Real Pearl devotes personal attention, regular positive feedback to the children and this way they can experience success in their work, and a chance to express their thoughts. The Real Pearl’s activity extended their work to the parents of children and gradually to the whole community in the most disadvantaged villages. Here they carry out complex social work and community development activities, which they build up and run together with the local Roma people.

Driver(s):
Long-term poverty in an economically deprived region with no traditional ways out
Public institutions not fulfilling their role in reducing poverty, tackling ethnic conflicts and preventing high rates of drop-out of poor and Roma children from schools
Personal skills and motivation of the leader and the staff of the foundation
Success reached through the special methodology of art-education in children’s performance and well-being
Promotion by a wider intellectual group and volunteers that foster new and innovative solutions
2. BASIC DATA ON HUNGARY

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population:</td>
<td>10,014,324</td>
<td>501,120,157</td>
</tr>
<tr>
<td>Proportion of population aged 0-5 years:</td>
<td>5.84%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Percentage of population at risk of poverty or social exclusion</td>
<td>29.9%</td>
<td>23.4%</td>
</tr>
<tr>
<td>Percentage of population under 6 years at risk of poverty or social exclusion</td>
<td>37.1%</td>
<td>25.2%</td>
</tr>
<tr>
<td>Expenditure on social protection (% of GDP)</td>
<td>23.1%</td>
<td>29.36%</td>
</tr>
</tbody>
</table>

3. SERVICE ORIENTATION. INFORMATION ABOUT THE HUNGARIAN WELFARE STATE

After the fall of the state socialist regime serious economic decline hit Hungary. The risk of permanent poverty increased especially for unskilled people, those living in disadvantaged areas, people living in small-size municipalities. The political elites expected that economic development and increase in national income would diminish the high rate of poverty. Therefore in the early 1990s they tried to hide the phenomenon with specific cash-transfers in forms of early-retirement, long parental leaves, etc. However the rate of population facing economic deprivation kept being relatively high and no real progress has been achieved. According the data of Central Statistical Office approximately one-fifth of the population at the age of 20-59 was long-term unemployed in 2010 and 3% of the population lived in poverty (Medgyesi and Scharle, 2012).

One of the main sources of reproduction of poverty is education. In absence of special tools for integration of disadvantaged children the schools fail to provide the necessary support for the disadvantaged children to catch up, to acquire equal opportunities when entering the labour market.

Although there are various active labour market policies adopted in order to enhance integration of disadvantaged people into the labour market, emphasis has been put on public works programmes recently. Training and consultation as well as social work have been gradually limited in activation policies. Public works programs, however, have not proved to be effective in raising employability of participants in the free labour market (Köllö and Scharle 2011). These programs do not correspond to the realities of the labour market, what decreases their efficacy (Medgyesi and Scharle, 2012).

Hungary maintains a relatively generous family policy system. Expenditure on family policy support has almost reached 3% of GDP in 2010 (Eurostat, 2012). However at current conditions it tends to benefit more the better-off families.

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1 2.34% was spent on cash benefits and 0.59% on services.
(especially through tax allowances), while it does not offer appropriate support for families at lower social status. Prior the financial crisis cash transfers had impact on reducing poverty (Gábos, 2008). Since 2008 cash benefits has been kept at the same amount, while its value has decreased (Ferge and Darvas, 2012). For a family in one of the most disadvantaged regions of Hungary it meant a considerable 10% decrease in monthly family income in nominal terms, and 17% decrease in its real value (Ferge and Darvas, 2012). The table below presents the social protection expenditure of selected countries

Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro.

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3,605,678.95</td>
<td>/</td>
</tr>
<tr>
<td>Hungary</td>
<td>/</td>
<td>2287.98</td>
<td>/</td>
</tr>
<tr>
<td>France</td>
<td>379,396.42</td>
<td>654,238.65</td>
<td>84.47%</td>
</tr>
<tr>
<td>Germany</td>
<td>565,683.07</td>
<td>65,717.82</td>
<td>52.53%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

Access to nurseries and family child-care centres for children under 3 years is highly limited, the share of children attending such services has been around 10% in 2010s (Central Statistical Office, Státat). Coverage of daycare services exceeds 20% in Budapest and in county seats, while on the other side of the spectrum, in small villages the rate of children accessing the services tends to be under 0.5% (Central Statistical Office – Státat). Regional differences are quite extensive in Hungary, reifying the existent territorial and social inequalities. In the least developed regions (Northern Hungary², Northern Great Plain³) the rates are the lowest ones. In terms of household income, children of better-off families are over-represented: Families of the two highest income groups use services of nurseries the most, while the families in lower income groups are under-represented (Tokaji, 2011). The demand for services by far exceeds the capacities of existing facilities and the development of the network is very slow, what is especially unfavourable for disadvantaged children who could benefit the most of early childhood education and care.

² In 2009 it was the 9th NUTS2 region with lowest regional GDP per capita in the EU (http://epp.eurostat.ec.europa.eu/cache/ITY_PUBLIC/1-13032012-AP/EN/1-13032012-AP-EN.PDF )
³ In 2009 13th NUTS2 region with the lowest regional GDP per capita in the EU
In contrast to nurseries, the network of kindergarten is relatively well-developed covering 85% of children of the age cohort (Transmonee). In Hungary the attendance of children is compulsory from the age of 5 (from 2014 age limit is decreased to 3 years). In 2009 the so called kindergarten allowance was introduced to encourage parents of disadvantaged children to attend kindergarten at an early age. Kézdi and Kertesi (2012) found that 2 in 3 children attend kindergarten at the age of 3, while in case of children of mothers with primary education it is only 1 in 3 children. They argue this is partially reasoned by lack of capacities in kindergarten, by limited parental intentions or other reasons on the demand side. Lack of capacity is especially characteristic for municipalities with high rate of unemployment and poverty, and where the Roma minority is represented in higher percentages (Kertesi and Kézdi, 2012).

20.3% of children and youth under the age of 17 lived under the poverty threshold in 2010 (Central Statistical Office, 2012). This rate duplicates in the least developed regions (Ferge and Darvas, 2012). According to the PISA data the impact of social background of families on the educational performance of the child is the strongest in Hungary among all countries examined, which highly underlines the need for early childhood education for disadvantaged children (Danis, 2011).

The Programme against Child Poverty was launched in 2005 and a detailed long-term strategy has been issued in order to deal with these challenges. The main purposes were to ensure healthy life conditions, to make children acquire the necessary skills enhancing their social integration, to reduce the considerable regional differences and ethnic inequalities. One of the main principles advocated was the role of early childhood education and care in reducing the social disadvantages. In 2009 the financing was shifted under EU financing. Recently the Programme against Child Poverty has been considerably disempowered.
4. INNOVATIVE IDEA OF SOCIAL SERVICE
4.1. Background information

It takes five long hours from Budapest by train to get to one of the 33 most disadvantaged micro-regions of the country near the Romanian border where the Real Pearl Foundation works. The centre of the Foundation is in Berettyóújfalu, the biggest town in the region, but it concentrates its efforts to Told, one of the most disadvantaged villages of the area.

355 people live there and vast majority (81.76%) of those aged 15-65 have no permanent earnings/income. More than 50% of the population is Roma. All the houses lack piped water in the village, thus people need to use the public wells in the streets. Electricity can be found only in a few houses, mainly as the result of the Real Pearl Foundation's social work and community development program. The buildings are not plastered, with uncared-for gardens, no fence. (The exception is the house of the local usurer, which has orange, freshly painted walls, high fences and flowery garden.) Streets are usually empty in Told - without passers-by, cars or buses. There is no main road which crosses the village, there is one way in and out, which makes it hard for the village to improve.4  
During the socialist era, the region had a flourishing agriculture, which provided

4 Such settlements are called ‘zsákfalu’ in Hungarian which means ‘dead-end village’
enough workplaces for the locals. After the collectivist agricultural cooperatives ceased to work, unemployment raised massively, and the life standard of the village deteriorated rapidly. For a couple of years smuggling cigarettes from Romania provided some source of living, but after the regulations and the control became more severe, they had to stop this activity too. Nowadays **less than 10 people have a fixed job place** in the local kindergarten, all others live from seasonal work mostly in agriculture (during the summertime only). Although alcoholism is a severe problem in Hungary, here the local pub closed years ago, people do not have money even for the cheapest kind of spirits. There used to be **only one shop in Told**, with enjoying complete monopoly, therefore the prices were twice as high as in the next town. In October 2012 this shop shut down as well. There are three buses a day to and back to the nearby Berettyóújfalu, but locals sometimes do not even have the money for that trip.

Because of the deep, hopeless and unalterable poverty, **ethnic and social conflicts**, thefts, and frequently violent arguments became usual in the ethnically varied community. [There live Olah, Hungarian and Romanian gypsies, and (non-Roma) Hungarian often as opposing groups next to each other]. As it is almost impossible to get a permanent job, the vast majority of the adult population completely lost its motivation and incentive to work. They are dependent on social assistance for their livelihood. Most of them are unskilled, and the illiteracy is high.

**Children** going to school from this **extremely poor, starving** and depressed environment face difficulties at school. The probability of becoming a drop-out has been extremely high for them. They are lagging behind the others already in the first school year, because they do not have the skills to be able to fulfill the basic requirements, and because the primary school system is not working well to compensate for social and economic disadvantages (OECD 2010; Kertesi and Kézdi 2010) and to prevent drop-out (Liskó 2003). Families in Told are not well prepared in terms relevant school equipment nor in form of parental support in learning and practicing. Many of the children do not finish elementary school and thus which **reproduces poverty** to the next generation. The difficult task is to break this vicious circle. There is a great need to help the locals in their basic needs but also to rebuild their positive attitude and motivation and to **empower** them. The cooperation between the local government and the local poor people, especially the Roma, seems to be very weak thus civil and informal initiatives like Real Pearl Foundation play a crucial role.
Agents of change
The director of the foundation; art teachers; volunteers; service users.

4.2 Activities

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of establishment</td>
<td>2000</td>
</tr>
<tr>
<td>Form of organization</td>
<td>Non-governmental, civil organization</td>
</tr>
<tr>
<td>Financing</td>
<td>State contribution, private donations, 1% of personal income tax</td>
</tr>
<tr>
<td>Size of the organization</td>
<td>App. 14 core staff; app. 10 volunteers; app. 4 local members of the community</td>
</tr>
<tr>
<td>Members and participation</td>
<td>Core staff includes art-teachers, social worker. Environmental activists provide assistant to the bio-bricket project. Users of the service include about 600 children and their parents.</td>
</tr>
<tr>
<td>Contact</td>
<td>Siehe unten im Lit verzeichnis</td>
</tr>
</tbody>
</table>

The **Real Pearl Foundation** founded in 2000, provides art-education (including fine and applied art, dance, graphics, painting, ceramics) to foster the psycho-social development of children. The Foundation involves parents in various economic and community activities, including an on-line art shop where handicrafts, based on the works of children are sold. The students who regularly attend art-classes include
approximately **600 disadvantaged, underprivileged Roma and non-Roma children from 12 settlements** surrounding Berettyóújfalu (including Told). Art school classes are organized after the normal primary school hours. The art school has a good relationship with the primary school of the nearby town, Berettyóújfalu, where many of the children from the surrounding villages study. The “link” between the primary school and the art school is the founder and head of the foundation, Nóra L. Ritók who has been a drawing teacher there. During her work as a teacher she found that children who come from such disadvantaged environment, need complex help to compensate their **disadvantages** before and during their education. This includes continous pedagogical and social support and attention and also subsidies which have not been provided by the public primary school.

The extra-curricular activities of Real Pearl apply an **integrated** and **child-centered educative methodology** developed by the teachers involved in it. It is based on the **creativity** of children while also improves their concentration. Central to this methodology is to build up children’s **self-esteem** which improves their performance also in the normal classes of the primary school. Real Pearl devotes **personal attention, regular positive feedback to the children** and this way they can experience **success** in their work, and a chance to express their thoughts.

The Real Pearl’s activity does not stop at the doors of the school. They extended their work to the parents of children and gradually to the whole community in the most disadvantaged villages, with the center of Told. Here they carry out **complex social work** and **community development** activities, which they build up and run together with the local Roma people. Besides the collection and distribution of donations the foundation helps to pay the meals of the children at school or the medicines children and adults need. They assist them in emergency needs, organize protection, against the usurers or provide daily help with, e.g. giving a lift to the hospital, help to get access to health care services and cover the costs of burials. Cultural programs aim at the preservation of the local (Oláh) Roma culture, and the possibility for both children and adults to express themselves through art. A **gardening program** was initiated in which families received seeds and plants to produce foods in the otherwise unused gardens.

One of the central programs has been the building up of the brand ‘SZUNO’ (which means ‘Dream’ in Romani language). Pillow- and cell-phone-cases, wall pictures, purses and bags are sold under this brand the speciality of which is that mothers of the Real Pearl’s students **embroider the drawings of their children.** The Foundation sells them via its social **webshop** and pays women for each piece they make (for more details see: [http://igazgyongy-alapitvany.hu/shop/](http://igazgyongy-alapitvany.hu/shop/)). It is an important source of revenue for the families and plays a **community building role** as women work together in a workshop. The Foundation plans to create a workshop where the local men can produce furniture for children also with motives created by local children. Through the gardening program and the SZUNO, the Foundation tries to help the community to be **self-sustaining** where work can breed enough money for the living.

One of the most recent activity of the Foundation, which raised attention among NGOs and experts alike, has been the production of “bio brickets” through which fuel poverty is being tackled. Unemployed people of the village Told recycle paper, reed etc. and press it with a special methodology into “brickets” during the summer-time which are then distributed among the poor to be used in the winter (see details
http://igazgyongy-alapitvany.hu/alapitvany/biobrikett-program/). Working in the “bio-bricket” farm of the Foundation is accepted as voluntary work by the local municipality which provides the unemployed with eligibility to (a very low level – 80EUR/month) social assistance from them.

4.3 Organization

The Real Pearl Foundation consists of a core staff with about 14 people, most of whom are art-pedagogues. They are supported by a number of volunteers and other promoters. The bio-bricket program, for example, has been run together with environmental experts, and promoters include the British Council and the Legacy Foundation (see details here: http://igazgyongy-alapitvany.hu/alapitvany/biobrikett-program/). The staff is lead by Nóra Ritoók who encourages and trains art-teachers to join the foundation and start up art-classes in the nearby villages. Local people, especially in Told, work hand-in-hand with the foundation, and by today, many of them have leading role in managing the handicraft workshop and the biobricket production. Also, the users of the services of Real Pearl are involved in the planning and decision-making process about new and running projects.

An important segment of the Foundation’s work is the effective usage of media. Besides running an informative, well-structured and regularly up-dated homepage documentaries have been filmed and interviews made about their activities. Exhibitions and auctions from the works of the children and the mothers are regularly organized not only locally but also in Budapest, raising funds among the intellectual elites of the capital. The blog written by Nóra L. Ritók is available on one of the most read on-line newspapers (Heti Világgazdaság, HVG on-line, see here: http://nyomorszeleblog.hvg.hu/2013/03/07/354-hol-vesztettuk-el-oket/ ). The fact that the Foundation is well-known also in the capital city increases its local acceptance, and smooths the co-operation between the foundation and public institutions.

4.4 Core innovative ideas

- Child-centered art education for disadvantaged children, fostering cognitive skills and personality development.
- Artistic activities with children are linked to social work, community building and income generating activities with parents (embroidery work sold through social webshop).
- Tackling fuel-poverty through the production of bio-bricket.
- Filling a gap left by the state in providing complex solutions in the most deprived and segregated rural settlements

4.5 Drivers of innovation

- Long-term poverty in an economically deprived region with no traditional ways out
- Public institutions not fulfilling their role in reducing poverty, tackling ethnic conflicts and preventing high rates of drop-out of poor and Roma children from schools
- Personal skills and motivation of the leader and the staff of the foundation
- Success reached through the special methodology of art-education in children’s performance and well-being
- Promotion by a wider intellectual group and volunteers that foster new and innovative solutions

5. References

A short version of a documentary about the Real Pearl Foundation. Available at:
http://www.youtube.com/watch?v=-yF_ju2n76E&feature=player_embedded# (Date of Access: 17.03.2013)

Eurostat (Statistisches Bundesamt) Hrsg. 2012: Tables by functions, aggregated benefits and grouped schemes - million EUR. Available at:


Full movie: Available at: http://www.youtube.com/watch?v=M-s7SrYsxk4 (Date of Access: 17.03.2013)

Homepage of the Real Pearl Foundation (in English). Available at: http://igazgyongyalapitvany.hu/en/ (Date of Access: 17.03.2013)

Homepage of Told (in Hungarian). Available at: http://www.told.hu/ (Date of Access: 17.03.2013)


http://fn.hir24.hu/itthon/2013/01/11/megmenekult-az-igazgyongy/ (Date of Access 17.03.2013)


OECD (2010) PISA 2009 Results: *Overcoming Social Background – Equity in Learning Opportunities and Outcomes*. (Volume II.)

Webshop (in Hungarian): Available at: http://igazgyony-alapitvany.hu/shop/ (Date of Access: 17.03.2013)

*Photo by Zsófia Kőműves, Told, 2012*

This report is a product of the INNOSERV project (grant agreement nr. 290542) which is funded by the European Union under the 7th Framework Programme.
Theoretically informed case study accompanying the film

Light Residential Projects - Italy

Please insert a photo

Authors:
IRS
Flavia Pesce, Eugenia De Rosa

WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/residential

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a European-wide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Light Residential Projects - Housing solutions for people with mental health problems in Italy
The aim of Light Residential Projects is to ensure a gradual transition to independent living and inclusion in the community for people with mental health problems\(^1\) through offering living arrangements out of residential structures and support in daily living.

Specific innovative elements of Light Residential Projects:

**Network approach:**
Blurring Approach' involving a change in values and practices overcoming the division between social and health in favour of an integration of these two fields.

**Community-based care:**
Social service provider: integrated intervention programs between the various services of the territory and open to collaboration with the informal network and the civil society.

**Paradigm turn in residential psychiatric care:**
Residential psychiatric care turns from the centrality of the residential structure to the flexible approach and person centred intervention.

**Key characteristics of the service**

**Organisation:**
**Aiutiamoli** is an association founded in Milan in 1989 to deal with the discomfort, pain and loneliness of the mentally ill and their families. In March 2007 the Foundation Aiutiamoli was set up as a non-profit organization to manage the Day Care Center "City of the Sun’ and for other rehabilitation and residential projects.

**User groups**
Users are patients clinically stabilized but in precarious social situations with regard to the relational, family and the environmental aspect, who are not fit to inhabit and own a residence for which a local community, in small groups, provides essential support to live.

**Principle:**
The main idea is to establish new models of residential psychiatry in order to allow the completion of the rehabilitation of the user favouring their right to independent living. Empowerment, Autonomy and Independent Living are the main principles.

\(^1\) Different definitions of mental health disorders and intellectual disabilities are contained in the Italian Law System.
Factors influencing Social Services Innovation

Drivers
- Modification of the local regulatory framework
- Due to paradigm shift

Challenges
- New needs (mentally ill users experience difficulties living autonomously)
- Paradigm shift: segregation to inclusion
- Community care
- Deinstitutionalization

Agents of change
- Users, relatives, and civil society organizations

Response
- Residential structures in the social area
  - Community-based care and integration
  - Flexibility, person-centred approach, and autonomy
  - Support to independent living and networking for people with mental health
  - Active users and involvement of civil society

- New practices for old needs
- New perspectives on old needs (see deinstitutionalization, community care, and the new inclusion paradigm)

- Sustainability
- Deinstitutionalization
- Better social integration
- Mutual support
- Higher social protection
- Supports users autonomy

- Need for housing solution for users with mental health problems
- Autonomy for the user
- Development of "social" rather than "medical" models

Individualization of care due to independent living (group apartment, home support)
2. Policy Framework relating to housing solutions for people with mental health problems in Italy²

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by local authorities</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Flexibility in the paths of residential psychiatric care and individualised approach: (a) From continuative structures to care programs. From the structure to the person</td>
<td>- All inhabitants shall have the same access to services. The organisational structure has three levels: the central state, the regional health care system and municipalities</td>
<td>Legal milestones: - Regional Plan for Mental Health 2002-2004. Resolution no. 7/17513 of 17 May 2004; - DGR 4221/2007; - Resolution no. VIII/8501 of 26/11/2008 - Guidelines for Regional Triennial 2009/2011; - the Social-Health Regional Plan 2010-2014.</td>
<td>1. Current public health expenditure in the Region: 16.083.43 million euros for 2011 (cf. Lombardy Region)</td>
</tr>
<tr>
<td></td>
<td>- The Regions are responsible for the actual provision of health care services.</td>
<td></td>
<td>2. Financing of residential projects: Light Residential Project are funded by public authorities. Lombardy Region for the health “quota”/portion and the municipality of Milan for the social “quota”.</td>
</tr>
<tr>
<td></td>
<td>- Legal Foundation for the service of light residential offer at local level to entire the population of the region.</td>
<td></td>
<td>- The health quota is about 45 euro and foresees the signing of a contract between A.O. or an accredited body and ASL.</td>
</tr>
<tr>
<td></td>
<td>- Government and actors involved in mental health care are: ASL (Local Health Unit), DSM (Department of Mental Health); providers (hospitals and accredited private actors belonging to the private and third sector); local authorities; social networks.</td>
<td></td>
<td>- The social quota is established in agreement with local authorities.</td>
</tr>
<tr>
<td></td>
<td>- Greater proximity might be found in the social-health district territory where there is more immediate involvement of natural networks, municipalities plans family physicians and the implementation of appropriate integration with the work of UOP (Operative Unit of Psychiatry), through the CPS (psycho-social center), the residential and semi-residential.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Integration of health and social sectors: (a) Blurring boundaries between health (rehabilitative competences) and social (active citizenship) sector involving services, (b) From the organization of work for structure to the development of &quot;teams&quot;.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Public-private partnership models and agreements with non-institutional actors: (a) provided by accredited actors (private and third sector) for providing housing solutions; (b) Trend to community integrated path of assistance (integration between sectors and actors).</td>
<td>- Programs of light residential are provided by accredited actors for activities in the field of psychiatry, most of them are non-profit organizations; - The regional data related to the implementation of programs of light residential for the period 2008-2008 indicate (cf. Percuadani 2009); - 128 patients in 2008 involved in LR programs; 166 in the first quarter of 2009, with an increase of 30% (cf. Percuadani 2009); - 11 ASL involved; - a greater presence of men (60%); approximately 50% of recipients younger than 45 years; the prevalent pathology is schizophrenia (60%).</td>
<td></td>
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<tr>
<td></td>
<td>- Community psychiatry encourages the therapeutic alliance with users and their families (Lombardy Regional Plan for Mental Health 2002-2004: 8).</td>
<td>The mental health system In Lombardy, the resignation rate for mental disorders, in 2010, was 42.93 while in Italy was 43.59 (Istat) (cf. Lombardy Region 2009)</td>
<td></td>
</tr>
</tbody>
</table>

² The service of light residential analysed is activated in the Lombardy Region, in particular in the Municipality of Milan. Data and information in the table above refer to this context.
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th></th>
<th>Italy (2011)</th>
<th>EU27 (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population:</td>
<td>60626442</td>
<td>502406858</td>
</tr>
<tr>
<td>Population projections 2010-2050</td>
<td>65915103</td>
<td>524052690</td>
</tr>
<tr>
<td>Proportion of population aged 65-79 years:</td>
<td>14.3 %</td>
<td>12.7%</td>
</tr>
<tr>
<td>Proportion of population aged 80 years and more:</td>
<td>6 %</td>
<td>4.8 %</td>
</tr>
<tr>
<td>Proportion of population aged 65 and over:</td>
<td>20.3 %</td>
<td>17.5%</td>
</tr>
<tr>
<td>Old-age-dependency ratio (15-64 to 65+)</td>
<td>30.9 %</td>
<td>26.2 %</td>
</tr>
<tr>
<td>Projected old-age dependency ratio 2010-2050</td>
<td>56.34%</td>
<td>50.16%</td>
</tr>
<tr>
<td>Life expectancy at 60 (2009) in years: male/female</td>
<td>22.4 years / 26.5 years</td>
<td>21.1 years / 25.1 years</td>
</tr>
<tr>
<td>Expenditure on social protection (% of GDP) 2010</td>
<td>29.87%</td>
<td>29.36%</td>
</tr>
<tr>
<td>Expenditure on care for elderly (% of GDP) 2008</td>
<td>0.14%</td>
<td>0.41%</td>
</tr>
<tr>
<td>Pension expenditure projections (% of GDP) 2050</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

3.2 Information about the specific Welfare State: Italy

National Government highlights priority targets and interventions for comprehensive local health services and mental health policy in Italy (cf. Ministry of Health 2008: National guidelines for mental health) and establishes the essential levels of assistance (LEA) in order to guarantee equity of care. As far as the mental health policy, in 2011, the Ministry of Health, in collaboration with regions, developed the ‘Action Plan for Mental Health’ to define objectives, priority actions and defining criteria and indicators for the monitoring and evaluation of service delivery. The supply of mental health services and interventions are provided by regional and local authorities that are responsible for planning and implementing interventions.3

Traditionally, in Italy, Regions are the main authorities responsible for providing health care while local governments (Municipalities, social-healthcare districts) plan, manage and provide social services. Since the reform of Title V of the Constitution (Constitutional Law of 18 October 2001 n. 3) health was characterized by progressive strengthening regional competences and regions have acquired legislative powers in social assistance, as subject not being expressly covered by national legislation. The integration of the health and social sector represents a historical theme for the Italian welfare state and numerous legislative interventions have occurred in this direction. In terms of resources, at national level the expenditure on social protection, in 2010, was 29.87% of GDP, lower than the EU27 average where the rate was 29.36% (the expenditure on care for elderly, in 2008, represented 0.14% of GDP against the EU percentage of 0.41%). Total health spending accounted for 9.3% of GDP in Italy in 2010, slightly below the OECD average (9.5%)4. In Italy, 79.6% of health spending

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3 According to the Report on the Health Status of Country 2009-2010 ‘the number of Mental Health Departments coordinating the care network dropped from 214 in 2007 to 208, partly due to their incorporation into the local health authorities, whereas there has been a parallel consistent increase in Mental Health Centres in the community (from 708 to 1,387)’ (Summary of the Report 2011: CCXXXI).

4 The expenditure on health, in 2011, was 112,889 billion euros (Ministry of Health 2012: 240); the per-capita value was 1.862 euros. (in 2010, 111,168 billion euros).
was funded by public sources in 2010, above the average of 72.2% in OECD countries (OECD Health Data 2012).

Toward an integrated system of interventions and social services, what is particularly significant is the reform of the social sector implemented with the Law 328/2000 that has redefined the Italian local social protection model basing it on the principles of integration, public-third sector partnership and a holistic conception of the citizen-user. New forms of cooperation between public institutions, health services, social services and civil society organizations have been encouraged through the elaboration of a new instrument of local planning, the Area Plan (Piano di zona). In the implementation of the reform the following aspects should be noted:

- different levels of integration between public and private actors and between health and social services (different local welfare models);
- territorial disparities in the economic resources of regions and municipalities. Fiscal federalism and reorganization of local autonomies are some issues currently being debated in relation to the provision of social services in Italy.

Also for mental health services, the provision and availability of integrated and support services differ among Regions and Municipalities reflecting different welfare regimes as well as the extent of progress towards de-institutionalisation and community living. In 2008, Italy celebrated 30 years since the issue of the National Mental Health Reform Law (Act 180/1978, known as “Basaglia Law”), which has started the process of de-institutionalisation in favouring the network of community services that currently represent the ideal core strategy of intervention in the mental health field. In such a context, light residential programmes and community psychiatry initiatives constitute innovative social policies, implemented at regional and municipal level, facilitating choice and control over their lives for people with mental health problems. There is a steady increase of expenditure in benefits in kind of social protection benefits (including social services), that shows the growing meaning in comparison to social protection benefit in cash. The table below presents the social protection expenditure of selected countries.

**Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro.**

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3.605,678,95</td>
<td>/</td>
<td>/</td>
<td>34,07%</td>
</tr>
<tr>
<td>Italy</td>
<td>241,249,28</td>
<td>463,992,0</td>
<td>127,52%</td>
<td>21,86%</td>
<td>25,86%</td>
</tr>
<tr>
<td>Germany</td>
<td>565,683,07</td>
<td>765,717,82</td>
<td>52,53%</td>
<td>30,79%</td>
<td>34,69%</td>
</tr>
<tr>
<td>Belgium</td>
<td>60592,78</td>
<td>106492,16</td>
<td>110,88%</td>
<td>24,18%</td>
<td>29,01%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012
4. Challenges and Drivers of Innovation

Istat data on mental health for 2009 and 2010 indicates a prevalence of mental disorders (classified as “nervous disorders”) of approximately 4.3% of the total population, which rises to 9.8% for the over 65s (cf. Ministry of Health, 2011). Population ageing and the higher risk for women to suffer mental health problems represent some challenges that trigger a growing variety of needs for mental health services.

In Italy also living arrangements and support in daily living, represent key areas of intervention to ensure an independent life and inclusion in the community for people with mental health problems (cf. FRA 2012).

Focusing on the Lombardy Region the discharge rate for mental disorders was, in 2010, 42.93 (against 43.59 registered at national level) and the rate of adults with disabilities and mental illness was, in 2009, 213.92 (Health for All, Istat). The number of socio-health residential structures [presidi residenziali socio-assistenziali] at 31.12.2009 amounted to 2,385 while the number of beds was 105,677 with a current public expenditure for health of 17,187.

In 2009 the expenditure for interventions and social services in the Lombardy Region was 17.3% of the total (1,208,044,688; in the Municipality of Milan it was 1,025,145,286 euro).

Structural weaknesses of the system:
For the Italian situation the following structural weaknesses are discussed:

- The impact of public spending cuts. Several cuts to healthcare and to the welfare system have been envisaged with expected impacts also in the field of mental health.
- Lack of person-centred support and community based socio-health services addressed to people with mental health. Unsatisfactory level of shared care (sharing of interprofessional care).
- Weaknesses in the health and social services offer of sufficient housing in the community and of support for independent living for people with mental health problems.

Focusing on the Lombardy Region and on the metropolis of Milan the following structural weaknesses are discussed:

- ‘the discrepancy between the offer of residential structures for high protection and the supply for low protection, preclude some patients, especially those young and of working age, from rehabilitation able to lead them out of the psychiatric circuit’ (gaps in supporting the transition from hospital treatment to independent living in the community);
- ‘persistence strategies of community clinics following policies centred on hospitalization and stigmatization of the patient’;
- ‘need to integrate the rehabilitation, through the achievement of a semi-autonomy of patients, not only by means of apartments, but also thanks to recreational activities and operations performed outside the centres, in laboratories or in cinemas, swimming pools and, last but not least, through
Drivers and Challenges:
The reason for this innovative project is to meet the need, for people with mental health problems, to live independently whether in a group apartment or in a home. An enabling factor is the modification of the local regulatory framework receiving a paradigm shift in the mental health sector. The regional law (Lombardy Region) of "redevelopment of residential psychiatric" introduced light residential projects to support autonomy for people with mental health problems through living outside of residential structures.

Innovation: Ideas, criteria, levels and added values

The need for housing solutions for people with mental health problems in Italy is unsatisfactory. This need is expected to increase. Reasons for this are both data on mental health and mental health residential services, and population ageing.

The basic principle of light residential programmes is that individualised support and integrated services should be arranged in ways that enable autonomy in people's neighbourhoods. For community living to be truly successful, residential programmes should be accompanied by a range of social services and offer activities for free time.

Only some Italian municipalities currently provide light residential programmes. With the Regional Plan for Mental Health 2002-2004 (Resolution no. 7/17513 of 17 May 2004) the Lombardy Region has promoted processes of institutional innovation including Light Residential Programmes in the offer of public mental health services, implemented in collaboration with third sector organizations, and setting up an accreditation mechanism.

There are six particularly innovative aspects about the service:

Flexibility, person centered approach and autonomy:
The innovation consists mainly in favouring and supporting autonomy for people with mental health problem through living out of residential structures and through the planning of personalized care paths (individualized integrated programmes) agreed between users and institutional and professional figures.

Support to independent living and networking for people with mental health:
Benefits of professional support in daily living and social networking between service users include increased user's confidence and control over their own life, more opportunities for socializing and easier access to resources in the neighbourhood where they live.

Integration:
A core element of the highlighted service is integration: (a) Institutional and Governance integration. The integrated approach in financing, planning and managing light residential programmes (community health governance and openness to local social services and civil society); (b) Organizational and Professional integration (shared care) in therapeutic rehabilitation projects for people in residential
Collaboration and coordination between different professional expertises and new social work practices are outcomes.

Communtiy based:
The social service provider represents an open and embedded element of community and neighbourhood. Users involved in Light Residential project can enjoy other activities (rehabilitative) offered by Aiutiamoli. For the implementation of its activities Aiutiamoli works in collaboration not only with local health and psychosocial centres (PSC) and other actors involved in mental health care, but also with territorial third sector organizations, volunteers, family and parent’s users. An added value is openness and connection of the organization provider to civil society.
The Blurring Approach’ involving a change in values and practices overcoming the division between social and health in favour of an integration of these two fields. Integration and connection both between the different stakeholder actors, institutional and non-institutional, involved in mental health care and between an integration with other projects, implemented in the same area, working in synergy with the residential one in order to avoid isolation. Aim: Connection of users as well as favouring social inclusion and participation in the community of people involved in the residential projects.

Institutional change and arrangements:
The regional law (Lombardy Region) of “redevelopment of residential psychiatric” introduced light residential projects to support autonomy for people with mental health problem through living out of residential structures. Light residential programmes have been stabilized within regional planning and included in the offer of public mental health services.

Financing:
The financing of programs of light residential (72 Euro per day) is based on two funding lines: (a) regional funds managed by the ASL for the health quota (45 Euro) to pay the work of the mental health practitioners; (b) funds provided by the Municipality for the social quota (27 Euro) to cover the costs for rent, utilities and food. Providers, as is in the case for psychiatric residency, are required to register the individual contributions made as part of such assistance programs. The psychiatric budget of the Lombardy Region for next year has is not to be cut.

Agents of Change
Users’ relatives and civil society organizations were the actors who promoted the innovation the most.
5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare, health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>Aiutiamoli: 1989; Day Care Center “City of the Sun”: 2003 Foundation Aiutiamoli, built in 2008</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Non-profit organization</td>
</tr>
<tr>
<td>Financing</td>
<td>two funding lines: (a) regional funds managed by the ASL for the health quota (45 Euro) to pay the work of the mental health practitioners; (b) funds provided by the Municipality for the social quota (27 Euro) to cover the costs for rent, utilities and food</td>
</tr>
<tr>
<td>Providers, as is in the case for psychiatric residency, are required to register the individual contributions made as part of such assistance programs. The psychiatric budget of the Lombardy Region for next year has not be cut.</td>
<td></td>
</tr>
<tr>
<td>Size of organization</td>
<td>Thirty practitioners</td>
</tr>
<tr>
<td>Members and participation</td>
<td>50 people among users relatives and users 17 users of the ‘light residential project’ 60 users of the Day Care Centre ‘City of the Sun’</td>
</tr>
<tr>
<td>Active role of relative’s, users and volunteers</td>
<td></td>
</tr>
<tr>
<td>Contact</td>
<td><a href="mailto:aiutiamoli@aiutiamoli.it">aiutiamoli@aiutiamoli.it</a></td>
</tr>
<tr>
<td>Name of the innovative example</td>
<td>Aiutiamoli</td>
</tr>
<tr>
<td>Homepage</td>
<td><a href="http://www.aiutiamoli.it/">http://www.aiutiamoli.it/</a></td>
</tr>
</tbody>
</table>

Aiutiamoli is an association founded in Milan in 1989 to deal with the discomfort, pain and loneliness of the mentally ill and their families. The association introduced innovation in a particular historical context marked by the start of the process of de-institutionalization. Since then the association has promoted mental health projects (preventive services and rehabilitation) through the work and the constant presence of psychologists, psychotherapists, practitioners, trainers, social workers and volunteers. Aiutiamoli acts on the discomfort through two channels:

- the Association 'Aiutiamoli'.

The Foundation is responsible for the day center "La città del sole" and manages ‘Light Residential’ projects through a partnership between the public and third sector.

The Day Care Center born in 2003

The psychosocial rehabilitation, carried out in the Day Centre, is followed by psychologists, educators, psychiatrists, flanked by art teachers. In this place the “patients” become "users", active users of services designed to meet their needs and care. Among the activities: social skill training, self help groups, the group body expression, soft gym, shiatsu, course of language (English), musicotherapy, theatre; (group exit) experience: cinema and trips.

Light residential projects

Currently the Foundation carried out two ‘Light Residential’ projects

Light residential represents a new model of residential psychiatric constituting the search for new solutions to old needs. Innovation emerges from citizen-led initiatives.
In fact the project of light residential was carried out firstly by the association Aiutiamoli during the Eighties to provide a response to the needs and concerns expressed by parents of people with mental health problem. The following local institutional changes - institutional arrangements and legislative framework - represented enabling factors for the consolidation of this new type of psychiatric residential service. Starting with the "three-year Regional Plan for Mental Health" implementing the Social-Health Regional Plan 2002/2004 the light residential became an ordinary activity. To be implemented, such programs must be based on finding appropriate housing solutions through appropriate forms of social support, involving the Coordination Bodies for Mental Health, also through public-third sector partnership. Aiutiamoli is one of the third-sector accredited actors for providing housing solutions.

Light residential represents a new model of residential psychiatric. The new approach is based on the idea of flexible, individual integrated therapeutic projects (PTI) and territorial care patterns of rehabilitation. Favouring easy access to housing is part of this strategy of intervention. Users of Light Residential are patients clinically stabilized but in precarious social situations with regard to the relational, family and the environmental aspect, who are not fit to inhabit and own a residence for which a local community, in small groups, provides essential support to live. Some users of light residential projects had lived in psychiatric hospitals or in residential structures; some are expected to return there.

Professionals guarantee support for daily living that helps people with mental health problems to exercise more choice and control over their lives. The concept of autonomy is a relative one and much attention is given both to the placements and the user's consent. The user needs to be the active, protagonist and to express fears and problems.

Actually Aiutiamoli offers two types of housing solutions for people with mental health problems: Living in group homes and Living alone.

**Living in group homes.** The ‘Clessidra’ project is managed by the Aiutiamoli Foundation and is carried out with the Department of Mental Health of the Fatebenefratelli Hospital of Milan. The project provides light residential for 14 people living in 3 apartments in the centre of Milan. The Foundation also has an apartment in the centre of Milan thanks to the donation of a user's family (‘Aquilone project’).

**Living alone.** Within the ‘Aquilone project’, the foundation manages in a peripheral area of Milan 5 public housing units where users experience an independent life. An operator guarantees his availability for 4 hours per apartment; then there is the availability of a referee 24 hours a day. Different strategies to make the 5 bedsits communicable have been experimented. Staff and peer support. To avoid the risk of isolation (a) an operator goes every day to each apartment; (b) once a week there is a group at the public houses (rotating in each one), with the operational coordinator of the project, the operators on duty and all the users of the project. During the meeting the group discusses positive and critical aspects. The group has a protective function.
**Integrated intervention programs** between the various services (social and health) of the territory - through the presence of expertise on social (related to rights of citizenship) and health (rehabilitative) and with a combination of line of funding - and open to **collaboration with the informal network and the civil society** are main features of the innovative practice. Light Residential is a typical example of the ‘Blurring Approach’. Actors included in the governance of the service are accredited private actors (Aiutiamoli), the Coordination Body for Mental Health set up within the ASL, ASL (Local Health Unit) of the macro-area, DSM (Department of Mental Health), local authorities and social networks. Other projects, implemented in the same territorial area, work in synergy with the residential one in order to facilitate social networks, to avoid isolation and to favour social inclusion of people involved in the residential project managed by Aiutiamoli. Some initiatives implemented are: Let's try together [Proviamoci Assieme], a project routed to foster care (for users in serious situations to avoid obligatory hospital treatment (TSO); the day care centers (psycho-social center; CPS) where users of the various projects meet one another and self-help groups are activated; the free time activities carried out by the Association Aiutiamoli. The association also provides **support for user’s family**. All these activities are addressed to favour participation and inclusion in community life. Openness to civil society and the active role of relative’s users and volunteers are value added of the practice.

The project might have a positive influence on the **debates within the European Commission** due to the fact that most countries in the EU are dealing with the inclusion of people with mental health favouring participation and inclusion in community life. Living autonomy is one of the key issues. The project can be used in other countries as well. Light residential projects, implemented in connection with other services/projects managed by Aiutiamoli, is an example of a new strategy of intervention which takes care of the need of autonomy and independent living for people with mental health problems. Planning and implementing further and effective integration between residential projects, activities favouring participation in the community and labour inclusion initiatives/projects/programmes represent common challenges.
6. References


Istat: Italian National Institute of Statistics, Health for All System
Lombardy Region, 2009, The Lombardy Region Mental Health System [Il sistema di salute mentale di Regione Lombardia]


OECD Health Data 2012. Available at: http://www.oecd.org/els/healthpoliciesanddata/BriefingNoteITALY2012.pdf (Date of Access: 11.03.2013)

Theoretically informed case study accompanying the film

Santé Communautaires Seclin - France

Author:
IAE Paris
Philippe Eynaud, Elisabetta Bucolo

WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/seclin

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a European-wide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Santé Communautaires Seclin
The project is part of a community well-being initiative involving elected officials, health and social services professionals and the inhabitants of a city, more specifically a given neighbourhood classified as a sensitive urban zone ("Zone Urbaine Sensible"), in the framework of city policies ("Politique de la Ville"). The primary objective is to set up synergies among different health or wellness skills and giving beneficiaries the role of fully involved actors. The targeted activity concerns "self-esteem" using theatre as a vector, led by an actress trained in "non-violent" communication and in the Theatre of the Oppressed (Forum Theatre).

The theatre work is taking up the problems and issues (linked to wellness topics) proposed by the inhabitants. Because of this, it is very much appreciated in the neighbourhood. They have themselves expressed the need for an approach to community well being based on self-esteem.

Specific innovative elements of this Community health initiative

Network approach:
The community health approach creates favourable conditions to allow the involvement of all stakeholders (residents, professionals, politicians, institutions).

Empowerment:
Community Health aims to empower the inhabitants and to involve them in the solving of health issues affecting them. For local governments, this way of addressing the health problems is relevant in a time of growing tensions over Public financial resources (Planète Publique 2011: 4).

Key characteristics of the service

User groups
The workshop "self-esteem" is open to residents, municipal employees, and healthcare professionals.

Presence in the public sphere
The theatrical productions of the "self-esteem" workshop (in relation to health) are played onstage in different public places to educate inhabitants as well as political representatives on these issues. Some themes have allowed political representatives to identify untreated needs and concerns raised on the local level.

Principle
The main idea is the recognition of the individuals’ expertise in the management of their quality of life and health. Community health is focused on building the needed personal resources (such as self-confidence and self-esteem) to foster individuals’ ability to make their own choices.
Factors influencing Social Services Innovation

Drivers
- 2 main Drivers
  - People concerned by quality of life (want involvement in public choices)
  - Policy makers willing to change public health orientation
- Impact due to social and economic crisis
- Growing tension over public financial resources

Agents of change
- "Faire les santé" (Make health) Debate between health professionals and residents
  - Identified:
  - Importance of work with self-esteem

Structural weakness of system
- Local public health policies taking on core concepts such as:
  - Inter-sectorial cooperation
  - Interdisciplinary
  - Cross-disciplinary
  - Partnerships

Decline response
- Involve and empower inhabitants to address health problems
- Self-esteem workshops
- Involvement of socially excluded and vulnerable users
- Help to self-help by recognition of individuals' expertise

Quality
- Self to self-help
  - Empowerment of user

Sustainability:
- Involvement of all stakeholders: residents, professionals, politicians, institutions
2. Policy Framework related to community health in France

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health includes:</td>
<td>The key actors are: - all stakeholders who participate to community health - experts, professionals, civil servants, politicians, and users.</td>
<td>In France, there is no specific legislation for community health, but there are some Legal milestones: The law of March 4, 2002 has promoted the patients' rights and the quality of the health system by modifying its governance. The users have been more involved in public choices in health sector.</td>
<td>The level of health expenditure is high in France: - The total medical consumption in France in 2001 is 131 billion euros (2030 euros per capita) - The amount of current health expenditure is 148 billion euros in 2001 (2437 euros per capita); - The national health expenditure: 140 billion euros (2305 euros per capita). For this amount France is ranked the 11th largest OECD countries; - France spends 9.5% of its GDP on health;</td>
</tr>
<tr>
<td>1 A comprehensive approach to health that involves different sectors and justifies multi-disciplinarity;</td>
<td>The organisational model for community health is based on: - a collective approach - the Involvement of all stakeholders (inhabitants, professionals, politicians, city representatives) in the different stages of the process (diagnosis, taking initiative, decision, assessment and evolution); - a collective identification of problems, needs, and resources (community diagnosis); - a multidisciplinarity and inter-sectoral approach; - a partnership; - the sharing of knowledge and power. - the change in the doctor-patient relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Ensuring equal access to quality care;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 The design of democratic practices that aim to involve everyone in maintaining, preserving or improving health;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 The solidarity that relies on social protection and health care accessible to all</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 The request for quality curative and preventive responses in health. (More information can be found on the Institute Renaudot web site: <a href="http://www.institut-">http://www.institut-</a> renaudot.fr/).</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

The health resources depend on Public actors and households: - Public social security system is funding 75,5% of health expenditure; - Households themselves finance 11.3% of health expenditure (Data SEPSAC). - Private insurance companies and mutual health insurances are funding the remaining part of health expenditure | | | |
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th></th>
<th>France</th>
<th>EU27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population, (2010)</td>
<td>501.1 million(^{14})</td>
<td>525 million(^{16})</td>
</tr>
<tr>
<td>Population projections 2035</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of population aged 65-79 years, (2010):</td>
<td>12.7%</td>
<td></td>
</tr>
<tr>
<td>Proportion of population aged 80 years and more (2010):</td>
<td>4.7%</td>
<td></td>
</tr>
<tr>
<td>Proportion of population aged 65 and over (2010):</td>
<td>17.4%</td>
<td></td>
</tr>
<tr>
<td>Old-age-dependency ratio (2008)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Projected old-age dependency ratio 2051</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth in years: male/female</td>
<td>76.4/82.4 (2009(^{15}))</td>
<td></td>
</tr>
<tr>
<td>Expenditure on health care (% of GDP, 2009)</td>
<td>10.2(^{10})</td>
<td></td>
</tr>
<tr>
<td>Number of people with a long term condition</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

3.2 Information about the specific Welfare State: France

Social protection in France is organized at four levels:

- The Public **social security system** provides coverage for basic risks such as "illness / maternity / disability / death / accident / occupational disease/ old age". Each of them corresponds to a different regime.

- The **Complementary regime (CR)** provides coverage for additional risks. Some CRs are mandatory (supplemental pension plans for private sector employees) and other optional (mutual health insurance institutions).

- The **UNEDIC** (National Union for Employment in Industry and Commerce) manage the unemployment insurance.

- The **Social assistance** (managed by the State and the departmental public authorities) supports the poorest.

In 2010, 75.8% of the consumption of Care and Medical services was funded by Social Security, 13.5% by Complementary organizations (mutual insurance companies, pension funds), 9.4% by households, and 1.2% by State and local governments. The Total Expense Health puts France in third place in the Member States of the OECD in 2009 (DREES, 2012).

In France, there is a steady increase of expenditure in benefits delivered in kind rather than in cash. The table below presents the social protection expenditure of selected countries.
Social protection expenditure: Aggregated benefits and grouped schemes in Millions. of Euro.

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Millions. of Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3,605,678.95</td>
<td>/</td>
</tr>
<tr>
<td>France</td>
<td>379,396.42</td>
<td>654,238.65</td>
<td>84.47%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>262,859.71</td>
<td>478,281.18</td>
<td>124.56%</td>
</tr>
<tr>
<td>Norway</td>
<td>32,512.53</td>
<td>80,833.67</td>
<td>152.74%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

4. Challenges and Drivers of Innovation

Structural weaknesses of the system:
During the last thirty years in France, local public health policies have more and more taken on concepts such as inter-sectorial cooperation, interdisciplinary, cross-disciplinary and partnerships. Developments that have been influential in this respect are:

- In particular, in the area of preventing and treating AIDS, and in relation to substance abuse, associations of patients and some health institutions have been able to call successfully for changes in professional practices and greater involvement of the people affected.
- The social and economic crisis has an impact on access to care for people who are socially excluded or vulnerable.
- Professional modalities for intervention of professionals, associations and governments have been modified.
- New practices have appeared designated as “Community health” without a clear legislative framework for community health.

Innovation: Ideas, criteria, levels and added values

Driven by the need to broaden the discussion and deepen democracy on the matter of health, institutional actors have sought to explore different forms of experience development in France. By allowing the active participation of citizens in the definition of the scope of health intervention, Community health provides new openings on the local level.

Community health programs are funded by the regional health authorities and by the local authorities through devices such as « Contra Urbain de Cohésion Sociale » (Urban Contract for Social Cohesion) and health workshops named “Ateliers Santé Ville” or by foundations such as the “Fondation de France”. (Planète Publique, 2011 : 2)

The Directorate of Health (within the Ministry of “Health, Youth and Sport”) considers Community health as part of public health policy and as a relevant strategy for promoting health. (Planète Publique, 2011 : 1).
Network approach:
The Community health approach creates favourable conditions to allow the involvement of all stakeholders (residents, professionals, politicians, institutions) on several stages: diagnosis, taking initiative, decision, and evaluation. This process guarantees the recognition of citizens’ skills and their ability to interact in network.

Empowerment:
Community Health aims at empowering the inhabitants and at involving them in solving of health issues affecting them. For local governments, this way of addressing the health problems is relevant in a time of growing tensions over public financial resources (Planète Publique 2011: 4). Individuals who have attended the self-esteem workshop have created three associations, which belong to three different areas: nutrition, physical health, social integration of women.

Spin-off process:
The idea is to develop workshops (see workshop self-esteem) to search for direct involvement of people in the targeted problems. This has a very interesting long-term effect. Thus, people are gathering in collective movements or are creating associations related to health issues. They intervene in the public sphere with other people. They also interact directly with local governments for defining local priorities in terms of public health.

User groups
The workshop "self-esteem" is open to residents, municipal employees, and healthcare professionals. Promoting "community health" requires being open to very different people.

Presence in the public sphere
The theatrical productions of the "self-esteem" workshop are played on stage in different public places to educate inhabitants as well as political representatives on these issues. Some themes have allowed political representatives to identify untreated needs and concerns raised on the local level.

Principle
The main idea is the recognition of the individuals’ expertise in the management of their quality of life and health. Community health is focused on building the needed personal resources (such as self-confidence and self-esteem) to foster individuals’ ability to make their own choices.

Drivers and Challenges
Two main reasons are explaining the growing interest for health community:
- **People** are feeling more and more concerned by the quality of life and they want to be involved in public choices relating to their health.
- **The policy makers** are willing to change public health orientation. Actually, the wellbeing of people is related to four factors: lifestyle, social/economic/ ecological environment, human biology, and health care system. The major factor is the first one “lifestyle”. It means that the improvement of the quality of life is particularly relevant for policy makers in public health sector.
Agents of Change
At the annual event « Faites de la santé » (Make health), a debate between health professionals and the residents has identified in 2007 the importance of working on self-esteem. In 2008, the workshop was created by representatives of the municipality in collaboration with two local associations and the residents of the neighborhood.

5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Health and welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>2008</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Combination of public organization and volunteer association</td>
</tr>
</tbody>
</table>
| Financing | Originally, the project was funded by the municipalities through the "Contrats urbains de Cohésion sociale » (Urban Contracts for social cohesion). But soon a residents' association took over. Currently, three partners are involved in the implementation of Community health:
- « Forme Santé Détente Seclin »
- The political department of the municipality
- "L'Homme debout" (Man up) |
| Size of the organization | Number of staff: 6
Number of users: 105
Number of members: 90 |
| The city's services department has four salaried employees with civil servant status.
The FSDS has only one employee (a woman coach for the gym).
The actress who leads the self esteem workshop is employed by the association, "L'Homme debout" (Standing Man) which is under contract to the city for this service. |
| Members and participation | - Residents, health professionals, elected representatives,
- Association « Forme Santé Détente Seclin » (Relaxation Fitness Health Seclin) which organize the mobilization of the residents;
- Political department of the municipality whose role is crucial in the phase of organization, provision and contact with the public;
- Association "L'Homme debout" (Man up) is part of the project through the management of the self-esteem workshop. |
| Contact | Gautier Delannoy
dirpolville@ville-seclin.fr |

This project is located in the Seclin district named “Mouchonnière”. This district is classified “Zone urbaine sensible” (Sensitive Urban Zone). The area is part of a wider local health policy in the “Contrat territorial de santé” (Contract for Health at the local level).

The workshop on "self-esteem" is part of a community health approach, an approach to health issues starting from the perception of people. Different actors (residents, health professionals, elected representatives) are involved in the process to promote a socially responsible approach to health issues:
Originally, the project was only supported by the Municipality as part of its policy, and
funded through the "Contrats urbains de Cohésion sociale » (Urban Contracts for social cohesion). The municipality was initially trying to involve residents in participative activities. But soon a residents’ association took over. Currently, three partners (local associations, municipality, residents) are involved in the implementation of Community health:

- The association « Forme Santé Détente Seclin » (Relaxation Fitness Health Seclin) which organizes the mobilization of the residents;

- The political department of the municipality whose role is crucial in the phase of organization, provision and contact with the public;

- The association "L’Homme debout" (Man up) is part of the project through the management of the self-esteem workshop.

At the annual event « Faites de la santé » (Make health), a debate between health professionals and the residents has identified in 2007 the importance of working on self-esteem. In 2008, the workshop was created. The workshop takes now place in an activity room in the heart of the Mouchonnière. To encourage the involvement of participants in the process, the self-esteem workshop focuses on an activity of theatrical expression that promotes discussions and public speaking in a pleasant place. A professional actress trained in non-violent communication, conflict management and the Theatre of the Oppressed is directing the participants involved in the theatrical production. Actually, this actress has also a postgraduate degree in health management and this curriculum is very relevant to ensure the quality and the adequacy of the collective work.

The workshop takes place twice a month (excluding holidays), alternating day and half-day in a safe room out of sight. The project manager is involved in the activity. The people who are targeted for this workshop are in a precarious situation, often unemployed and far from health centres. The opening of the workshop outside the district facilitates a sociocultural mix that is very interesting. Fifteen participants are attending the workshop; mostly women aged 45 to 70 years. The regular sessions of the workshop (1 every 15 days) and the long duration of community health project in the city of Seclin (10 years) have produced a virtuous circle.

Some people attending the workshop were able to create other associations that have more or less direct links with the community health project, including:

- an association named “Epicerie Solidaire » that manage a social grocery store,

- an association to defend the rights of women,

- an association for the promotion of physical activity.

The topics discussed at the workshop and presented publicly through theatrical performances are subject to special attention by the local authorities that analyse them as the signs of emerging needs.
6. References


Eurostat (Statistisches Bundesamt) Hrsg. 2012: Tables by functions, aggregated benefits and grouped schemes - million EUR. Available at:


Planète Publique, Pour un débat citoyen sur la santé plus actif, Etude sur les modes de participation des usagers citoyens à la prise de décision en santé, Ministère de la santé, de la jeunesse et des sports, Paris, 2011.


Theoretically informed case study accompanying the film

Digital Healthcare - Internet based Self-Management - UK

Author:
University of Southampton
Jane Frankland, Chris Hawker

WP Leader HAW Hamburg
Andreas Langer, Simon Güntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video:
Link to the video: http://www.inno-serv.eu/telemonitoring

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1. Digital Healthcare - Internet based Self-Management
This service represents the use of innovative digital solutions to improve healthcare services.

Specific innovative elements
The use of digital technology in healthcare
The project shows an innovative use of digital technology to provide a sustainable solution to care of people with pain associated with a long term health condition

Enhancing patients’ self-management skills
Embedding self-management support in mainstream health services, aiming to build patients’ confidence to self manage and to improve their own health outcomes.

Integration of an independent sector provider with the Health Service
The project involves the engagement of an independent sector digital self-management support provider working with a National Health Service provider to co-produce the service

Key characteristics of the service
Organisation:
The Somerset Pain Management Service (SPMS) provides support for patients with persistent and incurable pain. The SPMS is part of the National Health Service in England (Taunton & Somerset NHS Foundation Trust) and is provided at secondary care level. The service is primarily a self-management support service: it aims to help people with chronic pain to understand and take control of their pain, and to adopt strategies which allow them to live as full and independent life as possible. The SPMS provides an integrated service for pain, with patient provision including clinical provision, access to peer group support, and online support and signposting (Collins and Corrigan, 2012). The SPMS has partnered with ‘Know Your Own Health’ (KYOH), an internet based self-management platform for patients with long term health conditions, to provide on-going support for self-management and health related behavior change outside of appointments with the service.

User groups:
KYOH is aimed at people with long-term health conditions (LTCs). These are health conditions which cannot currently be cured, but are controlled by medication or other treatment/therapies. LTCs include diabetes, stroke, asthma, hypertension and dementia (Department of Health, 2012a). The example provided here is for people who are living with persistent, incurable pain who have been referred to KYOH by the SPMS.

Principle:
The principle is that people can be supported to feel confident and able to self-manage their long term health condition, thereby improving their quality of life and reducing their reliance on formal healthcare services.

Driver(s):
- Pressure on healthcare services from increasing numbers of people with long term health conditions
- Policy guidance regarding self-management support to patients with long term health conditions
- Technological advance allowing home internet access
- Social acceptance in the use and uptake of home based internet access
Factors influencing Social Services Innovation

- **Agents of change**
  - Clinical leadership of Pain Management Service
  - Independent digital service provider
  - Patients

- **Drivers**
  - Availability and accessibility of web based services
  - Search for alternative forms of care and support

- **Challenges**
  - Increasing number of people with pain associated with long term health conditions
  - No alternative treatment options

- **Response: Digital healthcare**
  - Internet based self-management
  - Patients become self supporting rather than dependent on formal services

- **Sustainability**
  - Patients feel more in control

- **Novelty**
  - Internet based self management service
  - Statutory health service partnering with digital technology company

- **Quality**
  - Patients able to improve management of their condition
# 2. Policy Framework related to care of long term conditions in the UK

<table>
<thead>
<tr>
<th>Principles/Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice and control shift in policy away from a traditional model of healthcare to one that offers the patients more choice and control over their care (The Health Foundation, 2012)</td>
<td>Health care in the U.K. provided by the National Health Service funded from taxation</td>
<td>The service model reflects a number of national policy statements regarding long term health conditions.</td>
<td>It is estimated that treatment and care of people with long term health conditions takes up 70% of the total health and social care expenditure (Department of Health, 2012a)</td>
</tr>
<tr>
<td>Shared decision making</td>
<td>Department of Health: UK health care policy is promoting and supporting self care and ‘shared decision making’; NHS Primary Care: General Practitioners refer patients with incurable pain to the SPMS; NHS Secondary Care: SPMS provide clinic based self-management support and introduction to KYOH</td>
<td>NHS Mandate (Department of Health 2012b) requires the English health service to empower users to manage their own care</td>
<td></td>
</tr>
<tr>
<td>Personalisation</td>
<td>KYOH is an independent sector provider of on-line self-management tools and support</td>
<td>NHS Outcomes framework (Department of Health, 2011) Includes ‘enhancing quality of life for people with long term conditions’ as one of the responsibilities of the NHS;</td>
<td></td>
</tr>
<tr>
<td>Supported self-management</td>
<td></td>
<td>QIPP Quality, Innovation, Productivity and Prevention programme (QIPP) (Department of Health, 2010b) The QIPP programme aims to improve the quality and delivery of NHS care while reducing costs to make £20bn efficiency savings by 2014/15. It identifies self-care and shared decision making as features of best practice in LTC care¹. It includes LTCS as a priority and promotes a model that includes self-care support (Department of Health, 2012a). It identifies the need for empowerment of patients to maximise self-management (Health Foundation, 2012)</td>
<td></td>
</tr>
<tr>
<td>Co-design</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service users and service providers work together to ensure development of a service that fits their needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowerment</td>
<td>Empowering patients to maximise their self-management, through provision of information about their condition and skills to manage it</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th></th>
<th>UK</th>
<th>EU27</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population projections 2035</td>
<td>73.2 million (ONS, 2011a)</td>
<td>525 million (Eurostat, 2011b)</td>
</tr>
<tr>
<td>Proportion of population aged 65-79 years, (2010):</td>
<td>11.9% (ONS, 2011b)</td>
<td>12.7%</td>
</tr>
<tr>
<td>Proportion of population aged 80 years and more (2010):</td>
<td>4.7% (ONS, 2011b)</td>
<td>4.7%</td>
</tr>
<tr>
<td>Proportion of population aged 65 and over (2010):</td>
<td>16.6% (ONS, 2011b)</td>
<td>17.4%</td>
</tr>
<tr>
<td>Projected old-age dependency ratio 2051</td>
<td>495 (ONS, 2009)</td>
<td>495 (ONS, 2009)</td>
</tr>
<tr>
<td>Number of people with a long term condition</td>
<td>around 15 million (Department of Health, 2012a)</td>
<td>-</td>
</tr>
</tbody>
</table>

3.2 Information about the specific Welfare State: UK

In the UK, the state provides a basic level of social support and social protection. Around half the UK population (approximately 30 million people) receive some social security benefit. These benefits are a mix of taxable/non-taxable; contributory/non-contributory and means/non-means tested benefits. The benefits can be divided into six categories of recipient: families with children, unemployed people, those on low incomes, elderly people, sick and disabled people, and bereaved people. Social security benefits for the period 2011-12 amounted to 13.5% of the GDP of Great Britain and is the largest single area of government spending (Browne and Hood, 2012).

Social services (social care and social support) are organised at a local level, with some schemes funded nationally but mediated through local government, and some funded locally. Local governments have reduced their role of direct service provider in some areas, with a growing number of independent providers and a growing social enterprise sector becoming involved. The system thus has a plurality of service providers. Social care services in England, Northern Ireland, Scotland and Wales are managed separately, although are similar in most respects (Theil, 2010).

Health care is provided through the National Health Service (NHS) which is funded through taxation and is free at the point of use for anyone living in the
UK. Again, NHS services in England, Northern Ireland, Scotland and Wales are managed separately, although are similar in most respects. Expenditure on healthcare in the UK in 2009 was £136.4 billion, or 9.8% of GDP (Qaiser, 2011).

In the UK, there is a continuous increase of expenditure in benefits delivered in kind rather than in cash. The table below presents the social protection expenditure of selected countries.

### Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Mio. of Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3.605.678,95</td>
<td>/</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>262.859,71</td>
<td>478.281,18</td>
<td>124,56%</td>
</tr>
<tr>
<td>Germany</td>
<td>565.683,07</td>
<td>765.717,82</td>
<td>52,53%</td>
</tr>
<tr>
<td>France</td>
<td>379.396,42</td>
<td>654.238,65</td>
<td>84,47%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

### 4. Challenges and Drivers of Innovation

**Structural weaknesses** of the system:
The current approach to the care of people with long term health conditions is not sustainable (Department of Health, 2012a). Around 15 million people in England, or almost one in three of the population, have a long term condition. In people over 60, this figure is 50%, and older people are likely to have more than one long term health condition. The management of incurable pain is often associated with such conditions and the incidence of people with multiple LTCs is set to increase as the population ages. People with long term health conditions are high users of health services, accounting for 50 percent of all GP appointments and 70 percent of all hospital inpatient bed days. It is estimated that the treatment and care of those with long term health conditions accounts for 70% of the primary and acute care budget in England. Moreover, people with long term health conditions are likely to experience a lower quality of life (Department of Health, 2010c), including the need to manage pain. Current methods of pain management rely on drug or therapy based treatments both of which are expensive and do not necessarily help support individual lifestyles and aspirations. Drugs can also have unpleasant side effects. With increasing numbers of people with LTCs and financial pressures on the NHS, a different approach to the management of pain is needed (Department of Health, 2012a).
Innovation: Ideas, criteria, levels and added values

This case study illustrates a new approach to the treatment of long term health conditions, and specifically persistent pain. It is based firmly within UK policy, which promotes that health professionals provide self-management support for people with long term health conditions (Department of Health, 2012a).

An innovative NHS pain management service has commissioned a digital self-management service provider to deliver an integrated and ongoing self-management support system to its patients. The self-management support package is available to users at home via the internet.

There are three particularly innovative aspects about the service:

The use of digital technology in healthcare:
The project shows an innovative use of digital technology to provide a sustainable solution to care of people with long term health conditions; the online programme is used at home, outwith and beyond appointments with the clinical service, and is embedded within a local network/community of other patients with a similar condition.

Enhancing patients’ self-management skills:
The project works to embed self-management support within a mainstream health service. It aims to build patients’ confidence to self-manage, to improve patients’ health outcomes, to change the way patients interact with health services from being a passive, dependent patient to becoming active and engaged, to reduce patients’ dependency on medication and services, and to improve their health outcomes and quality of life.

Integration of an independent sector provider within the National Health Service:
The project involves the engagement of an independent sector digital self-management support provider working with a National Health Service provider to co-produce the service.

This service is very new. Figures for the three months from 01.09.12 and 01.12.12: 42 patients from SPMS were signed up and actively engaged in KYOH; 33 of these have visited KYOH more than once, with 4 visiting more than once a week; 12 have engaged in on-line community conversations.

Agents of Change
The main player in developing the SPMS into an integrated service, of which KYOH is a part, has been with the clinical manager of the service. KYOH is a social business which was developed by a group of digital designers and communications experts to offer self-management as an online resource.
5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of organization</td>
<td>September 2011</td>
</tr>
<tr>
<td>Type of organization</td>
<td>National Health Service working with a social enterprise business</td>
</tr>
<tr>
<td>Financing</td>
<td>NHS</td>
</tr>
<tr>
<td>Size of the organization</td>
<td>The SPMS has 4 full time and 8 part time staff plus administrative support.</td>
</tr>
<tr>
<td>Members and participation</td>
<td>Part of the National Health Service in England (Taunton &amp; Somerset NHS Foundation Trust). ‘Know Your Own Health’ (KYOH), an internet based self-management platform for patients with long term conditions</td>
</tr>
<tr>
<td>Contact</td>
<td></td>
</tr>
<tr>
<td>Name of the innovative example</td>
<td>Digital Healthcare - Internet based Self-Management.</td>
</tr>
<tr>
<td>Homepage</td>
<td><a href="http://www.kyoh.org">www.kyoh.org</a></td>
</tr>
</tbody>
</table>

Patients with long term health conditions spend much time in their daily lives taking care of, or self-managing, their condition. Health professionals can help patients to learn how to better do this and to make active decisions that improve their quality of life (Health Foundation, 2012). This type of support for self-management aims to increase the confidence and ability of patients to self-manage, through the provision of necessary knowledge, skills and confidence (Department of Health, 2005).

The SPMS provides support for self-management for people living with persistent pain and who are referred to the service by their General Practitioner, Consultant or Community Health Professional. The service aims to help its patients to live with their pain, to manage its consequences, and to encourage them to take active steps to improve their quality of life (Musgrove Park Hospital, 2007). The SPMS is a multi-disciplinary team of specialists in pain management, which include consultants, nurses, physiotherapists and clinical psychologists. People referred to the service are offered a number of clinical appointments and options of referral to other services such as therapies, pain management courses, self-management resources and clinical psychology as appropriate.

In order to extend the support for self-management that it can offer, SPMS has partnered with KYOH, a digital self-management support system, which provides users with a range of online tools and techniques to encourage and support self-management. (Worth, 2012). KYOH offers its users a range of facilities to support their self-management (see www.kyoh.org). For example:

- users can search the internet for validated information relevant to their condition and can save and organise any information they find particularly helpful;
• users can identify and track aspects of their health which they consider relevant to the management of their condition. For example, a user may choose to track levels of pain, mood, exercise, and alcohol consumption. A recording of the level of each aspect can be made, and graphics created which correlate one aspect against another, to show which factors appear to impact on level of pain. Such tracking allows users to better understand the factors they can influence which impact on their pain;
• users can create a personalised action plan with individualised goals and can track progress towards those goals; users can access a telephone mentoring service to help them set goals and action plans;
• users can make online contact with a local network of other patients who are managing the same condition, in order to share experiences and gain support;
• users are provided with access to information about local support services which may be of interest to them;
• users can access evidence-based online and small group self-management courses

The SPMS introduces its patients to KYOH within the clinic setting. Patients then work with the KYOH system between appointments and after discharge from the SPMS, thus providing on-going and long term self-management support. KYOH has worked closely with SPMS clinicians and patients to ensure that the on-line service is locally relevant.

Relevance to EC

All countries within the EC are dealing with an increase in long term health conditions in their populations. Many people with long term health conditions are becoming more expert in managing self-support, others would want to be able to do so. Supporting self-management in long term health conditions could result in people accessing supports which are directly useful to them and thereby reducing dependency on formal services and wasted healthcare costs. There is evidence of self-management support being successful, particularly when support for behavioural change and self-efficacy is provided. Impacts have been shown on attitudes and behaviour, quality of life, clinical symptoms and use of resources (de Silva, 2011). The KYOH on-line portal is developed to be locally relevant, so could be applicable both to different disease conditions and different localities.
6. References


Service for Adults with Persistent Pain. Right Care Casebook Series. England: NHS.


Department of Health (2010a) Generic Long Term Conditions Model. Available at:

Department of Health (2010b) Quality, Innovation, Productivity and Prevention programme (QIPP). Available at:

Department of Health (2010c) Ten things you need to know about long term conditions.
Available at:


Eurostat Newsrelease (2011b). EU27 population is expected to peak by around 2040. Luxembourg: Eurostat


Office for National Statistics (2011a) Summary: UK Population Projected to Reach 70 Million by Mid-2027. Available at: www.ons.gov.uk (Date of Access: 09.03.2013)

Office for National Statistics. (2011b) Table A2-1, Principal projection - UK population in age groups, 2010-based. Available at: www.ons.gov.uk (Date of Access: 09.03.2013)

Office for National Statistics. (2011c) UK Interim Life Tables, 1980-82 to 2008-10. Available at: www.ons.gov.uk (Date of Access: 09.03.2013)


Theoretically informed case study accompanying the film

Changing focus for a healthier old age - Denmark

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Roskilde University (RU)
Hanne Marlene Dahl, Kristian Fahnøe

WP Leader HAW Hamburg
Andreas Langer, Simon Günntner, Gemma-Dorina Witt, Kerstin Müller

QR-Code to the Homepage and video: QR CODE FEHLT
Link to the video: http://www.inno-serv.eu/vitality

This report is part of the research project „Social Platform on innovative Social Services“ (INNOSERV). INNOSERV investigates innovative approaches in three fields of social services: health, education and welfare. The INNOSERV Consortium covers nine European countries and aims to establish a social platform that fosters a Europeanwide discussion about innovation in social services between practitioners, policy-makers, researchers and service users. This project is funded by the European Union under the 7th Framework Programme (grant agreement nr. 290542).
1. Changing focus for a healthier old age - Elderly care in Denmark

The target group includes elderly people in need of elderly care. Care is provided in their own homes by paid care workers according to a new principle satisfying old needs: help-to-self-help. This is not always easy to implement due to resistance of elderly and time strain on behalf of the care workers, wherefore ambassadors within the service organization ensures the realization of this principle.

Specific innovative elements of Changing focus

Help to self help
This idea concerns the content of the service i.e. what is being done. It’s not a new service but a new way of doing it. Providing the elderly with enabling help (help to self-help) rather than compensatory help in their own home aims to improve or maintain the elderly person’s independence and life quality as well as reducing demands for services in the short and long run.

Street level ambassadors
This idea concerns how the change is implemented through the use of ambassadors that promote the philosophy and practices of help to self-help among their co-workers during their work. The aim: to implement help to self-help throughout the organization to make it a lasting change

Key characteristics of the service

Organisation:
The municipality of Høje-Taastrup is responsible for the provision of home care and nursing homes. The elderly care is provided by the health and care centre (‘Sundheds- og Omsorgscentret’) which are responsible for delivering services to approximately 1600 elderly citizens.

User groups:
The users are primarily elderly people both living at home and at nursing homes. They are typically above 70 years.

Employees:
The majority (more than 90 per cent) of the employees are trained as social and health care professionals as well as social and health care assistants which are educations lasting respectively one and half year and three years.

Principle: Re-ablement / help to self-help
The core principle is to implement and maintain a care that involves the elderly citizen in the work rather than being passive. Thereby maintaining or improving the citizen’s functional capacity. The elderly either does some task together with the care worker or there is a division of labour between them. The care worker and the elderly either do the dishes together or alternatively, the care worker vacuum cleans the home and the elderly dusts off.

Driver(s): Economic challenges and users’ expectations
The particular form of service was introduced by the Municipality in 2007. The immediate drivers to implement the help to self-help were the need to address economic challenges due to the expected demographic changes and the increased service user’s expectations due to new, demanding generations. Thirdly, the Municipality reacted to evidence indicating physical activity as having a positive effect on the quality of life of elderly people (Sundhedsstyrelsen 2011).
Factors influencing Social Services Innovation

Drivers
- Structural weakness of the system:
  - Standardisation of care
  - Care seen as a task
  - Increasing demands for documentation taking time from actual care

Challenges
- New demands from user increasing service user expectation

Response: Changing focus for a healthier older age
- By implementing help to self-help throughout organisation
- Cooperation: care worker and elderly
- Implement & maintain care that involves elderly citizens
- Using 'ambassadors' to promote the philosophy: practice (help to self-help)
- Core principle: activation; "empowerment"

Agent of change
- Trigger for change structural reform of the local government
- Project to improve elder care

Quality
- Economy: Positive economic effects seem to depend upon the previous level of expenditures within municipality

Sustainability
- Users: Health and quality of life; concrete positive effects are identified within local study (done by municipality)

Novelty
- New practice for old needs
- The new practice consists of both the new form of service and of delivery
### 2. Policy Framework related to long term care in Denmark

<table>
<thead>
<tr>
<th>Principle/ Guidelines</th>
<th>Key organisations and actors</th>
<th>Services provided by government</th>
<th>Expenditure, Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Universalism:</strong></td>
<td>- The organizational structure of the public welfare system has three levels: the state, the region and the municipality. The state: The legal framework is passed by the parliament. While the government negotiating the economic agreements with the national association of municipalities (KL) and negotiates the level of autonomy with the municipalities (Finansministeriet, 2005). The municipality: is responsible for funding and providing the elderly care. It determines through quality standards the levels of provision. Private providers: provide services that are funded by the municipality. The private providers provide services to a growing share of the service users. The trade union FOA which organizes the care workers in both the private and the public sector. FOA and KL negotiate the collective bargain agreement that allocates funds for in-service training such as the training for ambassadors. Vocational training programmes (Social- og sundhedsskolerne): are responsible for the education of the majority of the care professionals. The User organization Ældre sagen (DaneAge Association): is a strong interest organization that safeguards the elderly peoples’ interests. Volunteers are not involved when it comes to the provision of elderly care as practical assistance and personal care. Burau and Dahl, (2013)</td>
<td><strong>Legal milestones:</strong> - The Social Service Act - The structural reform (2007) - The introduction of free choice of service provider (introduced in 2003) <strong>Service area characteristics</strong> - 165,860 elderly people get elderly care at their home (Danmarks Statistik 2012a:2) - 34,700 elderly people get elderly care at assisted living facility and 7,200 in nursing homes (Danmarks Statistik 2011a:1). The provided elderly care includes practical assistance and personal care.</td>
<td><strong>Costs involved in the nursing and care sector</strong> 1,68% of GDP (2008) <strong>2. Financing of municipal services</strong> The services are financed in two ways: through block grants from the state and local taxes that the municipality decides</td>
</tr>
<tr>
<td><strong>2. Decentralized Delivery:</strong></td>
<td>Municipalities are responsible for the provision of services e.g. pre-school care and elderly care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Free choice of provider:</strong></td>
<td>Service users have a free choice between public and private providers under contract with the municipality. The free choice contains a structural bias where citizens can buy additional services with the private providers on top of the one’s assessed.</td>
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</tbody>
</table>

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*INNOSERV - WP 7 Theoretically informed case study accompanying the visualisation*
3. The social, political and institutional context

3.1 Population/ Government

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population:</td>
<td>5.534.738</td>
<td>501.104.164</td>
</tr>
<tr>
<td>Population projections 2010-2050</td>
<td>6.037.836</td>
<td>524.052.690</td>
</tr>
<tr>
<td>Proportion of population aged 65-79 years:</td>
<td>12,2%</td>
<td>12,7%</td>
</tr>
<tr>
<td>Proportion of population aged 80 years and more:</td>
<td>4,1%</td>
<td>4,7%</td>
</tr>
<tr>
<td>Proportion of population aged 65 and over:</td>
<td>16,3%</td>
<td>17,4%</td>
</tr>
<tr>
<td>Old-age-dependency ratio (15-64 to 65+)</td>
<td>24,9%</td>
<td>25,9%</td>
</tr>
<tr>
<td>Projected old-age dependency ratio (2050)</td>
<td>41,79%</td>
<td>50.16%</td>
</tr>
<tr>
<td>Life expectancy at 60 (2009) in years: male/female</td>
<td>20.6 years / 23.6 years</td>
<td>21.1 years / 25.1 years</td>
</tr>
<tr>
<td>Expenditure on social protection (% of GDP) 2009</td>
<td>33,44%</td>
<td>29,51%</td>
</tr>
<tr>
<td>Expenditure on care for elderly (% of GDP) 2008</td>
<td>1,68%</td>
<td>0,41%</td>
</tr>
<tr>
<td>Pension expenditure projections (% of GDP) 2050</td>
<td>9,6%</td>
<td>12,3%</td>
</tr>
</tbody>
</table>

3.2 Information about the specific welfare state: Denmark

The Danish social service system is based on a classic Nordic welfare model that combines universalism and local autonomy (Burau and Dahl, 2013), where the majority of social services are provided by the municipalities. Firstly, this implies that citizens have a needs based access to benefits and services and that the elderly care services are free. Denmark is seen as the most universal in elderly care amongst the Nordic countries (Szebehely, 2003; Sarasa and Mestres, 2007). Secondly, as the local authority the municipalities are responsible for the provision of the elderly care as well as assessing the needs of the citizen. With 1, 68 % of the GDP the public spending on elderly care are relatively high compared to other countries within the EU. However, the system of long term care in Denmark continues to perform favorably in comparison with other countries (Sarasa and Mestres, 2007). The social services including elderly care are financed through taxation both national and local. There is a steadily increase of expenditure in social services, that shows the growing importance of services compared to economic transfers. The table below presents the social protection expenditure of selected countries.
Social protection expenditure: Aggregated benefits and grouped schemes in Mio. of Euro.

<table>
<thead>
<tr>
<th>Time</th>
<th>Expenditure for social protection benefits in Euro</th>
<th>Expenditure for social protection benefits in Euro</th>
<th>Increasing benefits in kind</th>
<th>Part of benefits in kind of social protection benefits</th>
<th>Part of benefits in kind of social protection benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU 27</td>
<td>/</td>
<td>3.605.678,95</td>
<td>/</td>
<td>/</td>
<td>34,07%</td>
</tr>
<tr>
<td>Denmark</td>
<td>45.334,15</td>
<td>78.367,78</td>
<td>102,60%</td>
<td>34,13%</td>
<td>40,00%</td>
</tr>
<tr>
<td>France</td>
<td>379.396,42</td>
<td>654.238,65</td>
<td>84,47%</td>
<td>31,94%</td>
<td>34,17%</td>
</tr>
<tr>
<td>Germany</td>
<td>565.683,07</td>
<td>765.717,82</td>
<td>52,53%</td>
<td>30,79%</td>
<td>34,69%</td>
</tr>
</tbody>
</table>

Source: Own calculations based on EUROSTAT 2012

4. Challenges and Drivers of Innovation

Structural weaknesses of the system:

- Since the late 1990’s a standardization of elderly care has taken place linking more directly the functional ability of the older person with categories of service provision (Burau and Dahl, 2013). This standardization of the assessment and provision has moved the focus away from the original principle of help to self-help due to its emphasis on care as tasks. Thus the standardization fails to take in to account the help to self-help which includes cooperation between the care worker and the elderly citizen as well as assistances in relation to specific tasks.
- Increased centralization due to tighter regulation by the central government leaves less room for professional judgment and care workers’ flexibility in relation to the needs of the individual service user (Dahl 2011).
- Increased demands for documentation of the work take time from the actual care.
- The coordination between the hospital sector and elderly care in relation to discharge from hospitals has proven to be difficult and involves conflicts between the different authorities on responsibility and timing of discharge. The structural reform has targeted this problem through various means (Dahl, 2007).
- Steadily increasing needs for care in an aging society and of expected increasing expenditures.

Innovation: Ideas, criteria, levels and added values
Changing focus for a healthier old age is about changing how care workers perform their work in order to transform compensatory help into re-ablement (help to self-help). The visualized case focuses on two innovative ideas in relation to this.
Help to self-help:
The first idea is help to self-help where the care worker either performs tasks in cooperation with the elderly citizen or they each do different complementary tasks. Further, the practice of help to self-help includes systematic training of the elderly citizen’s capabilities.

Street level ambassador programme:
The second innovative idea is the ambassador programme where the implementation of the practice of help to self-help is promoted at street level through a peer-to-peer support among the care workers. The ambassador programme is based on training a group of street level employees (care workers) as ambassadors. The training includes training in the methods of help to self-help and communication skills. The ambassadors are then responsible for the everyday promotion of the methods and the philosophy among street level staff as well as the elderly citizens.

Drivers and Challenges
The immediate drivers behind the municipality’s decision to implement the help to self-help was on one hand the need to address economic challenges due to the expected demographic changes where the old-age dependency ratio is expected to grow from 24,9 in 2010 to 41,79 in 2050 and the increased service users’ expectations that call for a more individualized service. And on the other hand the knowledge available indicating physical activity as having a positive effect on the quality of life of elderly people (Sundhedsstyrelsen 2011). Moreover, the structural reform of the local governments in Denmark in 2007 that meant that the municipality took over the responsibility for providing rehabilitation services made it possible integrate rehabilitation into the elderly care.

Challenges
The main challenges are to keep costs as low as possible, the coordination between the two sectors: hospitals and the municipality and to recruit street level employees.

Innovation as Response
The innovation is the new focus on training and maintaining capabilities of the elderly, so that they can perform as many tasks themselves instead of being dependent upon the care worker to provide them.

The street level ambassadors (ensures the implementation of the new principle by giving pep-talks, providing information and supervision. The service is taking place in the intersection between welfare (elderly care), rehabilitation (health) and training (education).

Novelty
The novelty is the implementation of the philosophy of help to self-help in the organization and its ways of providing service in the homes of the elderly (new perspectives). The new form of service and of delivery characterizes a new practice for old needs.

Quality
The quality of the service is characterized by the positive economic effects, the health and quality of life of the elderly (users) and by the positive effects upon the professional identity of the care workers (staff).
Agents of change
The immediate trigger for the change was the structural reform of the local governments in Denmark in 2007. A network of bureaucrats and politicians were the most important agents of change thinking in a new way and sticking to the innovative idea. The innovation took originally place in 2007-2009 and was later continued due to a favourable evaluation (Høje-Taastrup municipality 2009).

5. Key innovative elements of this example

<table>
<thead>
<tr>
<th>Field of service</th>
<th>Welfare, Health &amp; Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment</td>
<td>The municipality is a part of the decentralized government in the Danish welfare model, where the majority of social services are provided by the municipalities and has such it has a long history. The current geographical form date back to 1970 but the latest changes in relation to the services provided by the municipality provides were made in 2007. The introduction of the Changing focus a healthier old age practice was introduced in 2007</td>
</tr>
<tr>
<td>Type of organization</td>
<td>Politically governed public welfare provision</td>
</tr>
<tr>
<td>Financing</td>
<td>Publicly financed by taxation</td>
</tr>
<tr>
<td>Size of the organization</td>
<td>The health and care centre that provides the elderly care has 600 employees (75 of them trained as ambassadors)</td>
</tr>
<tr>
<td>Members and participation</td>
<td>1600 elderly people lives in the urban area, nearby towns and villages</td>
</tr>
<tr>
<td>Contact</td>
<td>Mariann Lyby</td>
</tr>
<tr>
<td>Name of the innovative example</td>
<td>Phone +45 43 59 10 00</td>
</tr>
<tr>
<td>Homepage</td>
<td>Email address: <a href="mailto:sundhedomsorg@htk.dk">sundhedomsorg@htk.dk</a></td>
</tr>
<tr>
<td></td>
<td>Homepage: <a href="http://www.htk.dk">www.htk.dk</a></td>
</tr>
</tbody>
</table>

Høje-Taastrup municipality is one of Denmark's 98 municipalities. The municipality is located in the outer edge of Greater Copenhagen and consists of both an urban area (a suburb to the greater Copenhagen area) and more rural area. The population is approximately 50,000 people. Høje-Taastrup municipality is governed by the city council that consists of 21 elected representatives including the Mayor. The municipality's Health and care centre provides the elderly care to approximately 1600 elderly people that live in the urban area, the nearby towns and villages. The centre has approximately 600 employees and 75 of them are as of September 2012 trained as ambassadors for “changing focus for a healthier old age”.

Help to self-help emerged as a policy principle in the 1980s (Dahl 2000) and has been a principle in the training of professional care workers for nearly twenty years. However, like other municipalities (Swane 2003) Høje-Taastrup has encountered difficulties of implementing the principle in practice. These difficulties stem partly from the political and bureaucratic focuses on standardization of care work and on economic efficiency in a narrow sense not seeing the benefits of help to self-help. Further, the implementation has been impeded by ongoing organizational changes - a tyranny of change (Clarke and Newman, 1997) - in the Danish public sector which to some extent have made street level employees exhausted.
Høje-Taastrup municipality decided to overcome these encountered difficulties through organizational changes. The ambition was two folded: to enhance self-sufficiency and improve the life quality of the recipients of elderly care and to improve economic efficiency. The immediate trigger for the change was the structural reform of the local government in Denmark in 2007. The structural reform of the local government addressed issues of coordination between the hospitals at regional level and the elderly care at municipality level. The reform meant that the municipality took over services that had previously been provided by the regions. Among these service was rehabilitation. One hand the reform accentuated the need to address the expected increase in public spending (due to both the demographic changes and rising expectations related to post-modernity). On the other hand the takeover of rehabilitation services provided an area where the staff qualifications could be extended to other fields such as the elder care. In other words the rehabilitation services served as launch pad.

In order to overcome the difficulties of implementing a help to self-help based care the municipality successfully applied for state funding amongst others from the Department of Social Affairs for a project to improvement of elder care. The project ran originally for two years (2007-2009) and focused on how to make lasting organizational changes. The project centred its work on promoting the ideal of self-help and produced knowledge on how to practice help to self-help as well as how to implement lasting organizational changes. The most significant knowledge to come out of the project was that the organizational changes had to be rooted locally rather than in a specialized unit or in a top-down organization. The “ambassador programme” provides such an approach to the organizational changes. The ambassador programme is in itself innovative in relation to implementing enablement (help to self-help) at a street level. The trained ambassadors promote and maintain the use of the methods among their peers through motivational talks, competent feedback and professional discussion in relation to the everyday work.

The elderly care as help to self-help also entails a newness in the service provided. Firstly, the form of service is new in regards to the close connection between the provision of elderly care and the training and maintaining of the elderly citizen’s capabilities. The close connection consists in the fact that training is incorporated in the performance of the care tasks. Secondly, the delivery of the service is new in the sense that the service delivery is based on a dialogue between the care worker and the elderly citizen about what care the citizen wants and needs and that the service is delivered in collaboration between them. Such collaborations could be that the care worker assists the elderly person in dusting off or they divide the care/work between them. Both these aspects are vital part of the way the service meets unmet needs and provides better solution to old needs.

This practice has had positive effects. While, it has been difficult to show economic effects changing focus for a healthier old age has had positive effects on the quality of life of the elderly due the more active and self-sufficient life. The evaluation of the initial project showed that the 43 % of the elderly receiving home care and 53 % of the elderly at the care homes were less dependent on help after 6 months. The evaluation also showed that 46 % of the elderly receiving home care and 53 % of the elderly at the care homes experienced and improved health related quality of life (Høje-Taastrup municipality 2009). Thus, it has to some extent been possible to rehabilitate elderly citizens to a degree that they regain their earlier functional capacity.
Although the practice is set in a Nordic welfare system with publicly financed elderly care it can be transferred to elderly care in other European contexts. This is about how care is provided, not which institutional context is responsible for the care.

6. References


INNOSERV - WP 7 Theoretically informed case study accompanying the vizualisation


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