CONFERENCE PROCEEDINGS

Why Train and Qualify Experienced Social Care Workers?

Edited by
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University College Galway, Ireland.

Why Train and Qualify Experienced Social Care Workers?

Proceedings of a Conference on Training and Qualifications in Social Care

December 3rd 1994

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Introduction

Catherine Mc Nelis
Conference Organiser

In May 1990, following an approach from a community group, University College Galway began investigating the possibility of providing an accredited course for Social Care Workers. A survey of Social Care Workers and their employers was conducted in 1992. Following the positive findings of this survey and with financial assistance from the E.U. Initiative New Opportunities for Women (NOW), the first cycle of the Certificate / Diploma in Social Care commenced in September 1993.

The Certificate / Diploma in Social Care is provided under the auspices of the Department of Health Promotion, and Adult and Continuing Education. The Social Care Team responsible for the delivery of the course has been: Director – Orla O'Donovan and Course Tutors – Genevieve Becker, Terry Connors, Ann O'Kelly and Catherine Mc Nelis. In 1993 the course was offered at centres in Ennis, Galway and Sligo, thus covering the three western health board areas. Two further classes were added in Galway and Roscommon in October 1994, bringing the total number of students undertaking the course to 136.

It was at this stage with a proven demand for social care training that it was decided to host a conference which would explore preferences, requirements and possibilities for the training and accreditation of experienced Social Care Workers. This conference supported also by the E.U. NOW initiative was held in the Cairnes Theatre, University College Galway on December 3rd 1994. Contributions to the conference came from those involved in the delivery of social care training in the Netherlands as well as in Ireland, from the employers of Social Care Workers, and from the Carers themselves. I am grateful to each of these contributors for their actual presentation on the day

and also for providing me with a draft of their presentations for publication. I am also grateful to the chairpersons of the three sessions Prof. Gearóid O'Tuathaigh, Seamus O'Grady, and Professor Gerry Loftus for their important contributions and management skills on the day. With the publication of these proceedings, it is hoped that not only will the formal work of the conference be recorded and reach a wider audience, but that it will also contribute to the debates concerning community care and the conditions of Carers both formal and informal.

During the college year 1994/'95 the Certificate in Social Care has been developed as distance education materials, and with the assistance of the County Roscommon Vocational Educational Committee and Tommy Murray in particular, piloted with students in County Roscommon. The development of such materials is intended to overcome some of the barriers to training experienced by informal Carers in particular, and to make such training accessible to many more groups and individuals. In the college year 1995/'96 it is intended to offer the Certificate in Social Care – Distance Education to Social Care Workers in each of the health board areas.

Ultimately the aim of the Diploma / Certificate in Social Care, this conference and conference proceedings, as well as all of the materials and documentation emanating form the course is to inform and assist all involved in the caring process to better serve the Carers and their clients.

Opening Address

Anne Taylor, Chairwoman
Council for the Status of Women

I am delighted to be here this morning and to have the opportunity to address you briefly as you begin your discussions on the important questions concerning the training and qualification of Social Care Workers. The fact that we now have a name for the many people – traditionally, overwhelmingly women – who carry out the vital care tasks in our community, is a measure of how society is changing and how the New Opportunities for Women (NOW) programme is underpinning the quality of that change.

When we talk about social care we are referring to a relatively broad range of tasks which ensure that our communities, and indeed our families, can provide an environment in which it is possible to live even if we are unable to take independent care of ourselves. This is not a new phenomenon – traditionally families have cared for older members or for someone who was ill or had a disability. More broadly within our communities, care for neighbours has also been common particularly, in smaller or close knit communities.

It is work which we have taken for granted, indeed expected of women. And as long as women were primarily based in the home, their identity primarily one of the Carer, then the system continued. It was not satisfactory. The very taking of this work for granted, ensured that it was effectively hidden in terms of its value as work. Hidden, it attracted little or no support, payment, holidays, relief or practical recognition.

Much is changing in our society, not least women. The change is not in our commitment to our family or our neighbours, to our desire to maintain our family and neighbourhood links, or our wish to have a cohesive and integrated community where young and old alike have

a place and respect. Nor are women interested in switching off from the very people centred model which has created the possibility that many people can expect to be cared for in their community at some point in their life.

What women want to see is far greater sharing of all of those features of our society which add greatly to the overall quality of our lives as individuals and as a community. We want the nature of the caring work recognised and acknowledged and necessary supports put in place so that it can be carried out to the highest possible quality.

All too often when we consider the question of caring, we consider the issues from the Carer's point of view, but it is also important to reflect from the perspective of the person who is being cared for. How many of us think that it is acceptable or appropriate that our care would lie with one person, that if we require continuous care, that that person would never have a break, a day off or perhaps even a holiday? And how many of us think it is acceptable that the person caring for us, perhaps providing us with our main or only human contact, should be given so little support or that their skills do not warrant development?

It is time to move on, to begin to recognise the valuable caring work in our community and to build on it. The University College Galway NOW Programme is a fine model for what can be done, and it is appropriate that this work has begun as the debate on the future of the health services is also underway. We have to see care in our communities as an integral element of, perhaps even a necessary foundation for, an effective health service.

Investing in social care can contribute to ensuring that scarce resources are used effectively and, most importantly, that people are given care in the most comfortable and most appropriate setting. Social care is valuable, but its value is seriously undermined if those we expect to carry out this work are disregarded.

Much of that disregard lies in the fact that caring work has been seen in the past as something which women have done almost as though they were born with the necessary skills. The idea of training simply did not enter into the equation.

Briefly, I want to set out the reasons why training is important and why an effective social care service, as part of a wider health and community care service, demands that the skills of those involved are maintained and developed. For those responsible for providing social care services, primarily our health boards, training is an invaluable means of creating high standards of care and to ensuring that the

skills of those involved are used extensively. Frankly it does not matter whether the Carer is working for a few hours a week or full time. The reasons for training still apply as they do, no matter what the nature of the caring work. Quality matters in every area.

University College Galway under NOW have developed a two year diploma course in social care. This course is run jointly the Departments of Health Promotion and Adult and Continuing Education in UCG. It is accredited by National University of Ireland. 84 women have been trained under this programme. Modules in the course also address the broad context of social care such as social policy. Training has been carried out in three locations, Sligo, Galway and Ennis. In addition, the project is developing Distance Education Materials which is being piloted in County Roscommon with the assistance of the Vocational Educational Committee there.

In many cases, Carers are working alone, often in isolation. Access to training can be valuable as a means of sharing information and gaining support as well as extending knowledge. The nature of the work of Carers demands a level of maturing and flexibility to respond to the needs of the person being cared for – training can be an effective means to increase the confidence as well as the skill of the Carer to do this.

As the health service moves towards a far more integrated approach, with the boundary between institutional and community care growing ever more blurred, the demands for social care and on the Carers will increase. Training programmes are essential if the service provision is to keep pace with the extent of the demand and the quality of care which people would be able to expect.

If we accept that social care is important work, then it follows that we will not only want our Carers to be well trained, we will want them to have training which is recognised, which leads to the question of accreditation. The provision within the Maastricht Treaty extending the involvement of the European Union into public health issues, provides an ideal springboard not only for the exchange of good models for care structures, work practice and training but also for the development of a European wide system of certification of training.

The NOW programme here in University College Galway with the development of the Diploma in Social Care, has helped to progress this and I hope that in the immediate future we will see the question of accreditation being addressed and resolved nationally and, in a European context.

I am aware that a number of health boards have piloted training, particularly in the Home Help area, but it is necessary that training for social care now receives the formality of a realistic budget allocation within every health board. It is also vital that the manner in which the training is made available, recognises certain realities such as the need for childcare and respite care, and utilises training methods which will reach those living in even the most isolated areas.

I think the childcare and respite care arguments are self explanatory – women who have full time caring responsibilities or who are formal Social Care Workers cannot participate in training if those responsibilities are not recognised and appropriate support provided. throughout the NOW Initiative, Childcare has received a high level of attention with models of childcare being developed which not alone provide the necessary service but also create employment opportunities. The issues underlying childcare and respite care policy have been thrashed out very extensively – the question now is one of political will, to commit resources.

NOW and many other European Union funded initiatives have also been at the forefront in developing training methods and systems of delivery. Distance learning clearly provides extensive possibilities for the development of continuous training and support for Carers and I would include in that a growing use of information technology as a means of delivering training and setting up new ways of linking people for support.

In less than a generation, technology has become part of our lives and I for one, refuse the notion that it is the source of opportunity for the next generation! As computer systems enter our homes, we must all be able to use their potential and to a degree, the motivation for doing so will be increased if we believe that they are relevant to us.

We may be some way from having a computer in every home, but in our schools and community centres, they are now a frequent feature. It should be possible to utilise such facilities for purposes such as training or information accessed through modem links. This, in the long term will be a crucial method of delivery of support and training to Carers working in isolated areas.

I have focused largely on the provision of training and its contribution to the development of Carers, to increasing skills and to extending the range and quality of social care which is provided in our community. I also want to say something about the importance of this development to people as individuals and to widening their horizons and opening new paths.

A first stage in that, and one which is also important to the formal provision of training, is the recognition of pre-existing skills and experience. All too often when work is unrecognised by society, not surprisingly, the people who are doing it can feel excluded and experience low levels of confidence and self-esteem. Training and support mechanisms are necessary to break this cycle and once broken, a great many people continue to pursue education and training opportunities. We are seeing a transformation of adult and second chance education driven in part by new training initiatives and by the extensive development of programmes by women's groups and community based organisations right around the country.

Increasingly the third level institutions, the social partners and the voluntary sector are coming together, new approaches to education, training and skills development are being formulated and the concept and structures of education for life are emerging.

Once the cycles of individual low self-confidence and rigid educational training structures are broken, the potential within individuals can be released. In every NOW initiative, the result of that potential are extensive and observable. The benefits are great to the individual, their work and organisation and to the community.

I am delighted that the Council for the Status of Women has been able to play its part in providing the Support Structure for the NOW Initiative. For years we have campaigned and lobbied for changes in policy to support the hidden work of women and, to open access to training and employment opportunities. NOW is one of the practical applications of that philosophy and it give us great pleasure to see so many women benefiting from it.

Furthermore, I thank the partnerships which have built up between women, training providers and employers, through NOW, will have a long lasting effect. People have to be committed to change if it is to be effective. Many of you here today can bring about that change through ensuring that Social Care Workers have access to the training, that not alone they deserve, but their clients should expect them to have.

Keynote Address

Dr. Ina Simnett
Centre of Health Planning and Management,
Keele University, England.

The information in this paper is based on ideas discussed in more detail in my book: Simnett, I. (1995) *Managing for Better Health: A Practical Guide*, London: John Wiley and Sons.

Summary

The paper starts by discussing why we need to train Social Care Workers, and suggests that we need to improve the quality of social care so that we improve the well-being and quality of life of both those we care for and of those who care. It discusses how we might do this and why it will mean increased attention on the training and development of carers. It moves on to outline developments in training in the health and social care field in the UK, and why open learning is likely to have a big part to play in the future. It ends by discussing some of the challenges open learning poses for the learner, and makes some suggestions about what you could do to ensure that your learning is effective, not only for your own development, but for the development of those you care for, and for the development of the organisation you work for and colleagues you work with.

Managing Services and Organisations for Quality of Life Gains

One important trend we are now seeing is an emphasis on the management of health and social care: managing for results (making sure we reach the targets agreed), and on providing high quality health and social care services. At the heart of managing health and social care is the outcome we desire: improved quality of life. Achieving it involves working through a cycle, or spiral (since, hopefully, as gains are made an uplifting spiral will be created and

the starting point each time will be at a point where well-being has improved). This spiral is the management tool for controlling the outcomes of health and social care. It is illustrated below.

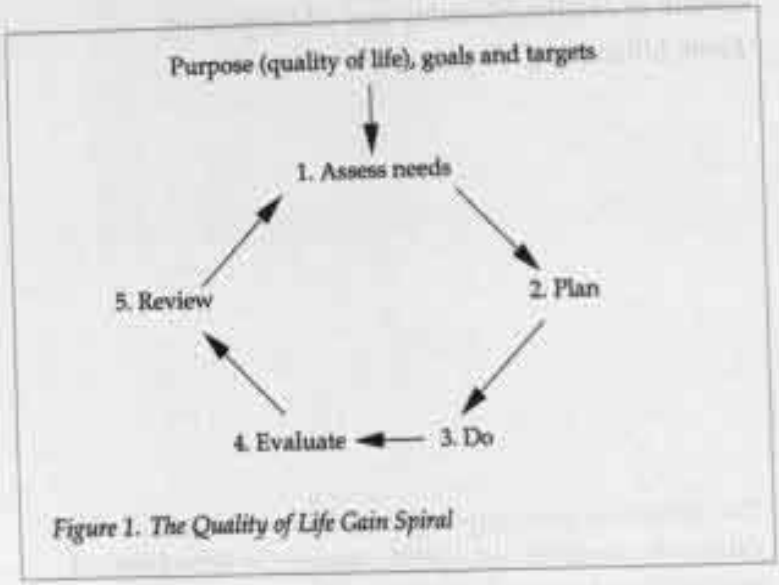

Figure 1. The Quality of Life Gain Spiral

The spiral involves five major stages:

Stage 1 Needs assessment (what are the areas for investment in health and social care in order to make quality of life gains? How can the needs best be met?);

Stage 2 Planning (What do we want to achieve? How are we going to achieve it? How will we know if we are succeeding?);

Stage 3 Implementation ('doing' the planned work);

Stage 4 Evaluation (showing whether we are on track, measuring the gains);

Stage 5 Review (How could we improve? What do we do next?).

This cycle or spiral may look 'scientific' but it actually involves making a number of value judgements, because it means juggling competing pressures and constraints on what is actually possible in practice. So, for example, the different views about needs, priorities and how to improve practice. In addition, it is not possible to make huge shifts in the sort of activities which are funded overnight. Hospitals and institutions cannot be closed down quickly; and developing effective social care and health promotion measures may involve considerable research and development work to get it right. Last, but not least, in order to improve quality of life we need to know about what it is that makes life top quality, since this may not be the

same as what makes a poor quality of life. On the whole, we know a lot about the latter (poverty, unemployment, discrimination, ignorance, etc.) but we don't know so much about what makes people have top-quality health and well-being (and therefore, how best to promote it).

Financial profit or loss is the yardstick to assess a company's progress in the commercial world. Quality of life gain is the equivalent for all the organisations playing a part in health and social care – the fundamental tool of management which measures our achievement of our common purpose.

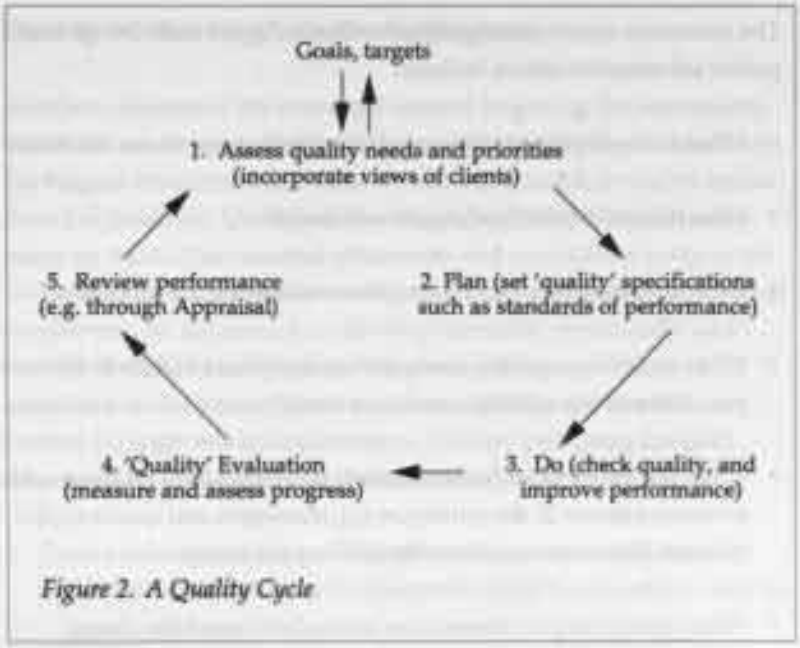

Figure 2. A Quality Cycle

In the same way, that managing for quality of life gains for clients involves completing a cycle, improving the quality of care involves completing a parallel quality circle (see Figure 2). One way to do this is through setting up quality circles. Whichever way you start it is the ideas of front-line workers and their clients which drive the engine of quality.

Quality Circles

Quality circles are 'action learning sets' (groups which meet regularly to help each other to improve work performance) which focus on improving the quality of the work of one particular function. They are one way of taking a bottom-up, staff-centred approach to quality improvement. Quality circles are 'natural' work groups of between three and twelve employees who do the same or similar work (the term 'circle' symbolises the fact that all the members of the group are equally valuable). They meet voluntarily and regularly to discuss and

find ways to improve quality. The aspects of quality they focus on are selected by the groups themselves and the outcomes are presented to management.

Quality circles work best where there are existing good relationships between managers and staff, and a sense of shared purpose. It is also important to note that the solutions to problems and suggestions made by quality circles, may have costs and managers must be in a position to meet these when appropriate. If the suggestions made by quality circles, which have costs, are always rejected, staff will quickly lose commitment.

The questions members of quality circles could ask themselves, and gather information about, include:

- What are we trying to achieve (what is the purpose of our function)?
- How do we know when we are successful?
- How do others (e.g. our clients) know when we are successful?
- What would top quality work, in our situation, be like? (what is our vision of top quality social care work?)
- What are the most important aspects of quality in to all those with a vested interest in the outcomes e.g. managers and local people/ clients? The views of clients should be paramount.
- What quality improvements can we make to meet the clients requirements more effectively and to move closer to our vision of top quality?
- How can we demonstrate that we are succeeding? (e.g. by setting standards, or by introducing systems for making regular checks on quality and continually improving quality).

Typically, a quality circle will:

- Begin by drawing up a list of issues for consideration, using techniques such as brainstorming. (Brainstorming is a way of opening up a subject and collecting everyone's ideas without comment or criticisms).
- Select the quality issue to be addressed.
- Gather and analyse, information about the nature of the quality need.

- Generate a range of proposals to improve quality, and establish the best options or combination of options.

- Prepare a report on their processes, findings and recommendations, for decision by management.

Quality circle members will often need training to carry their activities, such as training in how to identify key questions, in interviewing techniques (so that they avoid asking leading or ambiguous questions) and training in questionnaire design and analysis.

Quality of Working Life for Employees

Another outcome of the increased interest in getting the best results out of the resources available, is the realisation that in public services, the biggest investment is in human resources, and it is vital to realise their full potential. Quality of Working Life (QWL) is an initiative taken by ACAS (the national arbitration and conciliation body in the UK, which mediates to resolve disputes between employees and their employers). Its approach is to develop mentally, emotionally and socially 'healthy' workplace policies and practices, and thus contribute to the primary prevention of mental and other illnesses created through workplace stressors. The key principles for QWL organisations and institutions are that ideally jobs should:

- Form a coherent whole, so that performance of the job makes a significant contribution to the outcomes of the intervention or service.

- Provide some variety of method, location or skill.

- Allow for some discretion and employee control in the way the work is done.

- Include some responsibility for outcomes.

- Provide opportunity for learning and problem solving.

- Be seen as leading towards some form of desirable future.

- Provide opportunity for development in ways the individual finds relevant.

Organisations are working to do this through:

First, a *strengthening of team working*, and a weakening of formal units (such as functional departments, sections, etc.), narrow

specialisms and professional divisions within the organisation. Staff will begin to see themselves as primarily members or leaders of a number of teams (or task forces), with goals shared by each team. Staff may still have a line manager, but that manager will have more of the characteristics of a facilitator, coach and guide, and fewer of the characteristics of a traditional 'boss'. Some teams will be created for specific time limited projects, others will have continuing responsibilities for particular programmes, services or activities. Each team will require a designated team-leader, and for project purposes this will be the 'best' person for the job, so that project teams could be led by individuals who are junior in pay and grading to other team members. Teams will often cross departments and professions or even cross organisations, in partnerships. It will be important for team leaders to select the right blend of skills for the task concerned.

Second, *teams are semi-autonomous*, and responsible for continuously improving the quality of their work. 'Right first time' is the operating principle of continuous quality improvement, secured by delegating responsibility for designing appropriate quality improvement systems to the teams, and through ensuring that teams are developed and have the skills and capabilities to perform their tasks. Teams are thus accountable for both the processes and outcomes of their work. They invest time on team building and team development, as well as on the individual development of members, drawing as far as possible on their own resources. The autonomy of teams ensures that work is not held up by having to refer decisions up a management hierarchy. It is particularly important for effective joint working across a number of organisations.

Third, the management structure above the team level is reduced (flattened). So, a typical organisation might have a structure something like the one in Figure 3.

Figure 3. A Flattened Organisational Structure

Under this sort of arrangement, the Management Board (or its equivalent) is responsible for high-level scanning, for enabling the development of policy and strategy and for agreeing priorities, in the light of policy guidance from higher authorities, such as the government, and through agreements based on working in social care partnerships with other organisations at local level.

Team leaders include *programme* and *project co-ordinators*, such as co-ordinators of 'healthy lifestyles' projects, involving joint working by organisations such as social services, local media and voluntary agencies. Other team leaders provide leadership of continuing services, such as QWL residential homes for people with mental health problems, or QWL community care services.

Quality Management of People

Supervision is an interpersonal process through which people are helped to improve work performance. It is a key aspect of *managing people* as opposed to managing money and material resources. Most of money invested in health promotion, is invested in people. The people management aspects of health promotion management are thus crucial. Yet the people management systems are often incomplete and fragmented. Good people management involves completing a people-oriented version of the basic quality cycle. It begins with setting and communicating business goals (defining the purpose of an organisation) and then involves developing people to meet these goals through:

- defining the purpose of each job, and thence the required goals, objectives, targets and standards of performance;
- supervising performance through interpersonal discussions, focusing on congratulating successes and on identifying steps to be taken to improve performance when required;
- implementing the development steps and thence the improvements in performance;
- review (appraisal: Have the targets and standards been reached? What do we need to do next?).

These stages are set out in cyclical form in Fig. 4. The *Investors in People Standard* has been developed by the Employment Department in England, to encourage employers to be effective in human resource development and to improve people's performance through setting and communicating business goals and developing people to meet these goals. The standard is based on national criteria and reflects good

practice in training, development and organisational management, and hence gives assurances over the quality of the organisation to employees, potential employees, customers and contractors.

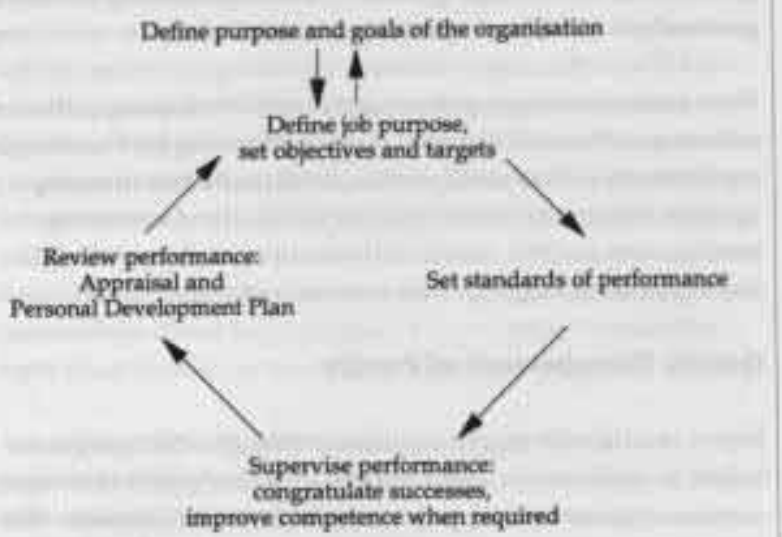

Figure 4. A People Management Cycle

Appraisal is a stock-take of the work performance of an individual (or a group of people), undertaken at an appropriate time in relation to their work activities (often on an annual basis), for the purpose of identifying what has happened during the previous period and what to do next (setting new objectives, improving standards of competence, etc.), including making a plan for the personal development of the individual or group concerned, in order to ensure that objectives and performance levels are achieved. Appraisal is thus the people management aspect of the review stage of the quality cycle.

Appraisal and supervision are both needed to complete the people management cycle. Often, however, managers attempt to implement one part of the cycle without the other and the system then fails. For example, a manager insists on appraising staff who she has failed to supervise. She then lacks insight into their work and their performance and is in no position to congratulate or to help and support further improvements. In fact she has not been there when she was needed and anything she says will have little credibility with the staff concerned.

There are some important reasons why managing people is often so badly handled. First, in our culture, we can have poor role models: parents and teachers and other powerful people in our childhood

often ignore our achievements and only comment when we do something wrong. We can be constantly judged for our mistakes but rarely praised for our successes. So, managers who behave like this are only copying what they have learned, it is not that they are 'bad' people. Another reason, is that in the past, they were 'kite-marked' as competent at their job for ever. So, if they fail to perform satisfactorily, they must be to blame! If they have training or development needs, this must be an admission of failure! Nowadays, in times of continual change, the nature of jobs is constantly changing, improved ways of working are constantly being discovered through research and the application of new technology, and constant learning and development is essential for everyone. Managers must therefore find new ways of relating to their staff, in order to reduce these barriers to high quality work of performance. Supervision should not be limited to helping *individuals* to monitor and learn from their own performance. *Teams, departments and whole organisations* need to be important, therefore, for all organisations, departments and directorates, etc. to have policies on supervision and appraisal (i.e. on how to manage people), which clearly state:

- *Why* supervision and appraisal are important (to ensure quality of work performance; to improve staff motivation and morale; to ensure quality is continually improved; to improve teamwork; to develop the whole organisation).

- *Who* should receive supervision and appraisal from *whom* (for example, staff from line managers, trainees from supervisors, professionals from more senior professionals, teams from team leaders and each other, whole organisations from their executive board, peers from each other, etc.). Mechanisms are needed for *upward* appraisal (appraisal of senior managers and team leaders by more junior staff), as well as top-down and sideways appraisal (co-appraisal by peers).

- *When* and how frequently each should happen.

- *How* they should be carried out – what sort of approach (a developmental one rather than a judgmental one). Supervision and appraisal should be empowering processes, liberating staff to develop their skills to 'do things better' and to enhance their contribution to the organisation ("do better things").

- *What* they should focus on – personal and organisational development.

- *How* training will be provided for all concerned. Enhanced communication skills are essential.

Developing the Potential of Social Care Workers

Operating within a 'flattened' organisation will bring improved job satisfaction to staff. It will, however, need better identification of the skills, knowledge and attitudes required by front-line staff, and better identification of the means of developing them, so that business objectives are achieved. This will mean prioritising training and development and taking steps to assure the quality of staff development activities.

For individual members of staff, training and development could bring a number of benefits, such as increased morale and self esteem, a sharing of problems and development of a shared sense of purpose, reduced stress through the opportunity to reflect and gain a better sense of perspective, a better understanding of the role of others, and increased commitment to the key purposes of the organisation. All these benefits are in addition to the actual acquisition of new knowledge and skills, which themselves will increase confidence in the ability to change and develop in a fast-changing world!

One of the most obvious ways to develop staff is to provide them with opportunities to attend courses and there is an increasing range of health promotion and education in-service education and training (INSET) courses available locally, in a range of learning modes such as full-time, part-time, college based or open learning. However, courses are not the only 'route to heaven' (becoming better at social care) and in many cases are not the most effective alternative to choose from, in a wide range of options (I explain this statement in the next paragraph).

What organisations need to make the best use of their staff is a system which links the individual personal development plans of staff with the well-being gains and quality of life goals and targets of the organisation. Once this is in place it is possible to empower individuals through individual-centred development: enabling individuals to take more responsibility for their own development and to be more effective in helping the organisation to meet its goals. In this way, the benefits to the individual and the benefits to the organisation can be simultaneously identified and justify the investment in the development of staff. Then personal development planning can drive the selection of the most appropriate development responses. The most effective responses bring development expertise *to* the organisations which enables it to develop at the same time as the individuals concerned. (Courses may not be the most effective responses because the person attending a course may develop and change, but the organisation may not change, and as a result the person may experience re-entry barriers to using their enhanced

abilities). The most powerful development responses (which act simultaneously on individuals and the organisation) include:

- Projects and research.
- Secondment to other organisations and 'shadowing' more experienced staff with social care experience.
- Action learning 'sets'. (Sets are groups of people who band together and meet regularly to share their learning experiences related to social care 'on the job'. 'Quality circles' are an example of action learning sets which focus specifically on quality improvement).
- The dissemination of good social care practice.

Some of these elements will often be built in to 'quality' training and open learning courses.

Most learning goes on in the workplace, so look at the way you do things – there may be better ways of doing them! Look at what works and also how it can be made to work better. This point is illustrated by the following story:

The Importance of Learning from Experience – a Story

A South American tribe kept pigs. One day a grass hut was accidentally burnt down. Inside a pig was tethered, and had come to grief. The smell of the charred meat was delicious and the people tried eating the burnt pig meat and liked it. So they deliberately burnt down grass huts with pigs tethered inside, and ate the meat. Soon they found that they had no huts to live in....

One of the most important tools for development, which is immediately accessible to any worker, is to set aside quality time to talk to colleagues, both individually, and as teams, in order to learn from workplace experiences.

Assessment of Standards of Competence

In the UK there is now a new national framework for vocational education and training managed through the National Council for Vocational Qualifications (NCVQ). These changes arose out of both the 'Review of Vocational Qualifications in England and Wales' (in 1983) and the government White Paper *Education and Training Together*.

The new qualification, called National Vocational Qualifications (NVQ's), is:

> *a statement of competence clearly relevant to work and intended to facilitate entry into, or progression in, employment and further learning, issued to an individual by a recognised awarding body.*

A competent person is someone who is able to:

- perform in a specified range of work related activities to a minimum, specified standard;
- cope with new working methods, employment patterns and practices in so far as these can be foreseen;
- transfer their skills from place to place and context to context (within reason);
- progress to higher NQV levels more readily than non-competent individuals.

Through the assessment of competencies, employees demonstrate whether they are competent to carry out particular activities. Thus the achievement of competence is based on *assessment* , not on whether a person has followed an agreed curriculum or syllabus of learning, or completed a course. Assessment is the process of gathering evidence about an individual's performance which allows judgement to be made about that person's competence.

There are two phases to the process. First, there is the collection of a portfolio of evidence, which comes from two sources: individual performance and a demonstration of knowledge and understanding. The second phase involves a judgement about whether the evidence meets the standards. Assessment usually takes place in the workplace. The system for making judgements is through work-based assessors and internal verifiers (provided within employment), monitored by an external verifier, appointed by the awarding body. The competence of the assessors themselves is assessed using the Training and Development Lead Body Units of Competence.

The body responsible for the development of standards of competence in the health and social care field in the UK, is the Occupational Standards Council for Health and Social Care, also referred to as the 'Care Sector Consortium' (CSC). In September 1992 the Health Education Authority established a three year project on 'Competencies for Professional Development in Health Education'. This is contributing to the work of the Occupational Standards

Council for Health and Social Care, in identifying competencies for the health promotion and health education work of a very wide range of professions. Adopting a competence based approach will bring many benefits and the key ones are summarised below.

The Benefits of Competence-based Assessment and Development

1. *Linking, training, performance and organisational development*
The published and agreed occupational standards of competence, which enable occupations as a whole to achieve their key purposes, also enable managers to develop strategic human resource plans for their unit or department. Thus, through a role mapping exercise, a manager can clarify the competence requirements for the operational work of a department, and therefore the staffing requirements in terms of competencies. Jobs can be re-designed, so that the manager's requirements in terms of clusters of competencies are met. Staff can be developed to meet competence 'gaps'.

2. *Recruitment and selection*
The recruitment and selection process is made easier. The job specification is clearer to both interviewers and candidates. Discrimination is avoided because objective standards are applied. Through identifying 'competence gaps' the training needs of new recruits are clear from the outset.

3. *As a basis for staff appraisal*
Because standards of competence are written, published and agreed, with performance criteria for assessment, it is clear what is expected of people in the work role and appraisal is, thus, more focused and more fair.

4. *For identifying and meeting training and development needs*
Within the context of published standards of competence, and performance criteria and evidence, it is possible for managers (and their staff) to assess the need for additional experience and/or education and training in order to develop particular competencies. The most appropriate 'learning opportunities' can be identified and incorporated into training and development plans.

5. *Improved quality of work*
Agreed National Occupational Standards for social care work will, when developed, provide quality benchmarks for delivery of social care. They will be, developed within the health and social care sector, by the sector, for the sector.

The competence-based approach helps managers and staff to exploit the full range of development opportunities, many of which can be provided 'on the job' through for example, coaching, secondment, delegation, action learning sets and projects.

All these developments help to minimise the time students are 'off the job' for training, provide more flexible training and development opportunities, and also help managers to assure the quality of the work performance of their staff. In a fast changing world, ensuring that staff are competent to carry out new roles is an increasingly important focus of the work of managers. The flexibility of open and distance learning means that it will have a key part to play, and therefore more often be the vehicle chosen. Staff and their managers control the personal development plan (the route), open learning provides a vehicle, linked to on-the-job work activities. Better quality of life for clients, and better quality of working life for staff, are the destination (the results we want). Because open learning is based on detailed learning materials, the quality of these learning materials is easily open for verification.

The key purpose of all the occupations working in the health, and social care sector includes health promotion at its heart. So, for example, the key purpose of health and social care has been defined as:

> *(to) enable individuals, families, groups and communities to optimise their health and social well-being balancing their respective needs with those of society as a whole and the resources available.*

This key purpose can be broken down into a number of functions and thence into the competencies required for each function. With respect to health promotion, the competencies required are about working with people to promote health in many different situations with a variety of different aims. To do this, knowledge of particular methods and special skills are necessary. These are not necessarily exclusive to health promotion work, but they are the core competencies of health promotion, which themselves are core competencies for all health and social care workers. ('Core competencies' is a term used to refer to those which are common to a number of different occupations).

The standards of competence for work in health promotion are not yet published. However, in the meantime there is much benefit to be gained by identifying your own health promotion role. For a current analysis of the core competency areas of health promotion work, see Ewles and Simnett.[1] They identify six clusters of competencies necessary for health promotion work:

- Managing, planning and evaluating.

- Communicating.
- Educating.
- Marketing and publicising.
- Facilitating and networking.
- Influencing policy and practice.

You can analyse your own health promotion role, by undertaking a role-mapping exercise, through considering how health promotion contributes to each of your functions. An example is provided below.

Example of Mapping the Health Promotion Role

Imagine you are social care worker in a residential home for children in care. Your health promotion and 'core' care roles include:

- *Communication and education* which contribute to care: the education elements may include explaining to the children why the policies of the home are necessary, what your job is, and what it will feel like living in the home.
- *Communication and educating* through providing information and counselling for the children: providing information about how the children can play an active part in running the home, and helping them to choose how to spend their time.
- *Managing, planning and evaluating* during the implementation of policies and regulations. You will be responsible for implementing regulations and policies designed to protect or maintain the health and well-being of children and staff (such as food hygiene regulations, policies to control the spread of infections, to prevent the misuse of alcohol and drugs, to promote healthy eating, on HIV/AIDS, to protect children from abuse and bullying, and no-smoking policies).
- *Influencing policy and practice* through profiling the social care and health promotion needs of the children and suggesting better ways of meeting them.
- *Facilitating and networking:* Most staff will belong to networks, such as branches of professional associations, or links with other residential homes, or other care workers, which are concerned with spreading good practice.

- *Marketing and publicising:* Some staff may be concerned with publicising the work of the home to relatives or to other groups in the community (for example, a home may wish to publicise 'open days' when parents and relatives can come and see for themselves what happens when a child stays in the home).

You can use the information gathered through such a role-mapping exercise as the starting point for a review of your performance, as a basis for your individual performance review (appraisal), for identifying your training and development needs, and for making your own training and development plan. In this way you are empowered to take charge of your own development, and to contribute to the development of the service which employs you, and to the development of the clients which it serves. In other words, you are *accountable* both to your employer and your colleagues, and to the citizens of your country.

Helping Clients Effectively

Getting clients involved in improving their own, and other's, quality of life means changing their behaviour, from being passive to actively participating. Health and social care workers may tend to assume that everyone *wants* a better quality of life, because it is something that they value. This is far from the truth. There are, in reality, many powerful forces which encourages people not to take responsibility for themselves, to be sick, and reward people for being dependent. The key to getting people to work for better health, well-being and quality of life, lies in improving their motivation to do so. This means that health and social care workers must have the skills to do this, and must make this a key component of their practice, along with the other functions of their particular occupation.

I now explore what these skills are and how health and social care workers can use them to best effect. These skills are essentially the same ones as those required by people to promote their own, and their family's health: life skills in how to relate to each other in a mutually beneficial way. So, if health and social care workers can change their behaviour and relate to their clients through using these behavioural techniques, they will be encouraging an uplifting cycle, through which their clients gain confidence in themselves and learn the life skills needed to run their lives more effectively.

Through our socialisation, we have all learned some ineffective ways of relating to, and communicating with, each other[2]. By adopting new approaches we shall all benefit, and some of the *cankers* institutionalised in our society, such as racism and sexism, will begin to break down. We need to all work together to break down these barriers to better health[3].

So, for example, Lord Woolf emphasises the importance of tackling one of the causes of the breakdown in social behaviour which is concerning governments world-wide – the total, or partial, failure of relationships between individuals, communities and institutions – in proposals for a radical new approach to the criminal justice system[4]. The emphasis in this new approach is on preventing crime, resolving conflicts, promoting relationships based on dignity and respect for all human beings and using 'cautioning plus' penalties whenever possible: penalties under which a caution is coupled with an undertaking by the offender to do something to repair the damage to the victim. Reform of court proceedings for young offenders to make them less confrontational and more of a 'conference' is also needed.

Empowering People for Better Health and Well-being

The goal of health promotion is to raise the level of wellness in individuals, families and communities. The means to this goal is through enabling people to take increased responsibility for, and to have more control over, their own and their family's and community's, health and well-being. The whole way health and social care workers have been trained and have perceived their role, in the past, has militated against this[5]. People have been cared *for* not *about*. Goals and care plans, have all been set by the health and social care workers, *not* by the clients. What clients *get* is plenty of interest shown in them and their condition or problems, lots of attention, and lots of things done *for* them or *to* them. So, the workers are active and in control; the clients and citizens are passive, dependent and even, sometimes, grateful. Many people will not be dissatisfied with these arrangements, as long as the benefits (attention, care, concern, income, support, health and welfare provisions, etc.) continue to roll in, and therefore will have little incentive to change. Indeed, the *costs* of change could be perceived as very high: taking responsibility can be a frightening prospect, particularly for people whose self-esteem and self-confidence has been eroded by the care process. If we are not to fall into the trap of 'blaming the victim' for their plight, what can we do instead to reverse this situation?

One thing we *can* do, is to change the way we relate to our clients. We need to:

- increase client's dissatisfaction with things as they are now;
- increase client's vision of what a better quality of life will be like and the benefits it will bring;
- ensure that clients have the ability to take a small, acceptable first step;

- reduce the perceived costs of change (make it easier for them to change).

At the same time we need to stop behaving in harmful ways:

- stop telling people what *we* (the workers) think they should do ('stop smoking', 'take more exercise', 'get a job', etc.);
- stop trying to persuade people to do what we think they should do, when they are not ready to change.
- stop trying to involve them in *our* plans for their development.

Telling people what to do and persuading people to do what we have decided is best for them, when they don't agree, are both intrinsically interventions which lessen the power people have over their own lives (they are 'disempowering'). Fortunately, we now have at our disposal skills and techniques which are intrinsically empowering, for all the parties concerned, and it is to these we must turn to 'operationalise' the change. These new concepts and methods lie at the heart of improving the quality and effectiveness of face-to-face health and social care. Using them may initially be very difficult and uncomfortable for the worker, because they involve accepting the primacy of the autonomy of the client. This means accepting that clients may choose to continue to behave in ways which are considered to be 'unhealthy' or 'bad' by the worker. It is hard for workers to accept the validity of such outcomes which may cut across the norms and values of the occupations in which they have been trained. For a discussion on education, autonomy and empowerment, see the suggestion in the note at the end of the paper.

Health and social care workers have often been given little training in how to do this. Their training has largely focused on how to solve presenting problems. Giving advice has formed the basis of most discussions on behaviour change[7]. This is despite the evidence that advising people to change aspects of their lifestyles is not very effective, with success rates of only 5-10%[8]. Thus, while some clients do seem to respond to advice, most do not. In addition giving advice can have a negative effect on the relationship between worker and patient or client. It often provokes resistance with responses such as 'Yes, but ...' from the receiver of the advice. Both the worker and the receiver of the advice may be left feeling frustrated and even angry. (It can also, arguably, be criticised as unethical, because it promotes the values of the worker, not those of the patient or client). Now that more effective (and ethical) ways are available for encouraging changes in behaviour, continuing to use advice as the primary method cannot be justified.

All these behavioural techniques are likely to be ineffective on their own. They are most effective when they form part of a wider *health promotion* and *improved quality of life* strategy, which includes policies and environments to 'back-up' the efforts of individual people. So, for example, teaching a client how to cook, needs to be backed-up by policies and environments which ensure that nutritious, affordable food is easily available locally (or that affordable transport is available to get cheap food). So, every one-to-one transaction, needs to be seen in the wider context of the supports available to the person, which makes 'healthy choices easier'.

Understanding Yourself and Your Clients[3]

An understanding of how people view themselves and their world is a very useful starting point to help health and social care workers to change the way they relate to clients. Transactional analysis provides a useful framework for analysing the relationship between health promoter and client.[3] Everyone has a basic position from which she (or he) looks at life, usually largely influenced by her family and the way she was brought up. People can adopt four basic life positions.

"I'm OK – You're OK"
A person adopting this position feels good about herself and confident in her work ("I'm OK"). She will also feel that in general other people are trustworthy and basically good ("You're OK"). It is a healthy, optimistic and confident position, operating with a belief that people are equal and have equal worth. However, it does not mean looking at life through rose coloured spectacles, but that people are basically 'good enough' despite their quirks and failings.

"I'm OK – You're Not OK"
People who take this position are often critical of others and find themselves putting other people down and blaming them. However, people who like doing things for others (rescuing other people) also often have this stance ("You're not OK, so you need me to look after you"). People in this position are likely to have difficulty in learning to trust and rely on others.

"I'm Not OK – You're OK"
People with this view will often put themselves down and feel inferior to others. They may feel powerless to change their circumstances and, as a result, get very depressed. People in this position will often discount compliments and praise from other people because "it can't be true because I'm not OK".

"I'm Not OK – You're Not OK"
People with this view are very vulnerable and may already have

chronic health problems such as alcoholism, drug-abuse or mental health problems. Working with them requires an awareness of how the helper can avoid being manipulated into confirming that "not OK" position.

It is important for helpers to work from the "I'm OK, You're OK" position, treating clients as "OK" equals, in order to start the process of helping them to feel more "OK" about themselves, more in control of their lives and therefore better able to make health choices. Using the "I'm OK – You're OK" framework can be useful for identifying some of the stances health and care workers and clients may adopt. For example, it is easy for worker to adopt the "I'm OK – You're not OK" position with clients. One version of this is a "persecutor" position, where clients are blamed or criticised. An example is "Yes but you don't *try* to remember to take your tablets". A more helpful response would be one where the patient is regarded as OK, such as "What would help you to remember to take your tablets?".

The same position of "I'm OK – You're not OK" may also result in the worker acting as a "rescuer". "Rescuers" want people to feel better, and to this end they may be falsely reassuring that everything is alright, and try to prevent clients finding out painful things about their situation. In the long term this is harmful, because it confirms that clients are not OK enough to take responsibility for, and control over, their lives. For example, a "rescuer" might say "Let me do it for you. It's easy really", whereas a better response might be "What do you find difficult?". Or a "rescuer" might say "There is no need to get upset. Your little boy will grow out of it" whereas it might be more helpful to say "You're obviously upset about this. Would you like to say more about it?".

Clients who adopt the "I'm not OK" position frequently portray themselves as "victims", thus putting up a barrier against any help the worker might offer. For example, a "victim" might say "What do you expect from someone like me – I'm past it at my age". A response which treats this person as OK could be "How much do you think you could still manage?". Another example is "I can't do that. I've never been able to manage the baby. You must think I am stupid". A helpful response, which treats the person as OK might be "Let's look first at what you *are* managing OK...". In these examples the worker encourages the "victim" to focus on what *is* OK, on what she *can do*, rather than focusing on what is not OK, which would merely confirm her helpless "victim" position.

I now turn to some of the recent research on helping people to change their behaviour, which identifies the skills workers require in order to be able to help effectively.

Developments in Behavioural Research

Several developments have taken place in behavioural research over the last ten years, which point to more effective methods of encouraging behaviour change. For example, there is good evidence that the key lies in improving the person's, family's, or group's *motivation* to change, and that this can be done by using a negotiation method in which the *patient* or *client* or *family* or *group* articulates the goals of change, the benefits and costs of change, and the steps towards change, rather than the worker. Finding ways of working with people who feel angry, 'disempowered', intruded upon, 'unmotivated', or resistant, is a key issue for all care workers, whether they are working with individuals, or families (where perhaps child abuse or neglect has occurred), or groups of people living in disadvantaged circumstances.

Any model of change must give workers a clear idea about how to work with people who may not want to be worked with. I now describe some of the key features of two models based on recent research.

Solution Focused Therapy

This is a model of intervention developed and described by de Shazer and colleagues at the Brief Family Therapy Centre in Milwaukee.[11] (It is also referred to as 'brief therapy'.) It focuses on helping people to discover what solutions or outcomes they desire for their problems, not on the problems themselves. It also stresses the importance of identifying successful behaviours (those which do not have problems) and encouraging clients to repeat and do more of these. Activities that help to enlarge and enhance these behaviours, which are exceptions to the problem, provide the key to the solution. Exceptions are those periods when the expected problem does not occur – for example, when a child usually has temper-tantrums at meal times, does not have a tantrum. Solution-focused therapy is goal-driven, but the goals are set by the client, *not* by the 'expert' (the doctor or other health or social care practitioner). The role of the facilitator is to help the client to identify realistically achievable goals, and steps towards goals. This is done by asking 'change-oriented questions'. One technique is to ask the 'miracle question'. To do this the facilitator says something like:

'Suppose there is a miracle and your problems are solved. What will you notice that's different that tells you a miracle has happened?'

The 'miracle picture' described by the client is used as a road map to find out what the client wants and for helping the client to identify what might be done to accomplish the desired changes. Using this

approach calls for radically different behaviour from traditional practice. The 'facilitator' (rather than the 'expert') is actively engaged in examining the client's experiences, from the client's perspective, looking for change, identifying exceptions, and helping the client to discover her or his own solutions. This done through asking questions which help the client to discover her or his own preferred future. Some of the key differences between traditional interventions and solution-focused interventions are set out below, and a case sample is provided in the following table.

Traditional intervention	*Solution-focused intervention*
The care worker advises the client and sets goals.	The care worker helps the client to identify her own goals.
The care worker focuses on problems, as defined by him.	The client and care worker together focus on exceptions to problems and the desired future.
The benefits and costs of change are defined by the care worker.	The benefits and costs of change are defined by the client.
The intervention produces resistance.	The intervention produces co-operation.
The intervention promotes dependence.	The intervention promotes independence.
The intervention uses the resources of the care worker.	The intervention builds on the strengths and resources of the client.

Case example[12]

The following is a conversation between a care worker and a single teenage mother.

Care worker: 'How did you manage to get yourself up this morning?'
Mother: 'I forced myself to get up because the baby was hungry and she was crying.'

Care worker: 'I can imagine how tempting it must have been just to have a lie in. What did you do to make yourself get up?"
Mother: 'Well I had to. I love my baby and I don't want her to go hungry.'

Care worker: 'Is that what keeps you going, that you love your baby?

Mother: 'It's the only thing that keeps me going. I don't want the baby to suffer because of my problems.'

Care worker: 'You must love your baby very much. You are a very loving mother, aren't you?'

In this discussion, the care worker identifies a strength in the mother – that she loves her baby. She then builds on this:

Care worker: ' So what would it take for you to keep on doing this?'
Mother: 'I will just have to remember that my baby needs me.'

Care worker: ' So what would it take to convince you that you are a good mother?'
Mother: 'I'll just have to believe in myself and not listen to people who put me down.'

The care worker is using the desire of the mother to do well by her baby as a motivating force. Once the mother has begun to feel good about herself as a mother, she will begin to find other ways of behaving like a 'good mother'.

The 'Stages of Change' Model[13]

One of the most influential concepts to emerge from behavioural research in recent years is that of 'readiness to change'. It emerged from a model of 'the stages of change' developed in North America.[14] This model considers change as a process during which people move through a variety of motivational states, and shows how people can best be helped to move from one stage to another. Research shows that strategies based on this model are effective for changing a range of behaviours, such as alcohol and drug abuse, smoking, taking more exercise, and weight control.

It integrates a range of factors such as the role of personal responsibility and choice, and the impact of social and environmental forces that set very real limits on the individual potential for change. It provides a framework for a wide range of potential interventions by health and social care workers, as well as describing the process through which individuals go when acting as *their own* agents of change, for example, when someone stops smoking without any support.

A crucial point is that the process of change can be thought of as a cyclical 'revolving door', which people usually go round more than once before emerging into a permanently changed state. It is also important to recognise that some people may never get as far as entering the revolving door.

There are five key stages related to the cycle.[15] Research into the behaviour of smokers has established that they do actually move through these stages in a sequential manner.

Stage 1: *Unmotivated.* This is the stage which precedes entry into the change cycle. At this stage a person has no awareness of a need for change, or does not accept it, and no motivation to change habits or lifestyle.

Stage 2: *Undecided.* People at this stage have entered the change cycle but are uncertain or ambivalent about the prospect of change.

Stage 3: *Motivated.* People at this stage are 'ready to change' – prepared to change.

Two further stages refer to those people who have already embarked on change:

Stage 4: *Action.* When people enter the 'action' stage they actively begin to change their health.

Stage 5: *Relapse or maintenance.* At this stage people struggle to maintain the change and may experiment with a variety of coping strategies. Although individuals experience the satisfaction of a changed lifestyle for varying amounts of time, most of them cannot exit from the revolving door the first time around. Typically, they relapse back, for example, they start smoking again. Of great importance, however, is that they do not stop there, but move back into the 'undecided' stage, engaging in the cycle all over again. Researchers have found that on average successful former smokers take three revolutions of change before they find the way to become fully free of the habit, and exit from the revolving door.

By identifying where clients are in the stages of change, health and social care workers can tailor their interventions to meet individual needs. For example, support with behaviour change, through exploring alternative coping strategies, is appropriate for someone in the 'action' or 'maintenance' stages. Education (information giving and awareness-raising) is appropriate for someone at the 'unmotivated' stage. Techniques to improve motivation are appropriate for someone in the 'undecided' stage, and strategies to help people to make decisions are useful for those in the 'motivated' (ready to change) stage. Research has shown that only a third of smokers and heavy drinkers are actually ready to change, the rest are in the 'unmotivated' or 'undecided' stages.[16]

Using this model a client's needs can be assessed and appropriate education or information be given, or motivational techniques be used, within the constraints of a few minutes consultation. It may also help to explain why advice-giving alone is limited in its effectiveness. If people are not ready to change, they will resist or rebel against advice, resenting the assumption that they are ready to change. It also highlights that actual behaviour change is not the only worthwhile goal to pursue for a brief consultation. Helping somebody to get a clearer view of the outcomes of change, and of the benefits and costs of change, could lead to success at a later point in time. In other words, interventions can be tailored to suit the position which a person is at in the 'stages of change', thus ensuring congruence between the agenda of the client and the care worker.

Many of the basic skills required for effective counselling can be applied to interviews using these techniques. For an introduction to the skills of counselling, including its application in helping people to change health behaviours, see Ewles and Simnett.[17] For further information about training in counselling, see the note at the end of the paper.[18]

Teaching Clients

Care workers are often in a position to teach clients things, such as skills needed for living (often called 'life skills'), which their clients may have failed to learn in the course of their lives.

Teaching people effectively is a very complex activity, partly because learning requires change and is mentally and emotionally hard work, and often because many people have felt 'put down' in school by their teachers or by other significant people in their lives. This means that when care workers teach they must avoid, above all, making their clients feel that they are 'being treated like children' (even when they *are* children!).

Imagine that a client responds to teaching with comments such as:

> 'I've always done it this way.'
> 'What's wrong with doing it like this?'
> 'I don't get it.'
> 'I can't do it that way.'

Your client has encountered a barrier to learning, and you must stop teaching and help her or him to work through this barrier through *listening*.

To take another example, a surprising amount of teaching assumes that it is the teacher who is more active – telling, explaining,

presenting – and the learner who is more passive. Yet we know from research that much more learning occurs when this is reversed – when the learner is more active. Getting learners more actively involved and participating in the learning process is the mark of an effective teacher. To do this you must *help learners to talk*.[19]

There is also evidence[20] that learning can be improved by making learners more aware of their habitual learning styles. This may be because they are then able to build on their strengths (the learning styles they are most comfortable with) but also, through awareness of the learning styles they are least likely to use, learners can consciously practice these alternative ways of learning and build a more flexible learning repertoire (i.e. a stock of regularly used techniques).

There are two key dimensions concerned with how people learn,[21] which operate independently.

1. *The holistic versus analytic dimension:* people who prefer to use the analytical style are analytic, deductive, rigorous and critical. They tend to think things through step-by-step in an objective analytical way. People who habitually prefer to use the holistic style can be described by words such as synthetic, inductive, divergent, and creative. They may be impatient with much reflection, and like to try things out in an unstructured way.

2. *The verbaliser versus the imager:* verbalisers are inclined to represent information verbally when they are thinking while imagers represent it in the form of mental images. Imagers learn best from pictorial presentations, verbalisers from verbal presentations. Imagers recall highly descriptive text better than complex and unfamiliar text, while the reverse is true for verbalisers.

Through helping learners to identify their own habitual learning styles, the teacher can help learners to be more flexible and adaptable through encouraging them to use non-preferred styles. This has the advantage of actively involving learners in restructuring the information and concepts to be learned, and so itself leads to better learning. In other words, teachers must focus on the process of learning (helping people to learn how to learn) as well as the content.

In summary, there is no one 'best' way to learn, but using a wide variety of ways can help people to learn effectively in a range of different situations. Further readings suggested in the note at the end of the paper.[22]

Finally....

You can apply all these understandings of your clients to yourself, in order to help you to be a good open learner. Good quality open learning materials are a prerequisite, but alone are not enough. They need your active participation. So you need to learn how to learn: to stretch your learning abilities beyond those that come most easily to you. Above all, you need to work together with others, so that you can learn from each other, and you need to build support systems to make learning easier: supportive environments for learning, and supportive networks of people. You need to link your learning into your day-to-day work. You need to build a vision of the future, which includes your own quality of working and home life, the quality of life of your clients, and the quality of the organisation or team of which you are a part. Keeping this vision alive will steer you towards a fulfilling destination.

Notes, References and Further Reading

1. Ewles, L. and Simnett, I. (3rd edition 1995) *Promoting Health: A Practical Guide*. London: Scutari Press. Chapter 2.

2. For a discussion on the ineffectiveness of most communication, and of the skills required to bridge the 'interpersonal gap', see:

   Bolton, R. (1979) *People Skills*. Englewood Cliffs, New Jersey: Prentice-Hall.

3. For a very readable and research-based account of what makes healthy individuals, families, workplaces, organisations, and societies, see:

   Skynner, R. and Cleese, J. (1993) *Life and How to Survive It*. London: Methuen.

4. Woolf, H., Tumin, S. and Faulkner, D. (1994) *Relational Justice: Repairing the Breach*. Winchester: Waterside Press.

5. A full exploration of the argument that health professionals undermine people's own ability to cope is found in:

   Illich, I. (1977) *Limits to Medicine*. Harmondsworth: Pelican Books.

   For a shorter account of this argument, see:

   Illich, I. (1978) Medical Nemesis. In Tucket, D. and Kaufert, J. *Basic Readings in Medical Sociology*. London: Tavistock. Chapter 29.

For a general discussion on the relevance of sociology for health promotion, and of the need for health promoters to ask key sociological questions, such as: in whose interests is this? How is power being exercised? Whose values are being prioritised? see the contribution by Nicki Thorogood in:

Bunton, R. and Macdonald, G. (eds.) (1992) *Health Promotion: Disciplines and Diversity*. London: Routledge. Chapter 3.

6. Weare, K. The contribution of Education to Health Promotion, in: Bunton, R. and Macdonald, G. (eds.) (1992) *Health Promotion: Disciplines and Diversity*. London: Routledge. Chapter 4.

7. See, for example:

Tuckett, D., Boulton, M., Olson, C. and Williams, A. (1985) *Meetings Between Experts: An approach to sharing ideas in medical consultations*. London: Tavistock

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8. See, for example:

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For further information on brief therapy practice in the UK, see:

George, E., Iveson, C. and Ratner H. (1990) *Problem to Solution: Brief Therapy with Individuals and Families*. London: Brief Therapy Press. Available from: Brief Therapy Press, 17 Avenue Mansions, Finchley Road, London NW3 7AX. Tel: 071-794 4495.

Brief Therapy Practice provide training in the skills of brief therapy. For further information about brief therapy training available in the UK, contact: Brief Therapy Practice, 77 Muswell Avenue, London N10 2EH. Tel: 081-794 4495.

13. For information about the availability of 'train the trainers' courses in the use of this model, contact the "Helping People Change' Project coordinator, HEA Primary Health Care Unit, Block 10, Churchill Hospital, Headington, Oxford OX3 7LJ. Tel: 0865-226045. These courses provide professionals with booklets of guidelines to support them in their work, and with self-help booklets to use with patients/clients wishing to change a particular behaviour.

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The Health Education Authority Primary Health Care Unit at Oxford, established in 1989, has assisted delivery of health education in primary health care through its programme of team workshops, publications, and research and through the national facilitator network. This includes a 'Helping People Change' project based on 'The Stages of Change' model. For further information, see note 14.

The 'Get Moving' project in Bristol is evaluating how GPs and practice nurses can help patients to take more physical activity, through a controlled trial using an adapted version of the Prochaska and Di Clemente model. This is a joint initiative between a multi-agency heart disease prevention programme 'Look After Your Heart-Avon' and Bristol University. For further information contact the Team Manager for Heart Health, Bristol Area Specialist Health Promotion Service, Southmead Hospital, Westbury on Trym, Bristol BS10 5NB. Tel: 0272-505050

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18. For further reading on counselling, see:

    Dass, R. and Gorman, P. (1985) *How can I help?* London: Rider Books

    Nelson-Jones, R. (2nd Edition 1988) *Practical Counselling and Helping Skills: Helping Clients to Help Themselves* London: Cassell Educational.

    The Scottish Health Education Group (SHEG), now the Health Education Board for Scotland (HEBS), have produced a guide for those wishing to set up and run short introductory counselling courses for nurses, midwives and health visitors:

    SHEG (1990) *Sharing Counselling Skills: A Guide to Running Courses for Nurses, Midwives and Health Visitors*. Available from: HEBS, Woodburn House, Canaan Lane, Edinburgh EH10 4SG.

    SHEG have also produced a series of six modular courses in counselling and helping skills, which are designed to be used separately or in combination:

Carruthers, T. (1991) *Initial Interviewing and Assessment Skills*. Edinburgh: SHEG

Woolfe, R. (1991) *Counselling Skills: A Training Manual*. Edinburgh: SHEG

Robinson, F. and Robson, K. (1991) *Problem Identification and Personal Problem Solving*. Edinburgh: SHEG

Woolfe, R. and Fewell, J. (1991) *Groupwork Skills: An Introduction*. Edinburgh: SHEG

Evison, R. (1991) *Personal and Intra-Agency Support and Supervision*. Edinburgh: SHEG

Cherry, C., Robertson, M. and Meadows, F. (1991) *Personal and Professional Development for Group Leaders*. Edinburgh: SHEG

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22. For a helpful summary of those criteria which have been established for effective learning generally, see:

Miller, A. and Watts, P. (1991) *Planning and Managing Effective Professional Development for Staff Working with Children who have Special Needs*. Harlow: Longman

For a helpful guide to study techniques, including guidance on the most effective ways of reading study materials, learning through group discussion, and writing articles, see:

Northledge, A. (1990) *The Good Study Guide*. Milton Keynes: Open University Press.

The Dutch Experience (I)

Jaap Zeyl
Joke Smit School, Amsterdam.

Many people now have cars, televisions and washing machines. These sometimes break down and you can't fix them yourself. Suppose your washing machine doesn't work anymore and you have someone repair it at your house. Do you ask this man (I've never had a woman in my house repairing any of these yet), if he is trained and qualified to do this work? I don't, I assume he is trained and qualified and has got enough experience to do his job. This relates to many other jobs as well. But when it comes to social care work, work which is mainly done by women, there is apparently a necessity to ask ourselves: "why train and qualify experienced social care workers" and to organise a conference about this subject. Is the job of social care worker less demanding, less complex, less difficult than the jobs I mentioned. I don't think so. Apart from skills like basic nursing basic and physiotherapy, you know how difficult it sometimes is to have caring relationships with people in general. Just think what it is like having to deal with people who are old, sometimes depressed, disabled, people suffering from all kinds of diseases. For them life is getting more and more difficult; even for people who are gifted with a friendly, cooperative, positive personality it is getting hard to keep feeling, thinking, behaving in that way. And those are the people social care workers have to deal with in their jobs. This is very demanding work for which skills and knowledge are required.

Now I will tell you something about my experiences as a social worker in the Home Help service and as a teacher in our 12 week access course to the Amsterdam Home Help service. Some eighteen years ago I became a Home Help Organiser and the boss of some forty Home Helps. What sort of people were they? They were all women. Thirty eight of them were not trained and did not have any qualifications. Two of them did a two year one-day-a-week social care

course., these were employed full-time. The others worked 6-12 hours a week helping two or three clients. They chose this job because they liked old people, their clients were generally grateful, and it was the only kind of work they were experienced in. They had enough time to spend with their clients to do the work and also to give personal attention. They did not regard their job as a real job. Their husbands (people still had husbands in those days) had the real jobs. They just earned some extra money for the holidays or a colour television. The clients often regarded their Home Help more or less as a member of the family. "She's just like a daughter to me". Clients were often very dependent on them. If a problem occurred the Home Help could call me or discuss it in the monthly group meetings. They learnt a lot from each other. They were often very wise women with a lot of common sense and a lot of experience in life. Home Helps gave up their jobs because they were having babies, their husbands retired or their husbands accepted a job somewhere else. Some 15 to 20% mostly young single women did a social care course and only a small percentage of these Home Helps were interested in a career in the service.

That was in the late 1970s. Now I'd like to tell you how the service developed after the second world war. The country had to be rebuilt, trade and industry were booming, the percentage of those out of work was lowest ever. The Home Help Service was organised by Roman Catholic and Protestant churches and much of the work in families was done voluntarily. In the nineteen fifties and sixties, however, the work was increasingly subsidised by the government. This was necessary because the level of informal care decreased. People simply did not have the time to help their parents and other relatives, also the family homes which were built in enormous quantities were not large enough to accommodate granny or grandad as well. People moved all over the country wherever they could find a job. As you will understand the Home Help Service expanded tremendously and increasing amounts of government assistance was required, although at the same time many homes for the elderly were being built.

The result of all this was that the organisations providing care had to cut down on costs. Reductions began in the late seventies. In our service for instance there was a ban on new jobs. This resulted in a waiting list of about a hundred clients. We were forced to have a close look at the number of hours each client received and consequently we had to reallocate the hours so that we were able to provide care to the urgent clients on the waiting list. In the same period the government introduced a nation-wide indication system in which every hour of help had to be accounted for and emphasis was laid on what people could still do themselves or with help of informal carers. So I started

asking 80 year old husbands whose wives had fallen ill: "Sir what do you do in your household?" "I can't do anything. It's women's work. I can't even make a cup of tea or boil an egg!" And I then said: We'll do it for you for a week or two and after that our Home Help will teach you!!

Perhaps it will be clear that these changes also changed the work of Home Helps in the eighties. They had to change from loving, caring, friendly "daughters" into professionals working cost effectively. They had to be able to think about ways how clients could become less dependant on them and discuss possible solutions with their clients. They had to learn how to stimulate clients doing the things they could still do. And for this you need to have basic knowledge about psychology and sociology but also about nutrition, nursing and the uses of medicines. And not only the knowledge but also the skills to apply this knowledge. They were asked to account for the hours spent on different activities.

In addition client situations became more and more complex as a result of the government's policy to close down a number of homes for the elderly and nursing homes which made the need for trained and qualified Home Helps even greater. People do prefer to stay in their own homes as long as possible when they are old, ill and disabled. But for the government it's also cheaper!

There is still another aspect which influenced and will influence social care work. The "GREY WAVE"! Demographic tendencies make issues in home care even more complex. A recent survey shows for instance that people will live longer but the number of years that they are ill or handicapped will also increase. From 1990 until 2010 the number of people with chronic diseases will increase from 3.4 million to 4. 4 million. So there will be more people requiring help and fewer people to help them. A serious problem in this respect is that other sectors like trade and industry want these young people. Moreover pay levels in social care are relatively low, Carers have long working hours, night shifts and career prospects are limited. Caring is not an attractive employment to many young people taking into account the work is very demanding and complex. Another demographic trend is the fact that the Netherlands has become a multicultural society. Especially in the big cities there are many migrants who can and want to work in social care. It will need a lot of training for the Dutch and the migrants to learn to understand something of each others cultural backgrounds and learn to be able to work with all sorts of different clients.

I hope it will be clear to you that the changes mentioned have made training and qualification necessary. Home Helps have to cope with really difficult situations with greater responsibilities, they have to

work together with District Nurses, Family Doctors, Physiotherapists, Social Workers and they are the ones who spend most time with their clients. It's only when Social Care Workers are properly trained and supported that they will feel sufficiently confident to do the demanding work and only then they will keep liking caring for people in different circumstances. Training and qualification will also give them the status they deserve. Social care has become a real job and will help women and men to become economically independent. And of course professionals have to be paid accordingly and valued for the work they do. Society needs them and will need them ever so more. We will have to invest in them if we want to be cared for when we need it.

Finally a few words about our school for secondary education. Adults from eighteen years of age come to our school to do access courses for health and social care courses, social work courses and teachers' training colleges. We also do a 12 week foundation course giving access to the Amsterdam Home Help Service. Students come to our school for lessons and do a work placement in Home Help Service. Those who pass the course receive a work contract. The Home Help Service in the Netherlands have developed training programmes at four levels of attainment A B C and D. The courses are taken during working hours and they are paid for by the employers. Our course gives access to the A level course.

A Home Help working at A level, primarily does household work. About 10 to 15% of their time is spend on social care. In level B there is less emphasis on household work; social care is more important; level C is mainly social care. These workers often work in the evenings with the most difficult client group: psychiatric patients, mentally handicapped, drug addicts with children. They sometimes do household work together with their clients when this is part of the programme.

The Home Help organisations spend quite a lot of money on this training scheme because they are well aware that only well trained workers will be able to cope with the work they are to do.

I've come to the end of my speech. Thank you for your time and for your patience. I hope you and your colleagues will be able to get training and qualification. You need it and deserve it, have a right to it because you do very, very useful work for your clients for society in very often difficult and demanding circumstances.

The Dutch Experience (II)

Willy van Diepen
Social Security Service, Hengelo.

The Social Security Service is a local government agency of the city of Hengelo. This is rather a small city of about seventy five thousand inhabitants in the east of the Netherlands near the German border. In the sixties, our region had a large decline the in textile and metal industries, which gave a high rate of unemployment. At present, we have an unemployment rate in our region of about 11%. But there are a lot more people who are not registered as unemployed, but yet have no job. Most of these are women.

What is the connection between working in the Social Security Service and social care training? Two years ago, we started a project within the European Union programme New Opportunities for Women (NOW), which finished on the first of August 1994. In this project, the Social Security Service worked closely with the Twents M.B.O. College which provides training in social care.

The women who are in receipt of benefits from the Social Security Service were the target group of our project. Some of the characteristics that they share are living on a minimal security basis, socially quite isolated, a low education level, lone parents with two or more children and lacking recent employment experience.

Two features, namely the low education level and the lack of recent labour market experience, can be explained by the fact that in our country most jobs are done by men. Most education and labour market experience of women is gained in what is a rather short period before marriage. After marriage many women stay at home, to care for husband and children. In the last decade, this traditional situation is changing.

At present in our country, most aged people are cared for in old peoples home – nursing homes. This situation is also changing. More and more elderly people prefer to stay in their own environment as long as possible. To make this possible, the help of an increasing number of qualified workers in needed.

NOW brought these two developments together. It offered these women a new opportunity for education and employment and it offered elderly people the opportunity to remain longer in their own home.

Necessary to activate and motivate the women were jobs, vocational training and guidance. For this reason, we concluded an agreement with the organisation, mentioned by Jaap Zeyl, which employs qualified workers to help elderly people, before approaching the women from our target group. The result of this agreement was the guarantee of approximately forty jobs.

It's obvious that women from our target group required a different approach from that taken with regular 17 year old students. What was particularly important with these women was that not only were they offered training or perhaps employment but they needed guidance from the beginning. They had always been oriented towards home duties. Now they had to combine study, job, housekeeping and leave their children in the care of others. Taking their situation into account, a new form of vocational training was developed and offered by the Twents M.B.O. College.

Why Vocational Training and What is the Contents of the Training Programme?

The relatives of elderly people requiring care won't or can't take care of them as was usual in former times. There are not enough volunteers available and the number of elderly people is increasing. This leads to professional care work. Professional care work asks for professional training because it has to be paid, so it has to be done as efficient as possible. In this training, it is also important to pay attention to the care workers themselves. For example, good materials are necessary and the care worker has to take care of her own health.

Professional social care work in the Netherlands has three levels. The first level is nurse, the second is care workers and the third is assistant. In the NOW project, women were trained to become assistants.

A training programme was developed and contained the following modules:

- Professional attitude
- The social care worker and her client as human beings.
- The process of ageing
- Supporting individuals
- Self supporting
- Care by relatives and volunteers
- Professional care of the elderly
- Cooking and domestic cleaning
- Communication
- How to cope with bereavement
- Employee in the social care

The module of professional attitude, for example, goes into the fact that the social care worker is acting with respect for the identity, the wishes and the habits of the client. She is acting with the goals and vision of the social care organisation. Important in this module, is that the social care worker is learning how to separate the working situation and the private situation.

The training took two years. The first year was a full-time course, the second year was mainly a practical year. The combination of a part-time and full-time course was unique within the Twents M.B.O. College. Our experience with this type of training for people with a lack of recent labour market experience is very positive and is to be recommended.

At present, some of the women of the NOW project have employment as assistance Social Care Workers. Some more of the women can expect such jobs in the near future.

The Irish Experience

Orla O'Donovan
Diploma / Certificate in Social Care,
University College Galway.

The contribution of social care workers to primary health care services has been acknowledged and applauded in Irish health policy for a number of decades. In the past ten years, health policies in relation to a number of target groups, such as *The Years Ahead – A Policy for the Elderly* (1988) and the *Green Paper on Mental Health* (1992) have called for the expansion of the services provided by social care workers. In the government's strategy for healthcare in the 1990s, *Shaping a Healthier Future* (1994), the concepts of health gain and social gain are used to focus on the impact of health services on improvements in health status and the quality of life. In the discussion on social gain, the role of social care is highlighted using the example of the 'quality added to the lives of dependent elderly people and their carers as a result of the provision of support services'. Furthermore, the provision of the 'most appropriate care' is a central element of the reorientation of the health services that is addressed in the strategy . In this respect, the development of community-based services, including those provided by social care workers, that can appropriately complement and substitute for institutional care, is given priority. Specific targets set in the strategy emphasise the importance of strengthening social care services. A clear example here is the target that by the year 1997, ninety per cent of people over the age of seventy-five will continue to live at home. Despite this attention, in practice social care services are low status and 'subsist in a grey area between informal and formal care' (Lundstrom and McKeown 1994: 11).

It is in this policy context that this brief paper examines trends in the training of social care workers in Ireland. The paper starts by reviewing attempts to assess the extent and nature of social care work, both that done informally and formally. It then outlines the

current provision of training and qualifications in social care. A detailed description of the Diploma in Social Care that has been developed in University College Galway is then provided. The paper concludes by highlighting a number of issues and challenges facing the training of social care workers.

The Extent and Nature of Social Care Work in Ireland

There is a growing awareness that health care work is not only done by those who are paid to do it and that in fact most health care is provided informally, or by those who are not paid. This public/private or formal/informal division is a crucial, if blurred, feature of social care work. There are three main groups of social care workers, namely, carers or informal social care workers, volunteers who are also regarded as part of the informal provision, and formal or paid social care workers. Women constitute the majority in each of these three categories.

While there are no comprehensive data on the numbers involved in the provision of social care, various estimates have been made. Ruddle (1994) estimates that there are 100,000 carers in Ireland who provide social care for dependent relatives, including elderly people, people with disabilities and people who are terminally ill. O'Connor *et al.* (1988) estimate that some 66,300 people over the age of sixty-five years who live at home require some degree of care. Ireland is generally regarded as having a vibrant voluntary sector, with large numbers of volunteers actively involved in the provision of social services. There is evidence that approximately twenty per cent of Irish people are involved in voluntary work, particularly in the fields of charitable, religious and youth work (Faughnan 1990). The Society of St. Vincent de Paul, for example, which provides child care services, day care centres for elderly people, social housing and hostels, has in excess of 10,000 volunteers. A wide range of types of workers are included under the heading of formal social care workers, including nurses aides, care assistants, house parents and home helps. There is evidence that there is a considerable growth in the numbers of formal social care workers. In their study of the Home Help Service conducted for the National Council for the Elderly, Lundstrom and McKeown (1994) found that between 1978 and 1993, the number of Home Helps employed by health boards and voluntary organisations increased from 5,206 to 10,461.

There is growing body of research on the nature of informal care, particularly for elderly people. O'Connor *et al.* (1988), for example, found that help is most commonly given with domestic tasks, mobility and personal care, such as bathing, dressing and shaving. They also found a wide spectrum of caring from just doing a few chores to what

amounted to practically full-time care. Similarly, Blackwell *et al.*'s (1992) study of elderly people who were being cared for by relatives found that the level of dependency ranged from elderly people who could be considered to be physically independent to those who could not perform any of the physical activities of daily living without assistance. In the study of the Home Help Service that was referred to above, it was found that the tasks of Home Helps fall under five headings, namely, personal care, home care, tasks outside the home, companionship and monitoring. While the amount of personal care provided by Home Helps was found to vary both between and within health board regions, typical personal care tasks performed included helping to clothe, toileting and changing incontinence pads, and draining catheter bags. Home care tasks include cleaning, washing dishes, preparing meals and washing clothes. In some health board regions, home care assistants are employed to provide personal care exclusively. There is, therefore, evidence of a large volume of social care work taking place and that while this is primarily provided by women relatives in the home, recent years have witnessed a growth in paid social care work. The nature of social care work tends to be wide ranging and to involve both domestic and personal care tasks.

The Current Provision of Training and Qualifications in Social Care

The increasing emphasis on the role of social care in health policy and the growth in the employment of social care workers have been matched by an expansion in the provision of training and qualifications in social care. This expansion of training and qualifications, has however, been very patchy.

Existing training courses fall into three categories: non accredited courses, courses accredited by British awarding bodies and courses accredited by Irish awarding bodies. Example of non-accredited training are the in-service training that is provided by some health boards for Home Helps and courses that are provided by carers' support groups. Non-accredited courses tend to be short and do not have a formalised curriculum. Social care training that accredited by British awarding bodies includes courses that have BTEC or City and Guilds accreditation. In 1992, the City of Dublin Vocational Education Committee, in association with the National Association of Home Help Organisers, for example, established a BTEC Certificate in Social Care that is targeted at Home Helps. FÁS, the National Training and Employment Authority, provides courses such as a Certificate in Mental Handicap and a range of childcare courses that are accredited by City and Guilds. Social care courses that are accredited by Irish awarding bodies include those accredited by the National Council for Educational Awards (NCEA) and those accredited by the National

University of Ireland (NUI). The NCEA is the main awarding body for social care training in the country and it accredits the National Certificate and Diploma in Social Studies that are provided by a number of Regional Technical Colleges. While up to recently, the main thrust of the NCEA courses was in the area of child care, a recent review of NCEA social and caring studies resulted in the recommendation that training should be provided in the broader area of social care.

UCG's Certificate/Diploma in Social Care

The Diploma in Social Care, that is provided by University College Galway, is the first social care course that has been accredited by the NUI. It is targeted at adults who have experience of social care work, but who do not have any formal qualifications. Prior to the introduction of the course, a survey of social care workers and employers was conducted to ascertain the demand for an accredited course in social care. This survey found evidence of an overwhelming demand from both informal carers and paid social care workers for training. It also found evidence that employers were prepared to provide substantial support to their social care staff if they undertook training. The first cycle of the course commenced in 1993, with assistance from the EU New Opportunities for Women Initiative.

The Certificate in Social Care is a one year part-time course, whereas the Diploma is a two year part-time course. The course is available as a distance education course up to Certificate level. The programme has three components, namely, course modules, seminars on different care settings and work placements. There are two types of course modules, those that place an emphasis on the development of practical caring skills and those which are knowledge based and address broad issues relating to social care. The twelve course modules are as follows:

YEAR 1

Redefining Health and Wellbeing
Basic Nursing
Caring for the Carer
Accessing Services and Support
Knowledge and Uses of Drugs and Medicines
Social Policy and Social Care

YEAR 2

Sociology of Social Care
Psychology of Social Care
Basic Physiotherapy
Nutrition
Counselling and Referral
Management and Administration Skills

The themes for the seminars on different care settings vary from year to year, but each year both community and institutional care are examined. Services for the key social care client groups of elderly people, people with mental and/or physical disabilities and the terminally ill are explored.

While all students on the programme have experience of social care work, they must complete work placements in order to provide them with insights into care settings in which they have no previous experience. Students have opportunities to develop their practical caring skills, knowledge based skills, interpersonal skills and vocational skills while on placement.

Issues for the Future

I think there are three sets of issues facing social care training and education in Ireland. The first set of issues relate to the cohesion, relative standards and mutual recognition of the various courses that are currently available; the second set relate to access and the third set concerns the broader, and more contentious, issue of the professionalisation of social care.

There has been a number of initiatives at both a national and European level to address the issues of the lack of coherence, clarity about the relative standards and mutual recognition of education and training generally. At the European level, two directives have been introduced with the aim of facilitating mutual recognition of qualifications in Europe. The first of these directives (89-48-EEC) relates to professional qualifications which involve three, or more, years training. The second directive (92-51-EEC), relates to non-professional training courses of a duration of less than three years. Prompted by these directives, the Minister for Education established the National Council for Vocational Awards in 1991 to develop a national framework of assessment and accreditation for vocational programmes within the educational sector. It is intended that this framework will promote access, progression and coherence in vocational qualifications. This issue of coherence in existing provision has yet to be tackled in relation to social care training.

The second set of issues concern access to social care training. Clearly because of the very nature of informal caring, it can be extremely difficult for carers to access education and training without provision for respite care. While the provision of courses in distance education format, such as UCG's Certificate in Social Care, can improve accessibility , support is required. A further barrier to access can be finance. This barrier applies to both informal and formal carers, as the latters' work is frequently characterised by lowly paid and temporary employment. Another issue concerning access is the accreditation of prior learning. Many social care workers do not have much formal education; the UCG 1992 survey mentioned above, found that 45% of social care workers had completed their formal education at Intermediate Certificate level or less. Despite this low formal education profile, many social care workers have extensive practical experience of social care work and a system of accrediting this prior experience needs to be developed.

The final set of issues relate the professionalisation of social care. Concern regarding the professionalisation of social care was highlighted in the National Council for the Elderly's study of the Home Help Service where the views of health boards were elicited on whether or not the Home Help Service would benefit from a nationally recognised qualification. While three health boards were in favour of such an initiative as the felt it would ultimately improve the quality of care, the other five health boards were opposed. Much of the opposition was based on the argument that the 'consequences of over-professionalising the service could be detrimental to its good neighbour / semi-voluntary dimensions and could result in an escalation of costs ...' (Lundstrom and McKeown 1994: 158). Further issues in this regard are the division of labour, responsibilities and expertise between social care workers and other professionals, most notably nurses.

While there is a need for debate on all of the above issues, one thing is clear. If community-based services for groups such as elderly people and people with disabilities are to be developed 'to the extent that they can appropriately complement and substitute for institutional care, or provide adequately for those in the community who are dependent on support' as is planned in *Shaping a Healthier Future* (1994: 10), education and training must be provided for those formally and informally involved in social care.

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What Do The Carers Want? (I)

Mary Cosgrove
Home-Help Organiser with Clarecare, Ennis.

I am a Home Help Organiser with Clarecare, working in a mainly rural area in County Clare, and have responsibility for approximately 140 Home Helps.

Of these Home Helps, one hundred and thirty nine are female and one is male. Comparing this with the 1992 University College Galway survey of one hundred and eleven Social Care Workers, 88% of that sample were female, with 12% percent, or 13 of Social Care Workers surveyed male. Other findings from that survey were:

Marital Status	Married	65% (72)
	Single	21% (23)
	Other	14% (16)
Age Group	25 – 39 years	49% (55)
	40 – 54 years	37% (41)
	Other	14% (15)

(O' Donovan *et al.* 1993)

These findings from that survey would reflect the trend in my area and also most other areas.

There are a number of things that carers, both formal and informal, want and they fall under the headings of payment, recognition, and support. They want to be paid for the work which they do. They also want recognition:

i) that the work that they are doing is worthwhile,

ii) that they bring skills to this work,

iii) that their caring is making a contribution to the individual and to society. Carers also want to be included in the decisions made in regard to and the case conferences concerning the person for which they are caring.

Carers want support i) from family members, as all too often caring duties fall to one person alone, and this is also true where the carer is a Home Help, ii) from the Home Help Organiser, iii) from the General Practitioner, Public Health Nurse, Social Worker, and other professionals involved with the client. Also important is the support received through attendance at Home Help training seminars, "caring for the sick course", and the Carers Association. Though many of these courses are intended to teach practical skills they are often seen by carers as an important social outlet, an opportunity to meet and talk with others in similar situations.

Carers need access to respite care to allow them to continue their work. Sometimes all that is required is a good listener – someone who understands the carer's situation, allowing the carer permission to express their anger, frustration and sorrow. If a carer does not have such outlets, the caring process suffers – the carer runs the risk of breakdown, or "Granny – bashing" occur.

Information about services and entitlements should be available and easily accessible to carers. Information about services would include the Home Help Service, Community Occupational Therapist and the Physio Therapist. Carers should also be informed about entitlements regarding Carers Allowance, Free Telephone Rental and the Fuel Allowance. Practical information regarding first aid and counselling would also be of assistance to many carers.

Training for Carers

Carers need training to enable them to cope with the day to day tasks of caring, where it be a relative or a Home Help client. Formal carers probably are better prepared in this respect as the Home Help service in each health board region try to provide training courses each year. Such courses are organised to meet the different needs of the Home Helps, for example Home Makers are usually work with families under stress and their training would include child-care, budgeting, family support without taking the role of a parent, increasing the parent's confidence in looking after their child. Likewise those who care for the elderly or infirm client need training in nutrition and healthy eating as well as some conditions which may affect the swallowing or digestive process, lifting and basic nursing techniques.

Carers may also need training to help them to look after themselves – to learn how to relax, how, where and when to ask for help or to organise respite care. The task of caring is demanding both physically and mentally, those in need of care deserve the best care that can be given to them. However the carers also deserve the best training and support that made available to them to allow them to continue their very important work of caring.

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What Do The Carers Want? (II)

Carmel Monaghan
Informal Carer, Sligo.

I care for two elderly ladies in my home. My mother who is 87 years and my mother-in-law, who is 77 years. They are both in reasonably good health. They are dependent in that I have to help them with personal care, medication, laundry, shopping, preparation of meals etc., the normal everyday routine that is done in every home.

The alternative to my caring would possibly be Home Help or residential care in a welfare home, where granted, they would avail of much more services than I can provide, but at an enormous cost per week to the tax payer.

In *Shaping a Healthier Future, a strategy for effective health care in the 1990's* (1994), the Minister of Health has outlined the following in regard to "Ill and Dependant Elderly", I quote:

> *"Priority will be given over the next four years to strengthening home, community and hospital services to provide much needed support to elderly people who are ill or dependent and to assist those who care for them".*

He goes on to outline a number of priorities to be achieved. I will refer to a few recommendations from *The Years Ahead – A Policy for the Elderly.*

1. To maintain older people in dignity and independence at home in accordance with the wishes of older people as expressed in many research studies.

2. To restore to independence at home those older people who become ill or dependant.

3. To encourage and support the care of the older people in their own community by family, neighbours and voluntary bodies in every way possible.

4. To provide a high quality of hospital and residential care for older people when they can no longer be maintained in dignity and independence at home.

Care in the community by the community is obviously on the cards in the years ahead. What this all boils down to is care for the elderly relative in the home by the daughter or daughter-in-law. With respect to other family members, though their intentions are good, the elderly person becomes attached and dependant on one member, which normally is the female resident in the home.

I may seem to be discriminating against the men here. Some of them too, are caring for dependant relatives. I am aware of a number of such men in my own locality, who are dedicated to the task of caring for a frail elderly relative, but what I am saying is that by and large the task of caring falls on the shoulders of the female resident in the home.

What is a carer: The Galway Carers Association set up in 1990 defines a carer as:

> *"Anyone who is leading a restricted life because of the need to look after a sick, elderly, or disable person". We can define it for ourselves in our situation.*

In 1993 Soroptimist International of the Republic of Ireland drew up the Charter of Rights for Carers which has adopted "Caring for the Carer" as its current national project. I am not going to go into all the details of the Charter, suffice it to say that there are sixteen rights in all. I will draw to our attention a few which I feel are relevant"

1. Carers have the right to be recognised for the central role which they play in community care and in creating a community of caring.

2. Carers have the right to financial support and recompense which does not preclude Carers taking employment or in sharing care with other people.

3. Carers have the right to involvement at all levels of policy planning to participate and contribute to the planning of an integrated and co- ordinated service for Carers.

4. Carers have the right to skills training and development of their potential.

The theme of the conference today is "Why Train and Qualify Experienced Social Care Workers", to which I say *WHY NOT!* We are providing a much needed service, with little recognition for the work we do and without any training in the tasks we perform. Caring for an elderly person is a twenty four hour a day job for most Carers. It is a demanding task and the burden of stress experienced by Carers is bound to have repercussions at some stage or another.

Don't get me wrong it has its rewards too; when gratitude is expressed by your relative for the good job you do in keeping them comfortable and happy at home. I, therefore, see a great need for training if we are to continue to care for our relatives at home and allow them to live in dignity and independence in their own homes surrounded by their family. Speaking on a personal basis, I have some experience of formal caring, as I work on a part-time basis in a welfare home, this is a great advantage to me in my home situation.

Education is no load to carry, training provides a high quality of care and it increases the confidence of the Carer. Skills obtained through training could be used more extensively, for example, if it were to be introduced at a later date carers could foster or adopt a person with no family of their own to care for them, rather than have to be institutionalised.

What I would like to see introduced in the training for carers is a programme incorporating:

- General Nursing Care
- Anatomy and Physiology
- Physiotherapy
- Diet – Nutrition
- Drugs and medicine
- Psychology
- First Aid
- Health Promotion / Education
- Communication with Professions, Doctors etc.

- Access to Information

And for the Carers themselves:

- Caring for the Carer.
- Counselling services available to deal with matters relating to death and bereavement.
- A training that would alert us to the onset of illness. By taking a temperature, if it were high it would indicate that there is infection present.
- Ability to test urine – if there is infection present what can we do to help the old person until we contact the Doctor or Nurse.
- If a person falls and we suspect that there is injury, do we get help and lift the person into the bed and risk injuring them further by lifting them incorrectly.
- Carers living in remote rural areas will not have instant access to a Doctor. Medical centres are not available like in urban areas. Therefore, Carers have to cope with the situation as best we know how until help arrives. Such are some of the problems we encounter.
- A knowledge of psychology to enable carers to understand the confusion that many elderly people experience. We could be more compassionate with dealing with this type of illness if we had an understanding of the symptoms and how to deal with it.

When the Diploma in Social Care was launched in 1993, I grasped the opportunity to broaden my experience in providing care at home. The knowledge and experience I have gained from the classroom, seminars and work placement have helped me enormously. Meeting with other students who are in a similar situation have given me a greater awareness of the needs of Carers throughout Ireland.

The course covered a broad range of subjects dealing with the care of the elderly, people with disabilities, and caring for the Carer to mention a few. While we got a good knowledge of each module one must appreciate that a part-time course can only strike the tip of the iceberg. I would like to have the opportunity to explore each subject in greater depth. Perhaps I may at some future date!

Research shows that there are 65,000 elderly people in this country who due to declining health depend on a caring relative for daily help

and approximately 25,000 of these require full-time care. In the future there will be increasing numbers of older people because of increased life expectancy and a declining birth rate in the European Community. The projections are that the percentage of people aged 80 and over will rise by 20.5% from 67,000 to 81,000 by the year 2001.

Looking at these figures you will have to agree that training and qualifying social care workers is a necessity if our older people are to live in dignity and independence in their own homes in the next century, as recommended by the Minister for Health in *Shaping a Healthier Future* (1994).

I have one final recommendation for the Minister for Health. Abolish the so-called carers allowance. It is so highly means tested that only small percentage of Carers are availing of it. I do not have figures to back-up that argument, but I know that it is very difficult to come by. Replace it with a weekly wage, thus enabling the Carer to carry out their daily task of caring in a responsible and dignified manner with due recognition for their status in society.

Those are my views on what training and qualification I feel home carers require. I hope they echo the thoughts and ideas of the group I represent here today. I take this opportunity to thank the organising committee of the conference for inviting me to speak.

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What Do The Carers Want?(III)

Éilish Campbell
Galway Carers Association

As a Volunteer Carer with Galway Carers Association I realise that specific training skills are required to assist the Social Care Worker achieve their aims. The following are the training skills I feel are required:

Communication Skills

to assist at:

Public meetings where relevant bodies could be advised and informed of the needs of Carers.

Committee Meetings where an agenda has to be drawn up – a time limit adhered to where we must learn the needs of our committee and be both assertive and encouraging in taking on specific tasks. It is important to listen and be aware of confidentiality – bearing in mind that a carer's initial contact is by telephone.

Facilitating Skills

would prepare volunteer Carers to:

Encourage full time Carers to become active on a committee.

Enable a committee to work *with* Carers and not *for them*.

Encourage full-time Carers to attend seminars/workshops and report back. Also to participate in any relevant Carer's courses – i.e. Certificate / Diploma in Social Care.

Media Skills

should assist us with publicity which in many areas of radio and television are free to voluntary organisations:

How to advertise through posters, letters and leaflets.

Radio skills are important as many Carers live in remote and isolated areas. Their main source of contact may often be the radio. Many of our Carers make contact with our association after listening to an interview with one of our committee members about a forthcoming event or about a Carer's needs. The plight of the Carer can also be highlighted on our airwaves if we have this training.

Organisational skills

are required to incorporate all aspects of organising and running:

Social/educational events – planning ahead – engaging guest speakers – booking the venue – arranging insurance cover and costing the event.

Respite day and weekend breaks require planning to ensure that the dependent and carers' needs are met.

Knowledge Based Skills

should cover all aspects of:

Funding – where to apply – who is entitled to it and how to complete a pre-budget submission.

Knowledge of the health board structure.

Good liaison with health board personnel and key people involved with other core groups – i.e. Irish Wheelchair Association – Alzheimer's Association.

Information on all services – supports and grants available to carers and dependants is necessary.

Assertiveness / Stress Management skills

would enable a volunteer Carer to:

Listen to a Carer's needs and problems without becoming stressed by their situation – i.e. it could often be a stress related problem between a Carer and their family which is outside the control of a voluntary organisation.

Visiting Skills

are necessary and important and should cover:

Good communication with carer and their family.

Ability to be a good listener.

Lifting and basic nursing skills.

Hands on skills in the Carer's home. Visiting the Carer and dependent takes time for many reasons. A Carer needs to overcome shyness and we, the volunteer Carer, need to gain their confidence and most important of all the cared for must approve of our visit.

Counselling Skills

would enable us to have:

Confidence in handling delicate and personal matters which occur on a regular basis in a Carer's life i.e. death – dying – bereavement – coping with bereavement and stress.

What Do Employers Want?(I)

Ms. Priya Prendergast
Galway County Association for Mentally Handicapped Children

The Galway Association for Mentally Handicapped Children Ltd. known as the Association, is the smaller of the two non statutory organisations providing services in County Galway to people with learning disabilities. It has been in existence for some thirty years. The Association which recently obtained ISO and "Q" Mark accreditation provides a high range of quality day and residential services to approximately 350 individuals and their families in 34 locally based units situated throughout the City and County.

The Mission Statement summarises the Association's philosophy and it is worth including it in full at this point: "The Association, founded by parents and friends in County Galway, provides a comprehensive, efficient and innovative range of personal, high quality, community based services to people with a mental handicap, on the basis of identified needs, enabling them to reach their full potential. We are committed to developing local services at standards of excellence, according to accountable, flexible and cost effective programmes. These are agreed through consultation with service users, their families, and staff members, in partnership with statutory and voluntary sectors."

The Association's budget in 1994 was £4m with the substantial part of the funding coming from the Western Health Board. Additional money from the European Social Fund and fund raising contributes to the shortfall. Approximately two hundred staff hold nursing, teaching, business, trade and health profession qualifications. Community involvement is epitomised by the 48 branches of Parents and Friends located at parish level across the County, and the Board of Directors includes parents of people with disabilities who may or may not be in receipt of Association's services.

The majority of Association staff work in centres, with support personnel who are based in Galway, providing services in both the centres and the family home. A few staff, such as the In Home Workers, provide a respite service to individual's within their own home setting, while approximately eighty volunteers, who are matched with individuals and linked to centres by the Co-ordinator of Volunteers, are involved in a variety of ways. Branch members and parents are also occasionally involved in service delivery in a variety of ways such as by organising and participating in Summer Holiday Projects or by providing transport for others on a crisis basis.

The Association's recruitment policy can be summarised as follows: Advertisements for staff make no exaggerated or unsubstantial claims and the Association is an equal opportunities employer. Job specifications give details about education, experience and health requirements, the duties of the post and the conditions of employment. Eligible candidates are short listed for interview, following which the panel select appropriate qualified and experienced candidates(s) for the vacant post(s), bearing in mind aptitude, qualifications, character and suitability. All successful candidates are appointed subject to satisfactory reference checks and a period of probation under supervision.

The calibre of our staff is extremely important. We want people who understand the nature and impact of disability on individuals and their families. People who have an awareness of issues such as rights, for example to choose, or national developments, for example the health strategy, or international trends, for example empowerment, can bring an added dimension to their work and relationships with service users.

Individuals who are committed to the welfare of people with intellectual disabilities and the concepts of "normalisation" and partnership; who are team workers who get things done with other people, and who have personal attributes which include being empathetic, non judgmental, reliable, honest and open, responsible, accountable, competent, resourceful and who respect confidentiality , are essential. People with some professional training, such as in social care, nursing and so on are necessary because staff must have skills to do the job, for example manage an individual having a seizure. Service users and their families must have the security of knowing that trained and competent staff can respond appropriately and promptly if the need arises, for example if their child has an asthmatic attack or displays challenging behaviour. Furthermore, the organisation as a service provider with responsibility for vulnerable individuals must ensure that all reasonable and appropriate steps are taken to protect and safeguard those attending its services by providing the best possible care and standard of carers at all times.

We believe that services will stand or fall on the contribution of the staff who provide them and that managing resourceful humans is more important that simply managing human resources. Accordingly, approximately £40,000 (1%) was invested in staff training in 1994. Training is perceived as a continuing process. It ensures that motivation and commitment of staff remains high, that people do things right rather than simply do the right things, that staff get orientation in current problem solving strategies such as challenging behaviour or in relation to legislation such as child protection and that staff have the confidence to take initiatives and calculated risks. The organisation supports student placements as it fosters a two way learning process in the real world. Quality action groups and circles also provide staff with opportunities for reflection and support as impetus for service improvements.

Having provided an outline description of the Association and its need for trained personnel some general questions are worth considering. Should informal/unpaid carers also enjoy access to training? How can this be facilitated with their heavy commitments? Hierarchical and authoritarian systems stifle communication. How can they become more flexible, responsive and personal when staff are powerless? If staff themselves at the bottom of the pyramid are powerless, how can service users become empowered? Will the current emphasis and effectiveness result in greater professionalisation of services? Is informal/unpaid care (conferred by virtue of social relationships) not "better" that formal/paid care provided by the impersonal agents of a human service organisation? Are professionals with "expert" knowledge disabling? Their training courses often reinforce notions such as "disabled people have to be looked after and guided". Most hands-on carers are women. It is important to remember that most managers of health and social service organisations are men. Would services be improved if women could break through the glass ceiling? It is important to remember that carers also consider themselves to be professionals – after all they know the situation and individual best.

While this conference is not the proper forum to debate such issues, they are important and worth discussing since they may well affect how human service organisations develop in the future.

What Do Employers Want? (II)

Joe Stanley
Caiseal Geal Nursing Home

I with my wife have run a private nursing home of twenty three beds just outside Galway City for the past 14 years – I am by training and qualification a Social Worker. I am also on the officer board of the Irish Private Nursing Homes Association which represents half the private nursing homes in the country and about one third of all non-public sector homes. Our main clientele group naturally would be the frail elderly, but not exclusively so. Most of the discussion today has concentrated on Carers and cared for in the community setting and it is important to note that there are 66,000 or 15% of over 65 year olds being cared for in the community both formally and informally. However, the 20,000 or 5% being cared for in residential settings cannot be ignored and I believe that we have to accept positively that there will always be a sizeable minority who need the protection of residential care and it follows that a significant number of Carers will continue to work, at least for periods, in residential settings.

I make my comments in the light of my own experience and after ongoing consultation with Association members – for all of us the issue of ongoing training and development is of great interest and regarded as important. From this perspective I will attempt to answer the question which is the theme of this conference "Why train and qualify experienced social care workers?" under three brief headings:

Trends for the Future

All the evidence suggests that the numbers of elderly will increase dramatically over the coming years – with the numbers of frail elderly particularly increasing. Many of these are going to require some degree of caring in a variety of settings outside that of the acute hospital and their care will largely comprise help with the activities of

daily living – but clearly with adequate supervision of the more medical aspects. Of equal importance to demographic predictions are the developments that are already happening in terms of staff training. With increased specialisation and professionalisation of already qualified staff together with the demands of accountability that go with increased bureaucracy it is perceived that the qualified Carer (the RGN or equivalent) will become more distant from the client. To maintain a quality service directly to the client another level of duly trained and accredited Carer will be required – if only to ensure that there are enough competent Carers to go round!

The Real Needs of the Client

As we in the private nursing home sector look at our residents and their day to day needs we see so clearly that they need practical help and genuine interest – what has often been rather soppily spoken of as TLC – Tender Loving Care. But what has been said over and over is that the competent Care Assistant has to have a 'hands on' direct involvement – and that any training programme must have this element at the top of the list. If the Carer has confidence in what she is doing it will communicate to the client and the client will respond positively and a relationship founded on trust will be built up.

We in our own situation have been in the fortunate position of having women work for us who got their first experience in Merlin Park Hospital, and others who qualified with the SEN in the UK and almost without exception they brought to our home a quality which was totally appropriate to the work they had to do. That dimension of 'caring' must be recognised as valuable and must be positively promoted as 'professionally' acceptable – accreditation by means of a recognised course would seem to be the obvious route.

The Real Needs of the Carer

While the 'hands on' element should not be underestimated, it is clear that in a rapidly changing world, working away as it were by instinct or good nature is simply not enough. Carers should both understand what they are doing and why they are doing it. They should have an appreciation of the particular regime they are involved in, and at the same time they should have an understanding of the wider context in which their work setting is situated. Concepts such as the 'continuum of care' and 'a holistic approach to care' should be familiar. Also, the Social Care Worker should be enabled to acquire a degree of self-knowledge as to how she relates to clients and other staff and the caring process in its different dimensions, and as to how sensibilities change. 'Desensitisation' is an acknowledged process as an individual becomes absorbed by the caring organisation perhaps moving from

being an informal to a formal Carer.

Thus while a Carer may be experienced that experience may be limited and may lack as wide an understanding as would be desirable. For a Social Care Worker to be flexible and adaptable in changing circumstances and take on a positive role appropriate to the clients' needs he or she would need exposure to both the theory and practice of different care settings.

Again these perceived needs would require appropriate answers in a training programme – and the achievement of a degree of competence in such areas would require appropriate recognition.

As a provider of services for the frail elderly in the private sector I see the answer to the question in very simple terms:

We need competent interested carers whose care is practically and directly involved with the client – and in years to come we are going to need many more;

Private nursing homes generally are small – the average size 21 beds – our reputation depends on the quality of care we provide and the happy positive ethos or ambiance that is immediately obvious as soon as you walk through the door. Any one care assistant represents a large percentage of the staff complement and is very visible to both residents and visitors – therefore what she does and how she presents herself is of vital importance to the continuing success of the home.

Where To From Here?

Professor Cecily Kelleher
Department of Health Promotion,
University College Galway

Firstly, I should like to thank all those who contributed particularly to the success of this meeting. As you will know, we have over the last two years developed a Certificate/Diploma programme in Social Care in University College Galway, which is the first of its kind accredited by a third level institution in this country. It has been generously supported by the European Union NOW (New Opportunities for Women) initiative and we are most grateful for this. As the Director of that programme, Orla O'Donovan, indicated earlier in this meeting, the role of caring in our society falls predominantly to women in their capacity of wife, daughter, daughter-in-law, sibling or mother. Our programme is geared to both formal and informal carers and it seeks to provide a basic training in the various skills required in that function. We felt that a conference on why and whether training of experienced social care workers should be undertaken merited attention. I am very grateful to all those who have presented papers here today, particularly to our guests from the Netherlands and Dr. Ina Simnett from the United Kingdom. I feel it has been an active, participative meeting and credit is due to Catherine Mc Nelis who organised it. I am also appreciative of our three chairpersons who themselves gave us their perspective on this issue.

The Government strategy document on health entitled *Shaping a Healthier Future (1994)* was launched in April of this year. It emphasises particularly outcome measures for health and the need to quantify health gain and social gain in activity related to our health service. How does that apply to Social Care? Chronic illness is a feature of life for many of those receiving such care and indeed for those providing that care. The management of a person with chronic illness requires a many faceted approach. Dr. Simnett in her contribution particularly emphasised the importance of

empowerment in the relationship between carers and those for whom they are caring and for the need for management skills at all levels in practical settings. It is important that we recognise the need for various skills besides those of diagnosis and treatment and the more holistic approach at the basis of health promotion which is necessary for the caring role.

There are many practical dilemmas in our society today in relation to who should take on the role of caring. This has been emphasised by several speakers and it includes practical issues such as the fact that we now have smaller families, reduced social networks and an increased population providing more people who need care and more complex caring problems. It is clear from the contributions of our various speakers that these predicaments are similar from country to country. We have heard from Jaap Zeyl and Willy van Diepen in the Netherlands how social changes have affected the profile of those needing care there. There are three key questions we need to address.

Firstly, when does experience give way to a need for training? This was illustrated by several speakers today. Basic human skills are important of course. There are two arguments essentially as to why training should be provided. Experience and training leads to confidence and the development of further skills. Several speakers referred to the need to explicitly recognise those skills and to the reasons why we need to give more recognition to them. Anne Taylor, Chairperson for the Council for the Status of Women, identified the hidden iceberg of Carers, many of them women, in society. Ina Simnett illustrated that many management theories are in fact practically applied all the time in the home setting. Jaap Zeyl emphasised the changes over twenty years from the approach that all caring was a natural and expected function of the family to the current recognition of a more professional approach. That shift from the traditional approach has been empowering in that it has promoted independence and recognition of skills. The contributions from our Carers have illustrated that. In particular, the description of Carmel Monaghan from Sligo of how her own personal experience was the basis for the need to learn and develop more is a clear definition of what is needed in the area of social care. We also have to acknowledge however the limits of Carers – they cannot expect to do everything nor should they be asked to perform tasks beyond their competence and this is an important issue in terms of caring.

Secondly, we have had to address the increased demand due to the increasing volume of clients. In all developed countries, there will be more people requiring care in the foreseeable future and their needs may indeed be complex. We accordingly need to define what the skill base is to meet those needs.

Thirdly, there is a shift in the concepts of course delivery and of job description for Carers. We have particularly emphasised here as part of our programme the need to define what we understand by health and well being and to establish what that means in the context of caring. In addition to the practical skills needed to nurse and manage a person with a chronic disability or disease, there are also interpersonal skills required. There is further need to define course content and accreditation for such training and to assimilate European experiences in this context.

Finally, we need to assess what the cost to society is of providing adequate social care. Community care is not cheap, it involves an understanding of all of the resources required to provide a comprehensive home-based programme of care, or indeed in an institution, as defined by Joe Stanley of the Caiseal Geal Nursing Home in his contribution. Accordingly, as a society, we need to define what benefits we anticipate.

What are the outcome measures, therefore, by which we intend to measure our service? These will include more people with a better quality of life over time. The cost to society will be those of training, of payment, of recognition and of management and organisation of those skills. This conference therefore has moved towards an understanding of empowerment of women in the home and we hope has opened the debate for discussion on why society needs experienced social care workers and whether it is prepared to acknowledge and support that role.

Why Train and Qualify Experienced Social Care Workers?

CONFERENCE PROCEEDINGS

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