LINK Baseline Study

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Introduction

This Baseline study is a try to give an overview of the individual national studies prepared by each of the partners. Each partner will firstly go through how the welfare system in their countries functioning and then focus on specific problems identified in social services to a distinct ultimate target client group (eg frail elderly people in the community, young people with mental health challenges, vulnerable families in the Roma community etc.) and will identify trends in the needs of/services provided to the group, policy developments, relevant staff training programmes / gaps in provision & the results of relevant research & projects piloted by partners.

The purpose with the baseline study is to identify trends in the development of services to different vulnerable target groups particularly relating to the growing unmet needs of the groups concerned, the gaps in service provision and the need for greater integration of the delivery of different service to create a more personalised holistic service to the individuals and families concerned.

The report is structured so that under each theme each of the partner countries' responses will follow after each other. The European social network gives answers when it is relevant. Its answers are sometimes very long as they try to tell a nuanced answer from all their partner organisations across the whole of Europe. The issues covered in the different chapters are firstly the societal level/ what different welfare systems that are used in each country and then in chapter two the questions of purpose, aim etc. are handled. In chapter three development and innovation is examined and in the end the report looks upon integrated care.

The report was developed through national studies by each partner region/country, a common questionnaire and discussions between partners to identify common issues which the project's products needed to address.

First of all we will give an overview of how the welfare model works in each country by a description of it being conservative, liberal, social- democratic, post-socialist etc. The questions raised in the Baseline study can be seen in the appendix.

Chapter 1 the societal national level

Welfare model

In **Slovenia** the welfare model cannot be defined uniformly because of historical reasons. The particular type of welfare state was developed when Slovenia was part of Yugoslavia. Some similarities can be found with the social-democratic model (dominant role of the state), others with the conservative corporative model (a considerable part of welfare was based on employment status). The system of social protection was well developed and granted more social rights than other communist states. In 1991 (after independence), a new social programme was adopted to direct the welfare state toward the corporative model. The responsibility for providing social security was transferred from the state to the individual, but the state took over the task of providing adequate conditions. Even though the legislation allowed for this, there were fewer changes than expected. After 2010, there were changes in the legislation that showed the principles more towards the neoliberal model.

As a prevailing principle of redistributive justice, the principle of means-testing (characteristic of the neoliberal model) is evident for some social rights, while for some social services the principle of universality (characteristic of the social-democratic model) continues to apply. The prevailing measures for securing social assistance can be defined as means-tested assistance programmes that leave more room for private organisation. The scope of the state′s role in providing social assistance appears to be limited. Even for some basic services (first social assistance, counselling with assistance) that are provided by public agencies under current law, other providers are expected to enter the field. As for the type of resources the state uses to provide social security, two types are used - financial social assistance (principle of the neoliberal model) and some services available to all those in need (social-democratic model).

The **Spanish** welfare model, developed in later ‘70s represented a mixed model of the liberal and the conservative ones (Mediterranean model). As it combines universalism with selectivity, this model involves a greater segmentation of the rights and status of people who receive subsidies, which is reflected in conditional access to benefits. Therefore, families have always been an essential element for the provision of social welfare. The state guarantees a basic level of social security and assumes the existence of informal help provided by family networks.

Since the dictatorship and transition period finished, the Spanish model has made important changes, but conservative elements remain mixed, with characteristics of the social democratic model, such as universal access to health and education benefits.

The Spanish constitution (1978) defined three levels of government: central, 17 Autonomous Communities (CCAAs), and municipalities. As a result, 17 regional different ministries were settled, with primary jurisdiction over the organization and delivery of healthcare, social services and other areas (education, justice, etc.), with their own government and administration within their territory. This decentralization is the key factor for organization, governance, funding, planning and policy implementation for the welfare model, that impacts health and social care provision in each region.

Spanish integration into the EU (1986) has followed: 1) the universalization of social entitlements (education, health and pensions) and the 2) diversification in the provision of social services by private and 'third sector' organizations.

Nowadays, the model combines universal and targeted access to services and benefits, in a whole system of social security and public services. It has undergone significant reforms in last years, aimed at modernizing and improving sustainability, while preserving its core principles of universality and solidarity.

The child welfare and family policies are a vital contribution to **Norway's** welfare state. The main priority in these policies is to ensure that children are brought up in safe and secure environments – part of an enabling society. Policies of a social investment state are also aiming to equalize families' wellbeing and security, both economically and socially, through empowerment and social provision, as well as having a work-life balance, and that everyone in the family should receive equal opportunities (related to gender and generational equality). Children and their families are entitled to appropriate and quality services which are supposed to be available at the right time. The Norwegian welfare system is typically a social democratic regime with a strong state and provision of universal welfare services. This is changing with increased outsourcing of welfare services and a shift from universal-based to more target-specific services, and a shift from equal outcomes to equal opportunities. Child welfare services have a broad mandate and have been considered as both family orientated and child-centred, with an emphasis on early intervention and a need- focus. It has been argued that the child welfare system has become increasingly child-centric with a strong child rights perspective.

In **Serbia**, there is a hybrid model that produces paradoxes, tensions, and incompatibilities for its prospective users. The prior socialist characteristics of the have been effectively dismantled towards the liberal principles as of the beginning of the 1990s when the paradigms of individual responsibility and elements of privatization have been introduced into the welfare policy. Its main characteristics fall within the domain of the conservative model, with the prominent existence of contributory-based schemes and rather limited social assistance programs, especially to vulnerable groups. The sustainability of public insurance schemes has been achieved at the cost of the adequacy of the number of benefits and the quality of services. The expenditures for the welfare state are at the level of the Mediterranean model, and its performance too. The gross domestic product (GDP) in 2021 was, at current prices, 6,270,097 million RSD. In comparison to the previous year, GDP is nominally higher by 13.9%, and in real terms by 7.5%. The poverty percentage was 29,8% in 2021 and 28,5% in 2022. Total public expenditure for 2021 was 47,4%; social transfers were 13,6% out of which pensions were 9,7%. In 2022, total public expenditure was 46,8%; social transfers were 13% out of which 9% were for pensions.

The **Swedish** welfare state model is a social democratic in terms of Esping Andersen's terminology. Welfare provision is considered to be universal; it covers the broad population, i.e. it is not limited to those with special needs and emphasises equality and generally high standards of living (instead of basic protection). Social insurance is an important part of the Swedish welfare system. It consists of tax-funded benefits and allowances that provide financial protection for families and children, for people with functional impairments and elderly people, as well as when people become ill or have an occupational injury. Almost everyone who lives or works in Sweden is eligible for protection through social insurance. Ideally, in the social democratic welfare regime, social assistance is seen as a last resort whereas social insurance is the rule.

In the 1930´s, Swedish welfare shaped the characteristic People's Home (Folkhemmet), where national models to the left and right of the political spectrum were built around "the people". At the time it was also labelled "the middle way" between capitalism and socialism. During the 1960s "record years" the Swedish welfare state grew rapidly. However, the welfare state and the economy,closely intertwined, soon entered into a structural crisis. In the early 1990´s,Sweden experienced a deep financial crisis and for some, the Swedish model became a cautionary example. Post-crisis arose a revised model in which welfare services were still mostly provided through tax-funding while at the same time there were reforms introducing customer/user choice and competition between public and private providers of welfare. Today this revised model is under attack due to the increasing existence of for-profit enterprises within Swedish welfare. It is also challenged by demographic developments – an ageing population and many immigrants lacking entry to the labour market.

Regarding the CEE welfare states, among others **Latvia**, Kuitto's assumption is that they do not embody any of the specifically Western models.[1] She argues, at the same time, that there is no common CEE welfare state model either. Rather, these countries join different clusters depending on the dimensions and programmes under scrutiny. The author thus confirms and further refines the findings of earlier research on the 'hybrid' or 'mixed' character of CEE welfare regimes (e.g. Cerami and Vanhuysse 2009). In sum, welfare states of the CEE region indicate an 'axiomatically Bismarckian type of welfare model, combined with universalist elements'.
Latvia case – Problems of political identity in all levels still exist. During the years of independence, the country was governed by coalitions between liberal democrats, centrists and conservatives, never ever social democrats. This effected the social policy systems reforms and development tendencies, made mixture of different elements.
Short history. Can be reflected in terms of colonization.
Baltics (Latvia) as part of the Russian empire (The 18th century – beginning the 20th century).

Latvia under occupation of USSR (1940-1941, 1945-1991)
The operation of the insurance system in Latvia was stopped and the social security system was based on the universal principles of provision. The employer was responsible for maintaining the income level, recreation of people (in cooperation with trade unions). During Soviet times, there was no private sector and the State was the only employer. The state guaranteed work, education, health system services, housing, pensions, family benefits. The individual was largely in the role of receiver and supplicant, and this did not promote his personal responsibility for his own well-being.
The social protection system of the former USSR was implemented and managed by a highly centralised governance system and powerful public institutions. Full time Kindergartens were fully covered by the state funds. No provisions were made for unemployment insurance, because the unemployment was illegal and could be punished.
After the restoration of Latvia's independence in 1991, extensive and deep reforms were carried out in social policy, mostly initiated and financed by World Bank, were aimed at reducing the role and responsibility of the state and increasing the responsibility of the individual himself for his well-being in the area of housing, pensions, social insurance and social assistance.

[1] Kati Kuitto, "Post-Communist Welfare States in European Context. Patterns of Welfare Policies in Central and Eastern Europe" (2016).

At the same time conservative approach in family policy - the family's responsibility for the individual's well-being (the current Civil Law from the times of the 1st Independence, 28.01.1937) provides for the mutual responsibility of family members (Article 188): children are responsible for the well-being of their parents, while parents are responsible for the well-being of their children. The rule of law comes into some conflict with the individualism emphasized in the liberal approach nowadays.

At the same time Latvia has been a member of the 1989 UN Convention on the Rights of the Child (hereinafter the Convention) since 1992 and children rights protection has been supervised by State Inspectorate for Protection of Children's Rights -a direct administrative institution under the supervision of the Minister of Welfare, which ensures the supervision and control of compliance with laws and regulations in the field of protection of children's rights and the operation of orphanages. The mixture of conservative policy, liberal finances, and human right based control very often causes resistance in the society and functions.

For **ESN** as a partner, not representing any special country, it instead gives a more European/ general analysis on the question of welfare models such as the following review.

The Welfare State (WS) refers to a pack of interventions aiming to guarantee minimum services through a social protection system. In Europe, this is based on a continuum of how developed the public pillar is as well as other several variables that can shape the so-called four models (Nordic Model, Continental model, Anglo-Saxon Model, Mediterranean Model). The WS has 4 main pillars:Health, Social Security, Social Services, and Education.

In Europe, depending on various variables, such as the degree of social protection or the distribution of the weight in the provision of services between the public and private sectors, we find four different models:

1. Nordic Model (Denmark, Norway, Sweden, Iceland, Finland): It is the model in which social protection is highest. Benefits are financed via contributions and the State is the main provider of services, with high quality standards.They usually base the provision of their services on the principle of citizenship, which means more general access to them.
2. Continental model (Germany, Austria, France, Belgium, Holland, Luxembourg): Based on the contributory principle, where employees and companies make mandatory contributions to create a pension plan for social needs.It also offers non-contributory benefits and subsidies, some of them not subject to any type of actions or commitments to reintegrate into the labor market.

3. Anglo-Saxon model (UK, Ireland): Social protection, both at the level of contributory benefits and social assistance, is much more limited. They tend to cover basic needs, delegating the full coverage of their needs to individuals. The criteria for granting aid and subsidies are less lax and are subject to active employ-ability actions.

4. Mediterranean model (Spain, Greece, Italy, Portugal): It is halfway between the Anglo-Saxon and the continental model in terms of aid and the role of the State in the provision of services.It is based on cultural peculiarities such as the presence of the family in the lives of individuals, which covers certain needs that in other models are covered by the State, such as child or elderly care.

Organisation of provision of social services

In **Slovenia**, the social assistance sector includes social assistance services or programs and financial social assistance for the most vulnerable persons who are unable to provide for their social well-being. Most social protection services (first social assistance, personal assistance, assistance to victims of crime, assistance to the family, institutional protection, assistance to workers) are regulated at the national level and are provided by the public sector. According to the Resolution of the National Program for Social Protection (2021), the state and local communities are responsible for creating conditions that allow all people to live a quality life and ensure human dignity when people cannot provide for their well-being. Both the state and local communities must ensure preventive, curative, and caring services and programs. The following are involved in the implementation of the social welfare system: the state, local governments, and social insurance agencies as regulators and financiers; public, private, non-profit, and nongovernmental organizations as contractors; individuals, families, relatives, charities, self-help organizations, voluntary organizations, and others who form the social networks of users of the social welfare system, including disability organizations in the case of programs for the disabled.

According to the decentralization of the **Spanish** government mentioned in a), 17 regional governments determine their respective way of planning and service provision. Although there are great differences in law in each CCAA, some common characteristics exist: the public social services system includes both economics, provision of services, and technological or instrumental benefits. In addition, services are divided into primary and specialized. Furthermore, not all services are guaranteed or maintain the same access requirements.

Its effective performance depends not only on the applicant′s compliance with the relevant regulatory requirements, but also on the budget availability at the time the service is requested.

Services are guaranteed in most of the autonomous communities that have their own portfolio of benefits. Although some citizens could be limited in their capacity to exert their rights and claim specific services. Local social services can detect needs and provide services directly though population depending on their number of inhabitants (>20.000). The role of the third sector in the provision of services is very important. However, there is a lack of integrated information systems and reliable and comprehensive data, due to the fragmentation and multiple providers. There is also a discontinuity between primary and specialized care. The decentralized model of competences generates complexity in management and financing of services, and gaps regarding portability of benefits throughout the country.

Barcelona City Council has their own model of providing social services, managed by an autonomous entity. Their units are distributed through 10 territorial districts, where proximity, accessibility and equity are some of the pillars of its social services organization. A social consensus approach between government and social partners is a relevant factor to its consolidation and sustainability.

The Ministry of Children and Families (BLD) has the overall responsibility in the **Norwegian** political system for the area of family support/policy. This ministry has responsibility on matters within child welfare services, family affairs, childhood development, religious and life stance affairs and consumer affairs. The Norwegian Directorate for Children, Youth and Family Affairs (Bufdir) and the Office for Children, Youth and Family Affairs (Bufetat) are responsible for matters relating to

state-funded child welfare services and family support/counselling services (Familievernkontor) and adoption. Their main task is to provide children, young people, and families in need of help and support with appropriate assistance nationwide. For geopolitical purposes, Bufetat is divided into five regions. services are in many regions provided at a (inter)municipality level by Child Welfare Service's (Barnevernet). Their mandate is to ensure that children and adolescents who are living under conditions that might represent a risk to their health and/or development receive the help they need when they need it, and to contribute to children and adolescents growing up in safe and caring conditions.

The NAV offices take care of adult services for work and welfare (state), including the old social service systems in municipalities. NAV is focused on the ideology of workfare, and responsible for handling pensions, unemployment benefits and poor relief. The family provision and support are generally defined as forms of social and economic support provided to the members of the family, mainly children and their parents. In this section, the focus is on the formal support and provision services, such as emotional, financial, professional, and childcare support provided to families. These services may be provided by both state and private actors.

The organization, delivery, and provision of social services in the Republic of **Serbia** are decentralized as a result of social reforms that started in the early 2000s. Legal regulation defines that services can be provided by associations, entrepreneurs, legal entities, and other forms of organizations determined by law in public, private, and civil sectors provided that they are licensed, which is aimed at providing a plurality of services. On a national level, service of social protection in addition to material provision (mainly cash benefits), are services of assessment, planning, and accommodation services (residential and foster care). Social services are financed from the budget of the Republic of Serbia, the Autonomous Province of Vojvodina, and local communities, as well as through other service providers. The state budget covers social benefits, accommodation for victims of trafficking, placement in social welfare institutions, as well as adoption and foster care. The national budget also provides salary compensation during maternity leave, parental allowance, child allowance, and allowance for assistance and care of another person.

Local governments are responsible for funding community-based services. This includes, for example, shelters, day-care, and support for independent living and housing for persons with disabilities and children and young people leaving care and counseling services. Local funds also cover the work of social protection institutions and training facilities that are set up and run at the municipal level, which is unaffordable for many underdeveloped municipal administrations. On a national level, supervising authorities for the organization and provision of services of social protection are the Ministry of Labour, Employment, Veteran and Social Affairs, and the Ministry of Family and Demography. On a local level, there are social work centers and non-governmental organizations that provide social protection.

Public health care and social services are central parts of the **Swedish** welfare apparatus. In Sweden, there are 21 regions that provide health care and 290 municipalities that provide social services and care (Swedish municipalities and regions 2021b). The state is also an important actor in terms of welfare governing. Regions as well as municipalities are politically governed organisations on regional and local levels. The Health and Medical Care Act (SFS 2017:30) and the Social Services Act (SFS 2001:453) are the overarching special laws framing the work of these organisations and they are both goal-oriented framework laws (Socialstyrelsen 2006) where the goals for the activities are stated but not governed in detail. Health care and social services can thus be adapted depending on

local and regional contexts. The municipal self-government, which is a part of the Swedish constitution, states that municipalities can make independent decisions and also charge municipal tax for financing the activities (SKR 2021b). The number of municipalities and the municipal self-government provides room for greater local variation in terms of conditions for changes in line with the ambitions of integrated care.

Public sector health care and social services constitute the main provider of welfare in Sweden. However, since the early 1990s public sector welfare also includes providers from the private sector as well as non-governmental organisations. Reforms concerning customer choice and social procurement within welfare services have fundamentally changed the organisational landscape for social welfare in Sweden. Private sector and NGO:s are important actors within social welfare, on their own as a complement to public welfare but also as a provider working on behalf of the municipal social services. As for internal organisation, the social and health services are mainly influenced by a development towards organisational specialisation. Accordingly, public sector social services are specialised towards different target groups focusing on helping individuals and families, rather than a more comprehensive organisation logic where efforts are focused on a wider understanding of social problems that also includes group and community work.

Since the 21st century the second decade in **Latvia** is oriented towards increased support for families with children as a national policy reaction to the demographic challenges, the migration to the EU countries and depopulation.

The purpose of social assistance is to provide material support to poor, low-income families (persons) in a crisis situation in order to ensure their basic needs and promote the cooperation of able-bodied persons in improving their situation. In Latvia, a mixed type of social assistance system currently operates, in which the specified social benefits must be paid in all municipalities (GMI, apartment allowance), but at the same time, municipalities with autonomous functions provided for in the legislation are provided with the right to provide other types of social assistance benefits at their discretion and financial capabilities, and determine their amounts. Social benefits are both types - universal and means tested. Current tendencies of reducing the decentralization features of the social assistance system and moving to a more centralized social assistance system in the medium term.

Free market liberal model – the providers of all kinds of social services (care houses, care at home, youth houses, shelters, day care centers etc.) can be 1) state run institutions (just special cases), municipality run institutions (mostly), NGO's (for certain sectors, as home care, depends on municipalities) and private business companies (developing very fast for certain sectors such as elderly care). The payment for the services is partly financed by client, family members, partly municipality budget. Youth houses are mostly run by municipalities or NGOs, financed by municipalities.

The national organisation of social work education

Social work education has existed in **Slovenia** for over half a century. The School of Social Workers was founded in 1955 as a two-year diploma programme. In the 1970s, it was integrated into the University of Ljubljana. It developed a four-year university-level programme and launched postgraduate specialisation programmes in 1992. In 2003, it became a faculty and introduced graduate study programmes. The Faculty of Social Work is the only faculty of social work in Slovenia.

Since its establishment, it has been a mainstay in the development of Slovenian social work and the field of social care in general.
Teaching is based on scientific research. The Faculty has developed basic forms and methods of contemporary social work such as counselling, group work, community work and work with families. Its achievements in voluntary work, action research and qualitative research in general have played an important role in Slovenian social sciences.
The Faculty constitutes a community of lecturers, students, former students, and practitioners. Its integration of practice and teaching allows for the immediate linking of work experience to theoretical reflection, which has been instrumental in the development of an elaborate concept of continuous education.
A significant part of the study at the Faculty involves practical work and training in social work methods and skills. Students are involved in practical, research and development projects throughout their studies.
Study programmes at the Faculty of Social Work are:
- Undergraduate: 4-year programme (240ECTS)
- Graduate: 1-year social work programme (60ECTS) for full-time students and another 4 programmes for part-time students
- Doctoral studies: 4-year programme (240ECTS)
- Lifelong education and training: short courses for practitioners; accredited programme on Supervision and Interdisciplinary child protection programme.

The **Spanish** social work education system works like the following description given below about the circumstances of Barcelona. Positions covered by Konsulta'm program (psychologist and social educators mostly, and social workers and nurses, in some cases) involve a community-based approach. Social work and Social education are disciplines that have the same purpose in common: to avoid the vulnerability and exclusion of the most disadvantaged groups, as well as to work on their integration into society. In addition, they share principles such as solidarity, empathy and social justice. The two disciplines are taught at the university level over a period of four years, receiving the qualification required for the provision of services. Social educators can carry out actions aimed at people suffering from social, cultural or personal issues that hinder their integration into the community. These professionals perform a pedagogical task devoted to the generation of educational contexts. It means educative actions to facilitate cultural and social promotion, understood as an opening to new possibilities for the acquisition of cultural assets which broaden the person′s educational, work, leisure and social participation perspectives. For this reason, these professionals may cater to a wide diversity of groups and intervene in different areas: education in leisure, day-care or residential services, home care, social health, civic and community action, culture, justice, social services, social and labour integration... Moreover, they can provide awareness and support for entities, during the development of their tasks.

In summary, while the social educator is an educational agent for improving target-groups circumstances through educational techniques, the social worker aims at improving both economic and social conditions, working with those who require special attention, mainly articulating social resources, benefits, referrals and advising to users. Both positions can complement each other and enrich the community and interdisciplinary intervention for any target-groups.

There are currently 16 social work education sites at universities and colleges in **Norway.** Many of them offer bachelor and master degrees for up to three kinds of professionals in the Norwegian context; social work, child pedagogy and protective care work. These may all work in sectors as child

protection/child welfare. Both at universities and colleges the staff works with both education and research, but universities tend to have higher qualified staff and more research activities. Only universities offer phd studies. Bachelor and master studies are under state inspection and regulated through learning programs/aims common for all studies on the same level (RETHOS). PHD programs are run by the universities.

Organizations like NAV and CP in addition run their own teaching and update programs developed by the central state aiming at qualifying workers to perform according to set performance indicators and political intentions.

In **Serbia**, from 1957, when the first Senior College for Social Workers was established (and 4 year Bachelor Social work program at the University of Belgrade in 1973), until 2008 the Faculty of Political Science – University of Belgrade (UB FPS) was the only institution for the education of social workers. After that, other universities in Serbia started with social work education. Now, in Serbia, aside from UB FPS as a state institution for social work education there are two more state faculties (one at the University of Novi Sad, the other at the University in Niš), so as two private Universities in Belgrade (the University of Singidunum and Higher School of Social Work). At each one of the mentioned institutions, basic and master studies of social work have been realized, but only the Faculty of Political Science – University of Belgrade has accredited Ph.D. studies of social policy and social work.

In **Sweden**, social work as an academic discipline was established in 1977 and after that the academic training and education of social work was also linked to the universities. With the entry into the universities also came the assignment to develop social work as an academic research discipline (Högskoleverket, 2003, p.21). The aim was to create applied science of social work, i.e. to make science from practical social work (Börjeson, Börjeson & Svedberg, 2008).

Social work education in Sweden is organised as a university-based, bachelor level programme and comprises 3.5 years of full-time studies. Education leading to a degree in social work is currently available at 19 universities in Sweden. In the academic year 2023/2024 Sweden has an estimated total of 9000 full-time social work students (Panican & Salonen 2022). The regulations for the bachelor level social work degree on bachelor level states: “For the social work degree, the student must demonstrate such knowledge and ability as is required for independent social work at individual, group and community level”. Social work education can also be described as a vocationally preparatory generalist education, which means 1. that vocational learning itself takes place in working life after education. Specialisation is accomplished mainly through training and education in the workplace but there is also an organisation for studies on advanced levels. The master's program (120 credits in total) is set up in different ways, but the program often includes a compulsory course in scientific theory and method (30 credits) which is followed by optional courses at advanced level and which ends with a thesis (30 credits). The master's program gives authorization to apply for doctoral studies (Panican & Salonen 2022).

Academic social work education on advanced and doctoral level is rather uncommon among qualified social workers in Sweden. In a thesis from 2020, Bengtsson states that 9 out of 10 social workers attend some kind of further education after their bachelor degree. Although, only a few move on to further academic studies in social work. In the last ten years, the proportion of academic further education among qualified social workers amounts to 2.7 % (among nurses it is 52.5 %) (Panican & Salonen 2022). Concerning doctoral studies in social work, postgraduate education rights in social

work are available at all 19 universities that offer social work education in Sweden. The number of social work doctoral students is relatively low at most universities and their educational background can be described as sprawling, in other words - not all doctoral students in social work have a background in the subject area of social work.

The Welfare ministry in **Latvia** is responsible for setting the qualification requirements. The degree level for qualified social workers is bachelor.
Social work education is provided in four state accredited higher education institutions – University of Latvia, Riga Stradins University, Liepaja University and Latvian (European) Christian Academy all of which provide both bachelor and master level education, and Baltic International Academy, which provides bachelor level education. There is no doctorate in social work in Latvia – students who decide to proceed with their academic career will choose sociology, social welfare or other related programs, but their research focus will be social work.

Three main welfare challenges to develop integrated care

In **Slovenia**, to provide integrated care in the area of working with families facing multiple challenges, there is a need to link several areas (social welfare, health, education, justice, etc.). The challenge is that each area has its own legislation, which does not necessarily presuppose the possibility of integrated care.
Therefore (second challenge), collaboration is highly dependent on the existing practises of the organisations (some have already established strong networks in the local environment, others see collaboration as an additional workload).
The third challenge is the lack of staff in all areas and thus the high workload of the professionals.
One of the challenges is also that Slovenia, like other parts of the world (Ferguson, 2004; Mongkol, 2011; Spolander et al., 2014; Hyslop, 2018; Zilberstein, 2021), uncritically adopted the neoliberal mentality that resulted in the introduction of New Public Management (NPM) into the functioning of social care services. NPM was introduced in Slovenia in 2018 when social work centres (SWC), the major public social services providers, were reorganised. The main objectives of the reform were rationalisation, financial efficiency, and control over the performance of social workers. In 2018, there were 62 SWCs in the country. The restructuring created a pyramid structure, resulting in 16 regional centres with additional units, thus totalling 63. In terms of numbers, there is not much difference, but in terms of independence and hierarchy, there is a significant difference, as only 16 SWCs are now considered legal entities, whereas there were 62 previously. This also implies less professional autonomy, more control over staff and service users, and complicated, costly computerisation and recording of the performance of employees.

In **Spain** as elsewhere there are different ways of understanding integrated care, but according to one agreed definition in Catalunya, one of the main challenges in developing integrated care is approaching the multi-level structure of competences, and care provision, focusing on pros of proximity, and needs detection for a better person-centered care opportunity. However, on the other hand, this complex structure implies big challenges such as the multiple divisions among departments, responsibilities and associated funding that impacts agents and service provision. Challenges involve functional and organizational integration at meso and macro levels, and the integration of professionals' work and service delivery, at the micro level.

Integration of data is also a big issue to tackle. As information systems are developed separately, it is difficult for them to communicate with each other, and for all care providers in one unique user data record. Even in the same region, multiple social providers don't share data records. Legal requirements for confidential issues are involved. The professionals have barriers to communicate among sectors.

Another challenge is the way professionals work under the integrated care paradigm, as a new way of applying interdisciplinary work and configuring teams of a network of services.

Integrated care for Konsulta'm services is a major challenge as it's an anonymous service and tracking and other user's follow-up is not possible nowadays by service's definition. Moreover, from a community-based perspective, not only does integration include social and health fields, but also it may involve education, leisure, sportive and, labor fields, as it is a youth-targeted program.

In **Norway** they especially identified the following three challenges:

1. Growing inequality – uneven distribution of who needs care and services. Overrepresentation of the poor in child and family services.
2. 'Hidden austerity', reduction in welfare provision, under the cover of an idea of a social investment state, those farthest away from the labour market experience most cuts in services.
3. New public management, managerialism and fragmentation of responsibility – separate systems of welfare provision and expert systems do not cooperate efficiently.

In **Serbia**, the first challenge for the development of integrated care is a mismatch between duties, division of responsibilities, and coordination of service providing between systems of social, health, educational, and legal protection. Among professionals in these systems, some ambiguities regarding job descriptions, responsibilities in the protection of users' welfare, and service providing are visible, as well as different interpretations of legal regulation that define this field.

A second challenge is an insufficient number of services on the local level, that could provide comprehensive protection and support, and unequal distribution of service in different local communities. In bigger and more developed local administrations, mostly there are an available higher number of services concerning smaller local administrations.

The third challenge is present in service standardization and licensing. While minimum standards for other groups of services are defined, there are no standards for social welfare services in the area of therapy counseling and socio-educative services.
There is limited coverage of services that could be licensed since the license procedure succumbs to organizations of social protection that provides daily services in the community, services of foster care, and services of residential/institutional accommodation and should fulfill certain criteria to have the right to be licensed. That is why many organizations provide support without a license and mostly on projects, so many services are ceasing to be provided with projects ending which has been a huge challenge.

In **Sweden**, R D Centre lists the following three challenges in society:

The first challenge is demographic development. The population is living longer and longer, which is a success for the Swedish welfare society, and during the next 10-year period, the group 80 years and

older is forecast to increase by around 50 percent. Integrated welfare needs to be further developed generally, but at the same time certain parts need to be highly specialised. Primary care, both municipal and regional, must be the base and hub of health and social care. It must be close to the residents and have good opportunities for promotion, prevention and proactive work. In primary care, continuity is built up to promote relationships and contribute to increased safety and accessibility. The increasing need for healthcare also needs to be met in a cost-effective way, which will require changed working methods and approaches in municipalities and regions, for example by using technology and digital services in innovative ways. It can also be about developing cooperation with non-public actors, civil society and other organisations.

The second challenge is the current organisations based on downpipes of specialisation and fragmentation. A major challenge linked to the transition towards integrated care has to do with the current organisation of health care as well as social care and services. From a global perspective, public health in Sweden is good and for large parts of the population, health is developing positively. But there are differences in health, lifestyles and living conditions between women and men, girls and boys as well as between socio-economic groups and certain other vulnerable groups. Cooperation between different parts of the regional and municipal health care, social services and other relevant actors needs to work more effectively, so that those with major and complex needs or co-morbidity do not risk falling through the cracks of the welfare system.

The third challenge is recruitment and retainment of competent personnel in public welfare. A basic prerequisite for public welfare to function well is that there is access to personnel with adequate skills. Municipalities and regions must work strategically to attract and retain personnel with the right education and training. From an employer perspective, the competency aspect of integrated care is a main concern, for example when it comes to enabling internal competence development. It is also crucial that the public sector in Sweden works to make better use of competence in existing staff groups. New ways of working, not least with the support of new technology and increased cooperation, can contribute to that development.

Funding - state budget healthcare expenses in **Latvia** are some of the lowest in Europe. Budget and planning is divided between 2 ministries - Ministry of Welfare and Ministry of Health.
Infrastructure - old, not systematically developed, its development largely funded by EU projects.
Human resources (lack of qualified staff, aging staff).
Results - services are unevenly distributed over Latvia, most of them are available in the capital. Long lines for state funded specialists, examinations, delayed diagnosis and treatment.

The **ESN** partner not representing a country, but the whole of Europe with its member organisations describe the following challenges below.

ESN Report “Integrated Care and Support, 2021” presented details of the questionnaires, practices, and meeting discussions of ESN’s Working Group on Integrated Care and Support between 2018 and 2021. It analyzed the integrated provision of support and social services for four population groups:

Group 1: Children and families with a focus on child protection;
Group 2: Youth with a focus on young people leaving state care;
Group 3: Adults with mental health problems;
Group 4: Older people with complex needs.

Barriers include, lack of resources, lack of effective management and leadership, lack of stakeholder engagement, unclear roles and responsibilities of team members, poor care co-ordination and interoperable IT systems with which to share information.

Niset (2004) Regarding the integration of social and health care services: Not enough public funding; The complexity of the system: Different regulations, legislation and procedures as well as very heterogeneous stakeholders' landscape with possible different interest, approaches, and power; Supply driven systems: Supply and providers' interest can be in practice very powerful; Workforce/human resources: Requirement for new type of professionals, and inter professional teams; Difficulty to determine who is responsible for the integration of services. No overall responsibility can negatively impact the decision making processes.

Children, Families and Youth (Groups 1 and 2)

Staff shortages and high caseloads have been found to threaten initiatives if professionals are forced to prioritize immediate concerns. Similarly, scale and pace of change have been found to undermine planned integration (Humphries and Curry, 2011).

WG participants on Integrated Care shared their concerns that the extent and frequency of reorganizations, as well as the frequency with which initiatives were introduced, had led to cynicism across the workforce. This, in turn, encouraged an attitude that if staff did not comply with changes the initiatives would eventually be abandoned. They were also concerned that staff confidence would be undermined if there was a lack of clarity, particularly about the distinct roles and responsibilities of the respective agencies and individuals. This included establishing the means by which agencies and individuals communicate and the means to address the different risk thresholds, styles and cultures that exist. These concerns reflect research which has found that tensions and differences between professionals may be barriers, particularly where there is a lack of clarity around roles and responsibilities (Rushmer and Pallis, 2002; Craig et al., 2004; McEvoy et al. 2011).

One of the most frequently identified barriers to closer and sustained integration is the difficulty of sharing information between agencies about people using services. Atkinson et al. (2007) and Statham (2011) point to the need for clear procedures for sharing information in order to conduct comprehensive assessments of need. There have been attempts to legislate for better information sharing but they have not necessarily addressed the problem. So, for example, in England Lord Laming found that health, police and social services missed 12 opportunities to save Victoria Climbié, often because of a failure of agencies to share information they held (Laming, 2003). In response to this failure, Section 11 of the Children Act 2004 places a duty on a range of organizations, agencies and individuals to ensure that their functions, and any services they contract out to others, are discharged when it comes to the need to safeguard and promote the welfare of children. However, agencies still report that they are encountering difficulties, either because of a failure to have a shared understanding of key information that must be shared or of the existence of agency-specific IT systems that are not accessible to professionals in other agencies in the same locality

Many of those at the Working Group meetings reported similar frustrations, which some said had recently intensified because of misinterpretations of the General Data Protection Regulation (GDPR). While this provides a framework to ensure that personal information about living individuals is shared

appropriately it should not be a barrier to agencies sharing information where and when necessary, but in some circumstances misunderstanding of its requirements has aggravated an already difficult issue.

Adults and Older People with Chronic Conditions (Groups 3 and 4)

In mental health, all respondents to the questionnaire stated that accessibility to integrated adult mental health services is an issue. Respondents from Finland, the UK and Malta presented as personal barriers poor public transport connections and commuting long distances, especially in rural areas. Respondents from Finland, Denmark, Malta, Latvia, Spain and the UK also highlighted the lack of an integrated and coordinated approach between sectors and agencies, problems of cooperation on organizational issues between government levels resulting in fragmentation of services and provision. The most significant barrier for integration identified across the questionnaires was a lack of resources. However, it is unclear whether this relates to resources required for service delivery or more specifically funding to support the process of integration.

Finally, the ESN 2021 Working Group discussion on Integrated Care for Older People identified additional barriers to integration including the lack of shared values between private and public sectors and the dominance of the health sector in leading integrated services for older people, which emphasized the disconnect between organizations with different cultural identities.

How does the welfare system impact the chosen problem for the lab?

In **Slovenia**, since the service of helping the family at home is otherwise provided as a universal (free) service in the system and is carried out by social work centres, this is definitely an advantage. Since it is provided at the national level, it is available to everyone and does not depend on the local level. However, the challenges already mentioned (incoherence of fields, diverse legislation, lack of staff, high workload and norms in social work centres) are an obstacle to providing a comprehensive service to all who need it.
For example, the norm for providing services of helping the family at home is 50 families per professional, who is usually also engaged in another area. As a result, the service is not provided proactively and continuously, but rather through so-called firefighting.

In **Spain**, the diversity of denominations and functional dependence of mental health care services are high among CCAAs. In some cases, there are differences in the extent to which health and social services are integrated.

Coverage and eligibility for mental health care services follow the framework of equitable and universal healthcare system. Usual primary care attention doesn't attend to youth mental health challenges. And special services for youth and children mental health are focused on pathology (diagnosis, symptomatic treatment and follow up of mental disorders) and treatment, with high burden of care for services and long waiting list. Moreover, these services are not used for young people as they are seen as stigmatizing.

Other youth community agents can also need counseling in managing specific circumstances with young people, and this approach is not included in any other educational or social services.

The fragmented welfare system impacts the youth population specially because they have little adherence to specific services (health, social…), and integrated services including education are very

limited for complementing some public health programs. Furthermore, mental health is not usually approached from a health and preventive perspective, specialized services don't address social and cultural determinants of mental health, with special attention to the most vulnerable groups.

As a community-based service Konsulta'm aims at integrating collaboration among other services for the young population such as, social and educational services, community youth programs, sports and leisure services, etc. It requires a high effort of coordination with all levels of the system, and other departments.

The **Norwegian** child welfare system is family service-oriented and child-centric and is a vast social welfare system that aims to provide for redistribution through measures aiming at children's caring environment, including their living conditions (Falch-Eriksen & Skivenes, 2019). However, Falch-Eriksen and Skivenes (2019) argue that the Norwegian child protection system has the following blind spots or five areas of improvements:

(1) including increased value pluralism in societies which is accentuated in relation to migration.;
(2) the wide scope for discretionary decision-making, which threatens the principle of equality.;
(3) the issue of the demands of professional competency can be substantially strengthened;
(4) the pattern of deficient involvement of children,; and
(5) the lack of attention and awareness around the conditions for choosing one's life course as an adult.

Kojan and Clifford (2018) caution that a stronger emphasis on rights will not necessarily lead to better child protection for children and families who suffer the most complex problems. The argument is that rights discourse can also reinforce and reproduce an already individualized, privatized responsibility for children's development, transferring obligations from the state to marginalized parents.

Although Norway is among the most generous welfare states in the world, inequality in earnings and wealth has steadily increased in recent decades The growth in income inequality causes disparities in access to work that the wage coordination system has failed to moderate inequalities, and that tax systems are not impacting on the richest centiles share of income and capital accumulation.

The welfare system in **Serbia** doesn't recognize enough significance of support to parenting skills during children's early development as a complex and challenging period in the life of each family. In the period of early development, it is of great importance to have coordinated action and support to parents by several systems, especially from social protection, education, and health protection, which mostly lacks in Serbia. In practice, we meet with a problem that adequate and on-time support is mostly lacking for Roma families as well as parenting skills for tracking and simulating the early development of children, which is especially important in promoting and encouraging the early development of children. Along with system overload, an insufficient number of professionals, unsuitable service coordination, and absence of appropriate services in the community, these all reflect on not recognizing the problem in Roma families on time or noticing problems after the situation that requires an emergency reaction of the system, has happened.

Roma families are insufficiently involved in the service system because representatives of different systems (pediatricians, patronage nurses, and other medical staff) that are establishing first contacts with families after the child is born, most aren't well informed on existing services from the social protection system and also with other services to which they can direct parents during the period of

early child development, or if they even direct them to that services, often the problem is lack of support in approach to that services due to several challenges (language barrier, completion of documentation, etc.).

In **Sweden**, the welfare system impacts the problem of involuntary loneliness among elderly and to understand more about why some engage voluntarily in society and others don't, by being so overwhelming in taking care of the citizens that relatives, friends and neighbours havenät been needed. This also takes away some initiatives from the persons that otherwise could help others as they know the municipality will do. This has made people very lonely and also the urbanisation has made many people have left the countryside and therefore seniors live mostly on their own. When the economy of the municipality becomes less good, then there will be fewer staff that can take care of the seniors and then voluntary people are needed again.

The welfare system in **Latvia** is responsible for providing protection and services to the target group. But, in its current state it often re-traumatizes them and is not effective in creating long term change. As described above – there is a contradiction between the responsibility of family and the responsibility of the welfare system. The welfare system is intervening, but it's not done systematically and preventively – more as problem solving, less as problem prevention.

However, right now the state is investing in this target group recognizing it as important for the future – potential tax payers, employees etc., that they need to keep from emigrating.

Summary

Section 1. Societal/national level

The countries welfare models (a)

Both Norway and Sweden describe their welfare models to be social-democratic. Both countries' welfare models provide universal welfare services, there Sweden for example provides welfare through social insurance for almost all citizens who live and work in the country. Serbia, Slovenia and Spain have a combined welfare system, containing a variety of welfare models. Serbia is described to have a hybrid model with main characteristics of the conservative model. Several countries have a mixed welfare model, where both Slovenia and Spain have a combination of the conservative and social-democratic models and Latvia don´t embody any typical model.

The organisation and provision of social services (b)

The social welfare system is organised in different ways in all countries. In Slovenia, the social assistance system gives financial support and other support to the most vulnerable groups in society that are not able to provide for their own social well being. The social assistance system is regulated by the national level and is provided mainly by the public sector. Many different actors are involved in the social welfare system, for example the state, local governments, social insurance agencies and financiers from non-profit, non governmental, private and public organisations. In Serbia, the social services are financed at the national level, regional level, local communities and other services providers. Like the Slovenian country, social services can be provided by different actors, which can be by licensed actors in the private or public sector. Latvia has a free market liberal model, where the social services are provided

through the state, municipalities and private actors.
In Spain, there are 17 different regional governments that provide service provision, but there is a great difference in the laws in each regional government district. Services are guaranteed in most regional governments, but not all services are guaranteed in all regions since they have their own portfolio of benefits. Even though the laws are different, there are some similarities in all regions, there the social service system provides economic, provision of services and instrumental or technical benefits which are divided in primary and specialised services. Both Norway and Sweden report that the states regulate the governing of social welfare, but like Spain, both Norway and Sweden are divided into regions. There are 5 regions in Norway and 21 regions in Sweden, and the difference in Sweden is that in these 21 regions there are a total of 290 municipalities that provide social welfare.

The national organisation for social work education (c)

In summary, it is reported that the education system for social work is different in all countries. Some similarities are found, for example that education in social work is an academic subject that is taught at the universities. The differences that are described characterises in the length of the programmes, there the universities in Serbia, Slovenia and Spain all offer a four year bachelor degree in social work. At Swedish universities, the bachelor degree in social work is three and a half years, and Norway and Latvia do not report the length of the education at their universities. The universities in Norway, Latvia, Serbia, Slovenia and Sweden also offer master's programs, and Slovenia additionally provides a doctoral program.

Four main welfare challenges associated with the development of integrated care (d)

In summary, there are four themes summarising the welfare challenges within the development of integrated care in the included countries, which are described below.
1, Organisational structure
All countries had to answer which three challenges they see in developing integrated care in their countries. A majority of the countries, Norway, Latvia, Serbia, Spain and Sweden, all described challenges within the structure, which may be about the current structure within the care provision (Spain) and the coordination of service provision between different systems, such as educational, health, legal and social protection (Serbia). There are also reported challenges with the organisational structure within social welfare in Sweden, which is described as based on downpipes. Norway describes that there will be an uneven distribution of those who are in need of service and that society collects welfare commissions for the most vulnerable. and that separate welfare systems do not cooperate in a well-functioning way.

2, Legislation
Serbia and Slovenia describe legislation as a challenge in their work, which is affected by different legalisation in different areas that are needed to be linked together, such as social welfare and health care. In Spain, professionals do not share the same computer system within the same region, which also involves legal requirements for confidential matters.

3, Collaboration
Collaboration is reported as a challenge by Norway, Serbia, Slovenia, Spain and Sweden, where, among other things, it is described that collaboration between different social

systems is needed and that collaboration is affected by the existing practice within the organisations. Furthermore, Spain describes information systems being developed separately. Even within the same regions, social providers do not share information systems, which leads to difficulties in communication between them. In conclusion, Norway also describes that separate welfare systems do not collaborate in a well-functioning way.

4, Staff

Staff is described as a challenge in different ways. For example, Latvia and Slovenia describe a lack of professionals in several areas, which can lead to a high workload for those working in the social welfare sector. Sweden also describes the need for professionals in the social sector, that staff needs adequate training and the organisations need to get better at retaining and further developing existing staff. In conclusion, Spain describes challenges regarding how staff should work under the integrated care paradigm.

The welfare systems impact on the different labs (e)

The countries all described multiple challenges within the welfare system that is linked to the different labs. Norway, Serbia and Slovenia describe that professionals in different ways can have a negative impact on the lab, for example, lack of staff (Slovenia, Serbia) and competence-enhancing efforts (Norway). Furthermore, Latvia, Serbia and Slovenia, describe that lack of collaboration in the social welfare system can have a negative impact as well as absence of appropriate services to the target groups.

Chapter 2 project aim, target group and stakeholders

The overall aim of the project was:
1. To develop & test a new 'Learning & Innovation Lab' model & approach to the delivery of more integrated & person centred health & social care services to particularly disadvantaged groups in the community including the elderly, families with young children facing multiple challenges & young people with mental health
challenges. The model will seek to create the environment needed to bring together stakeholders, including service providers, researchers, training providers & user groups to develop new approaches to service delivery & learning & key objectives will include the development of new tools to enable front line health & social care staff working with these groups to develop the new professional competencies & skillsets they need in the context of specific problems identified in delivery of services to these groups, & the move towards more holistic care models designed to improve the quality of care to individuals.
2. The motivation for the project was the urgent need, identified in all the partner regions/countries, for a new approach capable of fostering collaboration & overcoming professional & managerial barriers to more integrated & client centred service delivery & to provide flexible access to the skills required by front line professional staff & stakeholders to achieve this.
3. The project was also motivated by the positive results of small pilot Learning & Innovation Lab projects led by R & D Centre Linkoping & NTNU Trondheim (details below).
4.The project will develop innovative products/tools enabling staff in a major sector to gain access to skills they need to adapt to changing labour market needs , promote flexibility/innovation in VET & will use these products to establish a transnational network to promote innovation throughout the EU.

The main problem for the lab

The main problem that the **Slovenian** lab wants to address is how to organise services for families facing multiple challenges in the local community so that they can effectively address the needs of families. Currently, the problem is the heavy workload of professionals and the lack of staff to support families according to contemporary social work concepts. If staffing were improved, professionals would need mentoring support to consistently apply the theoretical knowledge they have developed to practise and develop new skills.

Responses received from focus group participants also indicate the following needs: time to work and opportunities for preventive work; accessibility to various forms of support. Another challenge is overcoming isolated work within sectors and professional groups. The analogy used by focus group participants is illustrative: professionals remain in their own ″bubbles,″ and we need to find ways to connect those ″bubbles.″

The main goals the **Spanish** lab Konsulta'm program addresses are to provide an equity community-based service to approach youth and adolescents mental health needs, by directly attending their request. It also provides listening and guidance for professionals in the community that work with this target group. The services are provided in natural environments for adolescents and young people to avoid the stigma of mental health settings.

A new model of community-based intervention is being implemented and the lab will help in its design and consolidation. It means to approach youth emotional needs in natural contexts, with

different agents and to early detect complex needs and respond with appropriate solutions. Some of the challenges the program must tackle, and the lab may help do it are:

1, To integrate the program in the community services network, with close collaboration with other services. To clear up and provide a good comprehension regarding its own mission, function, and actions, avoiding misunderstanding expectations for both users and other services.
2, To reinforce mental health prevention from a holistic perspective, without pathologizing, while offering psycho-social intervention and guidance, considering context complexity, and working with other youth agents in the field.
3, To improve professional networking and prioritizing detection and needs for referral to specialized services, when is required.
4, To support professionals at schools, campus and / or other facilities or services working with youth people (social educators, teachers, leisure instructors, municipal team staff, etc.) on a day-to-day basis.

In the **Norwegian** Famwel lab we want to work with families who experience multiple problems and who are in contact with the Child Welfare Services (CW/ CWS). The character of their problems can often be defined as wicked, and can be problems that are interwoven at structural, group and individual level. This can be poverty, school drop out, unemployment, poor housing conditions, discrimination, exclusion, health issues (physical/chronic, stress, mental, addiction) or relational problems such as domestic violence or high conflicts in the family.

We know from previous studies that the welfare services struggle to meet the needs of families with multiple challenges (Clifford et al., 2015; Kojan & Storhaug, 2021). Their situation is often not contextually nor properly understood or recognised by the CWS, leaving marginalised families even more behind (Thrana & Kojan, 2020). For example, a recent Norwegian study found that low-income families in contact with CWS have four times as high likelihood to receive CW measures as the overall population, but the socioeconomic hardship that frames their everyday lives are not recognised by CWS (Kojan & Storhaug, 2021).

The lab may deal with various aspects of the CW system, such as through direct involvement and collaboration with children and families in contact with the services, professional competencies, and practices, organisation, interprofessional collaboration and/or policy development. Topics may include the participation of children and parents, reframing understanding and how to provide better services for families experiencing multiple problems, or children suffering from environmental challenges at school and in their upbringing environment.

In **Serbia**, it is agreed that baseline study and future project activities should focus on Parenting skills in the early development of children in Roma families. The main idea is to deal with an integrated approach to encouraging nurturing and positive parenting in Roma families and to direct focus on strengthening partnerships among key factors that work on support to family skills and nurturing non-violent parenting.
There are significant differences between the Roma and the general population in Serbia in terms of access to education, health care, and social services. Many studies show that the Roma are the poorest and most vulnerable population in Serbia due to the generational reproduction of poverty and social exclusion, extremely poor living conditions and living standards, and omnipresent discrimination. That is why the improvement of the position of the Roma population is recognized as one of the national priorities in numerous strategic documents in the Republic of Serbia. The latest data from MICS 6 from Roma Settlements (2019) also testify about multiple deprivations of the Roma

community in Serbia in areas such as living conditions, housing, access to services and rights such as health care, education, and employment, as well as social protection system.

In **Sweden**, based on changes in demographics and other framework conditions, there are many indications that the current welfare system in the near future will not be able to deliver welfare services to the same extent and in the same form as today. This situation places demands on various actors to develop alternative strategies and solutions that contribute to welfare being maintained.

The overall problem and challenge in the planned lab is about exploring and testing innovative ways to create opportunities and incentives for civil society to contribute to social/other support for individuals/groups/society. More specifically, the lab will aim to develop an incentive structure for social volunteering that involves business, businesses, volunteers/civil society and users/citizens at the local community level. A central part of the challenge is to create incentives that benefit all these parties.

The primary target group on the citizen side is primarily older people who need support in their own home, but it can also be older people who live in nursing homes. The idea for this lab is inspired by multi-actor models where actors with partially different agendas can develop joint strategies that benefit all involved. In this case, it is about, in a local context, the elderly in need of support, municipal welfare activities, civil society/volunteers and business.

The main problem we want to work with in our **Latvian** lab is youth between age 13 and 25 who experience social and geographical obstacles that prevent their successful integration in society and workforce. Social obstacles – discrimination based on age, sex or ethnicity, anti-social behavior, young single parents, youth after out of family care, ex-convicts, addictions from substances or processes. Geographical obstacles – youth from remote areas, youth with limited opportunities and lack of services.

The goal is to participate in creation and development of a high-quality and sustainable system of work with youth to create tools for youth development, higher quality of life and strengthening their participation. This goal is developed in accordance with the national Children, youth and family development guidelines for 2020-2027.

For **ESN** being not a country, not choosing one problem to work with, there is still some to say about the facilitating factors for integrated care.

Among the most commonly mentioned factors is the importance of clarity. Of equal importance is the commitment of senior managers, effective leadership, training, learning opportunities and support for staff, and robust structures around planning, financing and commissioning, alongside secure funding arrangements.

Although training and learning opportunities and resources were considered to be very important by many responding to the questionnaire and taking part in the meeting, the commitment of stakeholders and effective leadership at every level were reported to be the key factors in supporting the delivery of integrated services. Over half of ESN members that responded to the questionnaire on youth leaving care reported that leadership and effective management and the commitment of stakeholders were very important. Half also acknowledged the importance of co-production.

Alongside committed leaders, stakeholder engagement was seen to be an essential requisite for establishing a receptive environment for integration.

In responding to the questionnaires, many also pointed out that leadership and stakeholder commitment had to be accompanied by learning opportunities aligned with new ways of working, as well as sufficient resources to sustain these. There was also a consensus among those participating in the meetings that an important starting point was the commitment of staff to new ways of working. This, in turn, depended on embedding a shared understanding of how and why things were changing as well as providing, as far as possible, assurances that this would continue to be a priority.

In discussions during the Working Group meetings participants agreed that successful implementation of integration depended on the extent to which there was a positive and receptive climate across the organizations involved. Johnson et al. (2003) examined the role of organizational climate in relation to integrated working and found a positive relationship between organizations that encouraged teamwork and flexibility with increased levels of integration. Huxley et al. (2011) found that secure professional identity within multidisciplinary teams was associated with higher levels of perceived integration, and Gardner (2003) identified a positive relationship between organizational identity and staff confidence in working practices.

In relation to children, just as it is vital to be completely transparent with staff, it was considered to be as important to achieve this with families. A number of participants to the Working Group referred to the distance, and frequent antipathy, that existed between some parents and the agencies that worked with them. Good communication was considered to be key to success. Domian et al. (2010) examined factors that influenced the abilities of mothers who were perceived to be at the highest risk for child maltreatment in a home visiting programme. They found that practitioners felt that better communication and information sharing were needed to improve multi-agency practice and that this would be helped by the adoption of a common language that would be used with families.

The introduction of new arrangements provided an opportunity to reshape this relationship and open new dialogues with families, particularly as many were designed to offer more intensive support than had previously been available in an attempt to route families away from more disruptive interventions. While not all research has confirmed the benefits of co-location (Cameron and Lart, 2003; White and Featherstone, 2005) others have argued that co-location is an essential component of integrated working (see, for example, Park and Turnbull, 2003; Memon and Kinder, 2016). There are subject – specific studies that indicate the benefits of co-location. For example, McNaughton and Paskell (2014) found that professionals reported that co-location was effective in improving the identification of boys and young men at risk of sexual exploitation. Those attending the Working Group meetings were overwhelmingly positive about the advantages of co-location in opening up the possibility of meeting and addressing specific needs in one place, even though there was very little experience of it in practice.

Creative ways of organizing and delivering services are being proposed to meet the growing demand for improved service user experience and outcomes for people using services. Key drivers and aims for integrated care and support can be categorized broadly at an individual or micro level, an organizational or meso level and a system or macro level.

At an individual or micro level, integrated care and support aims to wrap services around the person, so that their care and support is more personalized (Stoop et al, 2020). At an organizational level, the

aim is to increase collaboration and co-ordination between services to reduce fragmentation and prevent ‘gaps’ in services. At a system level, integrated care and support aims to create more sustainable public services through maximizing cost-efficiency, by reducing duplication of services, for example.

In relation to adults and older people with chronic conditions, the findings from the questionnaire on integrated care for older people allow us to categorize broadly facilitating factors for integration as: team processes, resources, and management and leadership.

Here is the list of all drivers mentioned/included in the questionnaire: Share vision and goals, effective management, sufficient resources, stakeholder commitment, teamwork, effective leadership, trusted relationships, involvement of older people, legal certainty (data sharing), supportive learning environment, joint training time.

Overwhelmingly, shared vision and shared goals are seen as the most important facilitating factor for integration.Integrated working requires effective management and leadership. Unsurprisingly sufficient resources are also a pre-requisite for integration as is effective teamworking and the development of trusted relationships. Surprisingly, education and skills development were deemed to be less important for integration, specifically joint training and a supportive learning environment.

These findings were further discussed during the ESN 2021 Working Group meeting on Integrated care for older people in which the importance of relationships between professionals, engagement, governance models, legislation and policy, information sharing and effective management were emphasized by participants. In general, the factors identified in the questionnaire echo the findings of other studies such as Nolte (2018) and Looman et al (2021). A number of actions can be taken to win ‘hearts and minds”,develop a shared vision of integrated care and learn about each others organizations, roles and responsibilities. For example, setting up regular meetings and joint training. In Latvia, for example, “[joint] meetings where common goals and values are discussed and established” contribute to a smooth implementation and in Spain: “Continuous training, identification and dissemination of practices” are seen as key facilitators for integration (Jimena Pascual Fernández, Regional Ministry of Social Rights and Welfare Asturias Spain). The importance of the development of personal and trusting relationships, which takes time and ongoing commitment is cited in other studies (MacInnes et al, 2020), and confirms the questionnaire’s findings.

Main drivers of integrated care:

<u>Children, Families and Youth (Groups 1 and 2)</u>

It is now widely accepted that families with complex, multi-layered problems require an integrated package of support (Platt, 2012; Ward, et al., 2014).

Integrated working seems particularly suited to the early identification and management of risk, improved information sharing, and shared decision-making, and it has been more widely adopted by preventative and early intervention services (Siraj-Blatchford and Siraj-Blatchford, 2009).

Integrated working practices are seen to have the potential to address the multidimensional nature of many problems faced by families by allowing access to the expertise of more than a single professional.

The main drivers for change in nearly all the responses to the questionnaire submitted in 2018 and in descriptions of the practices identified were: First the desire to establish preventative approaches. The second driver was to achieve improved outcomes for children and families by avoiding the most intrusive interventions such as removing a child from their family's care. In some cases, this meant new services had been established, for example the National Association of Social Workers in Italy has been involved in the establishment of reception centres for unaccompanied children seeking asylum. Policy and legislative changes were also significant drivers when attempting to do things differently. While there were references to specific pieces of legislation to mandate integration, such as the Italian Law 328 (2000) and the Children and Young People (Scotland) Act 2014, there were far more explanations of how legislation covering aspects of child and family life has supported the development of greater integration. In Scotland, Children's Services are responsible for social work with children and families, as well as services for early years, young offenders and education services. It developed different ways of working with a range of agencies – police, prisons, courts and the voluntary sector – to provide focused support for vulnerable families. The work was supported by an Integrated Children's Services Plan for 2013–16, Reach for a Better Future, which set out how multiagency services would allow professionals more opportunities to work together to improve outcomes for children, young people and their families. It only focused on services provided on a multiagency basis, and services provided by individual services and agencies were set out in separate plans. In Hungary, for example, there is no one piece of legislation, but various laws relating to child social care, health and education contain elements that support the provision of integrated support. Even in countries without specific legislation or policy directives some professionals and agencies had decided that the only practical way to improve service delivery was through greater collaboration. The Rainbow Project in Arad, Romania brings together a range of professionals to provide support for families who are at risk of having their children taken into care or who might otherwise abandon their children. It offers, among other things, childcare, education, counselling, recreational activities and independent life skills.

Integration may also be a way of making the most effective use of resources. In recent years this has been another powerful driver. As many countries have faced the reality of declining resources for public services, agencies have adopted new ways of working which, in turn, have frequently involved adopting more integrated approaches to service delivery (see Solar and Smith, 2016; Barnes et al., 2018).

In a few instances, the need to achieve savings and deal with pressures on services were mentioned.

The need to break down barriers and provide more seamless services. Ghent Public Centre for Social Welfare (OCMW), Belgium has worked to demolish the traditional divides between professions. The Flemish government has done much to encourage greater collaboration and Ghent has designed a service to allow the early detection of families in need by placing social workers in schools and allowing appropriate support plans to be developed. The collaboration is judged to work well and be leading to families receiving earlier and more sustainable help. Montero and colleagues' (2016) study looking at how local public services are working together to improve people's lives highlighted that a recurring aim in integrating social services was to improve outcomes for service users (see also Pasco et al., 2014; Carlisle, 2010). However, they also identified that multiple drivers lead to more integrated service delivery, including a commitment to prevention, new policy and practice, and research evidence that signals the benefits of new models of care (Devanney and Wistow, 2013; Webber et al., 2013; Collins and McCray, 2012). Findings from the 2019 questionnaire on supporting

the transition to adulthood of young people leaving care revealed that the most important reasons for cooperation with other sectors were: • Legal and policy developments; • to promote more preventative approaches; • to improve outcomes for young people leaving care. Cooperation with other sectors in response to financial difficulties was also acknowledged to be very important by ESN members from eight countries.

Adults and Older People with Chronic Conditions (Groups 3 and 4)

Findings from the 2020 questionnaire on integrated care and support for adults with mental health issues revealed that the most important driving forces for cooperation with other sectors were to:

- Improve service outcomes, meaning the outcomes for service beneficiaries either in the community or in care settings appropriate for care of mental health. All respondents identified as 'very important' or 'more important' to improve service outcomes. Broadly in line with other studies including the report by the ESN on Integrated Social Services in Europe (2016) in which outcomes for service users was a significant motivator for integration.

- Promote preventative approaches, meaning measures, primarily undertaken within the community which sought to identify, together with other services and the beneficiary any potential problems or issues which could escalate, requiring more intense support or potential hospitalization. 89% of the questionnaire respondents identified as 'very important' or 'more important' to promote preventative approaches.

- The introduction of new policy legislation and addressing financial issues was identified as important by 87% of the questionnaire respondents.

- At a policy level, integrated care is seen as the essential service delivery model to ensure the sustainability of health and social care within the context of increasing demand and limited resources.

- Addressing financial issues was identified as important respectively by 75% of the questionnaire respondents.

How does the lab problem relate to challenges related to integrated care?

In integrated care in **Slovenia**, it is important that support for families facing multiple challenges is continuous and based on mutual cooperation and understanding among all parties, with the family playing a central role in the joint project of help.
Previous research shows that one of the problems of inadequate support and assistance for families facing multiple challenges is that families are overwhelmed by the number of times professionals enter and leave the family and that assistance is not integrated (Matos and Sousa, 2004; Walsh, 2006; Madsen, 2007; Melo and Alarcão, 2011, 2013, etc.). This is what we are trying to overcome in the Lab. We want to help professionals work coherently (both within SWC and with other services/sectors). Given the needs expressed, there is a need to explore opportunities for preventive work with families facing multiple challenges.

Integrated care is a big challenge for Konsulta'm program in **Spain** due to its characteristics and the recent implementation: community-based, with professionals being part of the youth mental health specialized care, and the need of close networking coordination with other agents. It involves high efforts to define the model, without missing identity or covering other services' needs that are not included in the own model.

Coordination among services that take part of the same network, even at different levels of the system, is very important to guarantee the quality-of-service provision. Especially for this target-group, the need of complementing approaches (social, health, educational…), and integrating care is highlighted with new open-minded interventions. There is a need for common spaces to share experiences and reflection regarding coordination and integration strategies. This may improve interventions and boost exploring all possibilities to better approach other demands, such as working with groups and with family members. Community-based interventions involve referring protocols and agreements for different kinds of circumstances and complex cases which need to be clarified.

In **Norway** the problem is connected to the uncertainty about responsibility for the families′ living conditions between different parts of the welfare and service system. The families have complex issues that require interdisciplinary cooperation and clarification about the responsibility and progress of the measures. It also requires close collaboration with the families and children.

In some circumstances, the complexity of the welfare system can lead to the most marginalized users not getting the help they need. Many families are in contact with several parts of the welfare service system at the same time, which often requires a lot of resources and motivation. For some families being in contact with CWS, is experienced as an additional burden to the other challenges and problems in the families′ everyday life. Some of the families′ challenges can be language barriers and health problems or that the welfare services are fragmented and complex. Another side is that the CWS, which often has the responsibility to coordinate the help for the families, is in a pressed work situation. Interdisciplinary collaboration with many professional services involved l require capacity in the services and time enough for each family.

Government institutions in **Serbia** play a significant role in providing services to Roma, such as health services, education, and social benefits (cash benefits and children's allowance being the most significant ones). However, in the field, most of the so-called "soft services" are being provided by local NGOs. An important role in increasing the inclusion level of the Roma population should be played by caseworkers at centres for social work. It is pivotal that they should be linked to a professional network in the community and fulfill their role as coordinators when working to achieve social integration of the isolated Roma families.
The local policy of inclusion of Roma implies a multi-sectoral approach and the participation of several institutions at the local level with the active participation and coordination of local mechanisms for the inclusion of the Roma community. The position of vulnerable groups cannot be improved without comprehensive consideration and cooperation of institutions belonging to different sectors. Certain problems also require the establishment of integrated services or at least precisely defined cooperation protocols, information exchange, and the formation of joint bodies/commissions.

The challenge in **Sweden** addresses Integrated Care in several respects. A challenge in the transition to Integrated Care is related to a lack of resources in relation to the need for care and care. An increased commitment and a developed incentive structure for civil society to contribute to the welfare system can have a relieving effect on the existing welfare system. The efforts that civil society

can contribute can have a preventive effect when it comes to, for example, countering loneliness, but also contribute to meaningfulness for volunteers.

In **Latvia**, often these are the young people that don't have access to preventive or rehabilitation services, that have suffered from abuse or neglect from their caregivers, that haven't received appropriate healthcare, timely diagnosis and treatment for their mental health challenges.
At this point the awareness is growing about the necessity for systematical approach and it is being developed for integrated care for infants and young children. But there is a lack of systematically coordinated support and services as well as collaboration between institutions and specialists for this age group (13-25). It is important to develop methods and participate in the creation of this system.

The target groups's living conditions according to research and written material

In **Slovenia** families facing multiple challenges are families living in poverty and facing internal and external stressors on a daily basis. They face circumstances that contribute to multiple crises. These families struggle to adapt to a harsh environment that provides them with unfavourable resources. This causes families to become overburdened and destabilised. They often lack opportunities and the necessary time and support to learn, develop, and strengthen their skills and knowledge (Mešl, 2018; Mešl and Kodele, 2016; Sharlin and Shamai, 2000; Melo and Alarcao, 2011, 2013; Madsen, 2014). The narratives of these families are too often dominant family narratives of failure that are inherited from generation to generation (Madsen, 2007).
No quantitative data are collected at the country level on the living conditions of the target group. Our research to date has been qualitative. The families we have worked with have cited poverty, unemployment, housing problems, financial support, help with learning, relationship problems, domestic violence, substance abuse, etc. as the most important issues to work on. Another problem also in Slovenia is the transmission of the experience of a family facing multiple challenges, from one generation to the next. Ways must be found to provide adequate support and stop transmission.

In Barcelona, **Spain** lives a total of 144.072 adolescents and young people between 12 to 22 years old, 48,6% girls and 51,4% boys (Statistics and Data Dissemination of Barcelona City Hall).

The FRESC survey in the city (Risk factors at secondary schools), elaborated by Barcelona Public Health Agency, provides a global vision of adolescents and young people in the city. Compared to FRESC survey 2016, some indicators worsen, and gender and socioeconomic inequalities are evidenced. Furthermore, it shows a tendency of psychological distress and a worsening mental health among adolescent population, especially in girls: 4 out of 10 girls show emotional distress (38,6% girls and 20,4% boys 13-19 age). Moreover, 19,9% of girls and 11,1% of boys are at risk of suffering a mental health problem, and 24,8% of girls and 18,1% of all boys are on the verge of suffering from poor mental health. Regular or bad perceived health is higher in disadvantaged socioeconomic neighborhoods, it increases with age, and it is higher in girls.

There is an increasing discomfort with body image in adolescents. Body dissatisfaction exceeds 50% in both sexes and is higher in girls (63,6% girls and 56,7% boys). On the other hand, 12% gambled last year and 6% may have problematic behavior regarding gaming. In general, there is a tendency for insufficient sleep and excessive use of screens. Globally the consumption of tobacco, alcohol and cannabis continues its downward trend, especially in boys.

Moreover, 16% of girls declare the feeling of loneliness, and it doubles that of boys, and is greater in neighborhoods socioeconomically disadvantaged. Physical appearance is the main cause of discrimination in both sexes. In girls, gender is the second cause of discrimination, while in boys it is the origin or ethnicity. Finally, there were three deaths of adolescents (during 2020-2021) by suicide (2 girls and one boy).

In **Norway**, families experiencing complex living conditions have difficulties. Parents are often unemployed / in insecure employment. Parents often suffered abuse / neglect as children and / or abuse and dysfunctional relationships in early adulthood. Many one parent families. Low incomes and poor living conditions. Family members with poor mental or physical health including physical and learning disabilities. Families socially isolated from relatives and communities. Many children have ADHD diagnoses. Many children have also developed poor health, and are often ill.

Often the families are not sure where to get help and whom they should relate to in the "helping services." Many of those families experience little help in the responsibility groups- that nobody takes responsibility and that the "helping services" are to a small extent concerned with their lives.

In the 2011 census, there were 147,604 ethnic Roma registered in **Serbia**, composing 2.1% of the total population on the territory of Serbia excluding Kosovo . Individuals and families living in substandard settlements are in a particularly unfavorable position. A total of 583 substandard Roma settlements in 169 cities and municipalities were mapped on the territory of the Republic of Serbia. It is estimated that the number of Roma living in absolute poverty is increasing, that around 40% of them face discrimination, and that the Roma population still often faces hate speech and threats that have not been investigated and sanctioned. Within the Roma population, there is a widespread perception of institutional discrimination, primarily in terms of more difficult access to the right to social protection and discriminatory speech by professionals.

Children from Roma communities face numerous difficulties in exercising their right to quality education. Members of the Roma community are often confronted with negative stereotypes and discrimination on behalf of schools. Roma children under the age of 5.5 are far less involved in preschool education. While the coverage of children aged 3 to 5.5 in preschool education amounts to about 50% in the general population, the rate in the Roma population is only 6%. Major disparities have been observed between the mortality rates, nutritional status, and education among Roma children and other children. 60% of children from Roma settlements receive child benefits. Child benefits are received by 53 percent of children whose mothers have no education as opposed to 68 percent of children whose mothers have completed secondary school or have higher education. In 2014, in Roma settlements almost every second household received cash social assistance, and among the poorest, according to the quintile index of well-being, as much as 63.8%.

In **Latvia** material from experts that are currently developing methodology for social work with youth show:

According to the Youth Law, a young person in Latvia is any person between the ages of 13 and 25, regardless of life experience, state of health, skills, needs. The Law on the Protection of Children's Rights and the Law on Youth are among the legal frameworks that also determine the social worker's responsibility, care and the need for professional intervention in working with young people, including:

1. support and promote youth initiatives, creating favorable conditions for their intellectual and creative development;
2. to provide young people with the opportunity to acquire the skills, knowledge and competences necessary for life through non-formal education;
3. to provide young people with the opportunity to make good use of their free time;
4. to provide young people with access to information appropriate to their development needs.
There are around 214,000 young people in Latvia who, according to the "Youth Law", are defined as a separate target group that requires special attention and a series of support measures to promote the development of a versatile personality. Of these 214 000, 27 033 live in Zemgale region and of these 52% are male and 48% are female.[2]

Aspects of these different norms sometimes see the young person as a child, sometimes as a young person who is in between a child and a young person, and sometimes as a fully responsible adult. The theoretical materials discuss the period of development and maturity of a child, early adolescent, teenager, late adolescent and adult. Consequently, confusion may arise in social work as well, whether one is working with a child, a young person or an adult. In the following chapters, we will clarify the client's target group in social work with young people.

After 2021, according to various statistical data, the situation in Latvia is described as follows:
1. 32% of children have suffered from parental physical punishment as a method of upbringing [3].
2. During the year, a total of 532 children were victims of criminal offenses, of which 304 were minors, 152 children were victims of criminal offenses against morality and sexual integrity, 118 children were victims of cruelty and violence [4].
3. 1085 protocols of administrative violations have been drawn up for physical or emotional violence against a child [5].
4. Orphan courts informed municipal social services or other responsible institutions about 1,344 families with 2,418 children (of which 701 children were young people aged 13 and over), in which the child's development and upbringing were not sufficiently ensured.
5. In total, for 1009 children (of which 279 were young people aged 13 and over), 900 persons have had their parents guardianship rights terminated [6].
6. Until December 31, 2020, information on 902 children aged 5-18 declared in Latvia, who for various reasons are not registered in Latvian educational institutions, was entered into the State Education Information System.[7]
7. With the answer "rarely or never", 49% of children (10-17 years old) answered the statement "I like going to school", 21.3% answered the statement "Teachers listen to my

[2] Centrālās statistikas pārvalde
[3] Pārskats par bāriņtiesu darbu 2021. gadā kopsavilkumu, Valsts bērnu tiesību aizsardzības inspekcija, izgūts no
[4] Pārskats par bāriņtiesu darbu 2021.gadā kopsavilkums, Valsts Bērnu tiesību aizsardzības inspekcija, izgūts no:
[5] Pārskats par bāriņtiesu darbu 2021. gadā kopsavilkumu, Valsts bērnu tiesību aizsardzības inspekcija, izgūts no
[6] Pārskats par bāriņtiesu darbu 2021.gadā kopsavilkums, Valsts Bērnu tiesību aizsardzības inspekcija, izgūts no
[7] Informācijas apkopojums Par obligātā izglītības vecuma bērniem, kuri nav reģistrēti nevienā izglītības iestādē (2020./2021.m.g.), Izglītības kvalitāte valsts dienests, 18.05.2020., izgūts no:

opinion and treat me with respect", 34% for the statement "If I have problems at school, I know who to turn to for help and advice"[8].

8. Young people have most often experienced emotional abuse (31.5%), physical neglect (27%), emotional neglect (23.8%), less often physical (16.4%) and sexual (10.3%) abuse. Girls experience violence more often than boys. They do not feel appropriate at school (24%), and also experience physical or emotional violence at school (9%).[9].

9. In Latvia, the number of children who live in overcrowded rooms is extremely high - a total of 57% of minors do not have their own room or live in a room with adults or more than one other minor. It can also be observed that Latvia has the highest number of children who live in poorly maintained or unrenovated housing. For example, 14% of children do not have a shower or bath at home, 13% do not have an indoor toilet, while 9% of children estimate that their home is too dark[10].

10. In 2020, minors committed 812 criminal offenses, which is 143 offenses less than in 2019[11].

11. In 2020, 4,716 protocols of administrative violations for minors were drawn up[12].

12. In 2019, 2828 administrative violation protocols were drawn up for smoking committed by a minor, which is 29.9% of all administrative violation protocols, and 2077 administrative violation protocols for drinking alcoholic beverages, which is 28.3% of all administrative violation protocols.

13. In 2019, municipal administrative commissions have adopted 1,782 decisions to issue a warning to a minor, 1,128 decisions to set behavioral restrictions, 37 decisions to impose an obligation to undergo treatment for alcohol, narcotic, psychotropic or toxic substances or other addictions. [13].

14. Urban social workers, working with families with children, have an average of 30 youth cases per year. In rural areas, less than 20 cases. The average number of active cases is most often (47 respondents) 1 to 5 youth cases, 16 respondents indicated 5 to 10 cases, 11 respondents 10-20 cases, 7 respondents more than 20 cases (including 2 answers of social pedagogues)[14].

15. According to the data of the survey carried out by the developers of the methodology, the most important criteria when a young person becomes a client in the social service are: administrative violations 62 answers (hereinafter: resp.), problems at school (being late for school, difficulties in building relationships at school) 34 resp., behavior problems 27 resp., uses alcohol and other substances/addictions 15/27 resp., vagrancy 13 resp., parental problems (this includes parents with GRT, poverty) 13 resp., violence 11 resp., others under 5 resp. (young people with special needs, conflicts with peers, a young person after out-of-family care, a young person with a child, suicide attempt, difficulties with social integration);

16. In more than 90% of cases, social workers do not continue working with young people after the age of 18, except for working with young people after out-of-family care or GRT cases. In only 22% of cases, social workers work with young people according to separately developed approaches and case management conditions [15].

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[8] Pētījums "Bērnu līdzdalības novērtējums" (2017). Pieejams

[9] Rīgas Stradiņa Universitāte (b.d.) Latvijas jauniešu psihoemocionālo traucējumu saistība ar bērnībā pieredzētu vardarbību ģimenē. Pieejams:

[10] Bērnu labsajūta un labklājība Baltijas valstīs: kopsavilkums. Pētījums (2019).

[11] Valsts policijas 2020.gada pārskats (pieejams

[12] https://www.ic.iem.gov.lv/lv/media/1440/download?attachment

[13] Informatīvais ziņojums "Par bērnu noziedzības novēršanas un bērnu aizsardzības pret noziedzīgu nodarījumu pamatnostādņu 2013.-2019. gadam izpildi" 2.pielikums

[14] Metodikas „Sociālais darbs ar jauniešiem" aptaujas rezultāti, 101 dalībnieks, iegūtiem datiem, 01.2022.

[15] Projekta izpētes laikā 2021-2022, no 102 respondentiem iegūto atbilžu kopsavilkums;

According to the above data, it can be concluded that from 10 to 20% of children and young people are in the field of risk or danger, which hypothetically could correspond to the target group of clients of social work with young people. Numerically, it would be between 21,000 and 42,000 customers in Latvia. According to the data of the survey conducted by the developers of the methodology, 95% of social workers in Latvia combine their work with young people with other social work practices, such as social work for families with children, social work with adults, work with all groups in municipalities, etc. The majority of young people end up in the social service after being notified of administrative violations (protocols).

The most unclear cooperation and support is related to school information reports about school violations or irregular school attendance. The wide range of the target group in terms of age, problems, difficulties or difficulties of other cooperation partners in working with young people, even often the non-differentiation of problems according to severity, complexity or professional association (functions), affects the boundaries of the field of social work and professional work.

Possible stakeholders, key staff groups and organizations concerned

In **Slovenia**, the national level consists of Ministry of Labour, Family, Social Affairs and Equal Opportunities, The Association of Social Work Centres, Director of SWC Gorenjska, Social Inspector, Dean of the Faculty of Social Work, Social Protection Institute of the Republic of Slovenia, Ministry of Health, Ministry of Education, Association of Friends of Youth.
The local community level consists of director of SWC Spodnje Podravje, head of SWC Ptuj, school counsellors, counsellors from kindergarten, police officer, representative of Ars Vitae Association, municipal representative, community nursing.

In 2016, in Barcelona, **Spain**, a consortium of mental health was created (Taula de Salut Mental) where around 50 entities actively participate to improve social support and mental health. Some of them are: Mental health specialized care for children and youth (CSMIJ); specialized social services that are working with youth and their families, and other socio-educational settings, leisure and cultural settings, schools, sports clubs, etc. Moreover, there are entities carrying out public programs at local level. Programs such as: Heath and School ("Salut i escola"), Here, you are listened ("Aquí t'escoltem"), Risk adolescence, program, Aprop Jove (Social and labour integration) etc.

Barcelona's programs are according to the strategic lines of Barcelona Mental health Plan (2016-2022) and to the Mental Health Master Plan in Catalonia, aimed at implement preventive interventions in mental health for the child and youth population in vulnerable situations. On the other hand, other programs for youth involve youth information and participation points, and educational centres.

In summary, there are many agents working with youth at different levels and different departments that need to be linked and coordinated. One of Konsulta'm program goals is to respond to agents working with youth needs in the community, so coordination between resources and programs is a must to guarantee a good development for the program.

The Municipal Child Welfare Services is the centre for the Famwel lab in **Norway**. This means that the lab will include different actors and stakeholder groups such as families in contact with CWS, professionals/front line workers in CWS, managers and decision makers in the municipality, private and NGO (non-governmental) organisations providing various CW measures and services in collaboration with the municipalities. Although the municipality will be the centre of the lab, the governmental level (e.g Bufetat) will indirectly be a part of the lab.

In **Serbia**, the most important stakeholders for our target group are the Ministry of labour, employment, veteran and social affairs, Ministry of demographic and family, Ministry of Health and Ministry of Education as umbrella organizations in charge of monitoring and supervising the local institutions. At the local level, there are institutions responsible for each sector: for social protection, it is Centres for Social Welfare, health sectors, local health institutions, and education schools and local school administrations. A significant part of services and protection is provided by the NGOs; there are more than 60 NGOs in Serbia working with Roma families and children, most of them with more than 10-year experience in this work.

In **Sweden** the target group of elderly people in need of support and care in their own home, stakeholders can be divided into the following clusters. 1. The user group but also their relatives, it can also be neighbors and friends. 2. On the operational side, it is management who plans and sets the framework for the individual's efforts and the staff who carry out daily social and nursing efforts in the elderly person's home. In the same cluster, personnel with more specialized tasks can also be added, e.g. for rehabilitative tasks or home health care for medical interventions. 3. Volunteers, people and civil organizations with an interest in contributing with various types of social efforts. The group is probably heterogeneous in terms of age, experiences, interests and social situation and background. 4. actors from local businesses who can contribute resources and support the incentive structure.

In **Latvia** there are the following stakeholders from all different levels:
Welfare ministry, Department of children and family matters; Welfare ministry, project “Development of professional and modern social work”(“Profesionāla un mūsdienīga sociālā darba attīstība”) Children's Rights Protection Inspectorate, project “Support for Barnhaus implementation in Latvia”; Latvian social workers’ association; Ministry of education; Education institutions in Jelgava (social edagogues); Jelgava social department (social workers with families and children); Jelgava municipality police (specialists in work with minors); Adolescent Resource centre (Pusaudžu resursu centrs); Jelgava SOS youth home (Jelgavas SOS Jauniešu māja); Jelgava youth centre (Jelgavas pilsētas jauniešu centrs)(youth workers); Target group – youth in Jelgava city and surrounding rural areas and Parents of the target group youth.

Educational background of frontline staff working with the target group

In **Slovenia** professionals who work with families facing multiple challenges come from a variety of professional backgrounds (social work, psychology, education, police, health, justice, and prosecution, etc.) SWC professionals indicated in the focus group that they are competent to work with families facing multiple challenges, but that they are often prevented from doing their jobs really well by overwork (e.g., SWC professionals work with up to 60 families on top of all their other responsibilities - writing reports, team meetings, attending court hearings, etc.).

Education professionals also agree that bureaucracy prevents them from working competently with families facing multiple challenges. The police representative pointed out that police officers receive very little, if any, training in working with families facing multiple challenges.

Paraprofessionals often work with families facing multiple challenges. According to SWC professionals, they need additional skills in communication, recognising violence, and working with children with emotional and behavioural needs. However, all agreed that professionals collaborating with families with multiple challenges need a broad knowledge base (because there are so many problems in these families - self-injurious behaviour, addictions, mental health problems, etc.). Professionals from SWC felt that those working with families in SWCs, in particular, need ongoing and continuous training and regular supervision.

Professionals indicated that there is never enough knowledge, and the mean agreement with the statement ″ Frontline staff have sufficient knowledge and skills to be able to work evidence-based for the transition towards integrated care and social support.″ is 2.6.
Experiences from research projects (NFM, LIFE, SWC Gorenjska) show the importance of continuous support in applying modern concepts of social work with families in practice through reflective dialogue and knowledge development.

In **Spain**, young people attend an enormous variety of services and programs in the community. That means a big variability in educational backgrounds in staff from all kinds of resources for this target group. Mental health or social services includes professionals with university degrees (psychologist, social workers, social educators, nurses, etc.). On the other hand, leisure and cultural programs professionals′ background is related to other kinds of certifications, according to professional training (middle or high degrees) or even a course certification (sports and leisure, etc.).

Konsulta'm program professional front-line workers providing services are: 46,79% psychologist, 28,57 % nurses, 21,74% social educators and 2,9 others (mainly social workers).

In **Norway**, mainly staff with bachelor in child welfare pedagogy and social work, some with master. A smaller percentage have a background from other disciplines such as psychology, pedagogues.

In **Serbia**, in government institutions, i.e., local Centres for social work, the majority of the staff has at least a bachelor′s degree in social work or other related disciplines which is a prerequisite to obtaining a license for working in the formal social protection system. Staff working in the NGOs are mostly professionals with a bachelor′s degree, not necessarily in the humanitarian discipline, but many people working in NGOs are paraprofessionals i.e., workers who are not qualified or licensed to serve in particular professions but who handle tasks in support of qualified professionals in those fields. Paraprofessionals often work alongside fully qualified professionals, but they also sometimes work more independently, as is the case with some of the services being provided to Roma families. A continuous campaign to increase the enrolment of children in the preparatory preschool program and the first grade of elementary school.

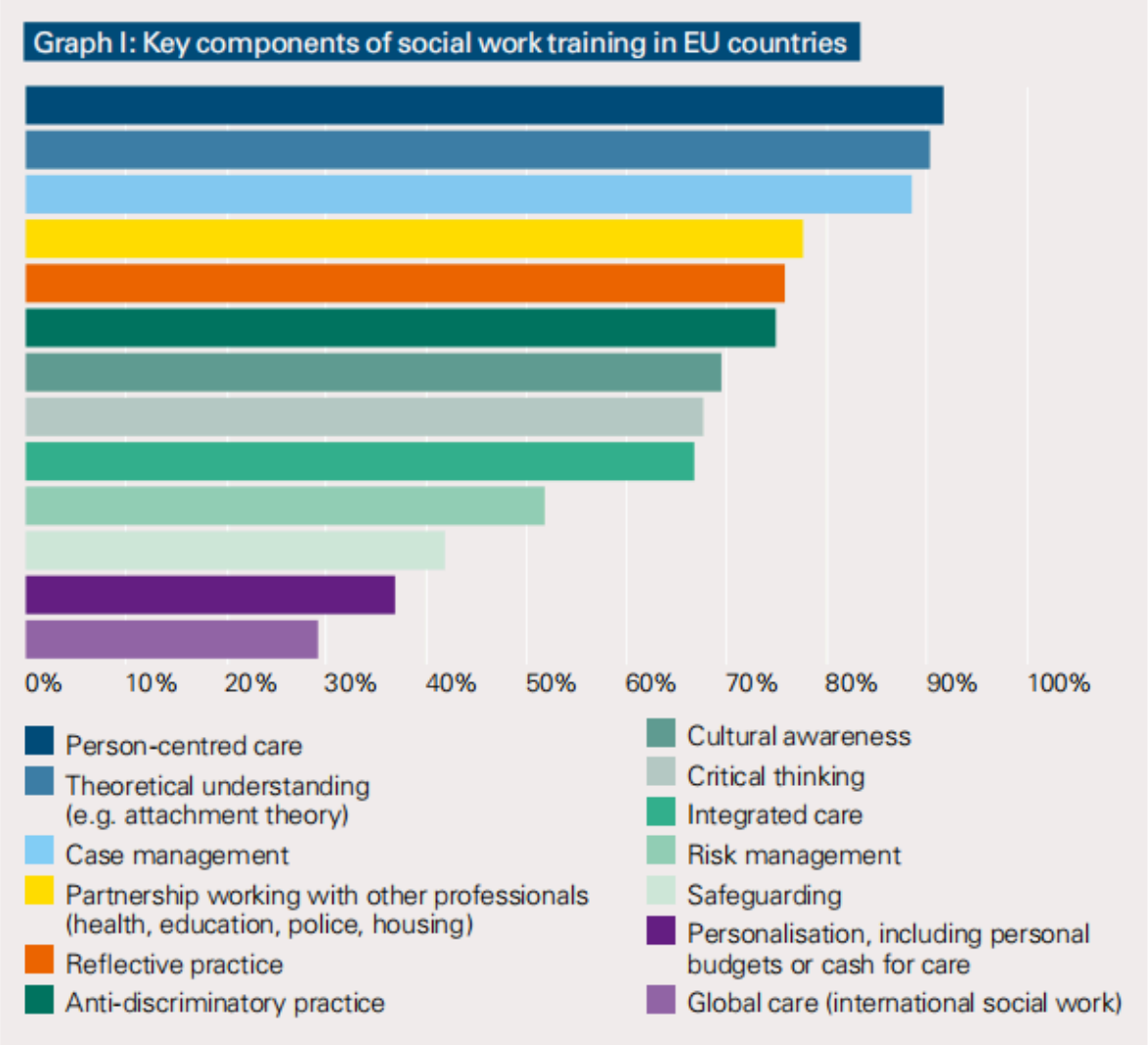
In **Sweden**, the target group of elderly people in need of society's support (in their own homes or in nursing homes) meets different categories of frontline staff. Educational backgrounds vary between staff who lack formal vocational training for their assignment, it is mainly people employed in home care activities. A large professional category that the target group of the elderly meets are assistant

nurses who have a high school diploma from the nursing program. In addition, the target group meets older staff who have an academic professional education, for example nurses and physiotherapists.

In **Latvia**, social workers have at least bachelor level education in social work.
There is no official specialization in social work with youth, it is still considered and treated as part of social work with families and children. Social pedagogues have at least bachelor level education in social work (with social pedagogy courses) or in social pedagogy.

ESN Note: From their report , "Investing in the Social Services Workforce". The report analyses key issues concerning the social services workforce in Europe, with a focus on social workers and social care workers. It is based on secondary literature and policy analysis, the results of a questionnaire, and discussion groups that took place during a seminar organized by ESN in Bratislava in November 2016.

There is a clear distinction between social workers' training, qualifications, roles and activities and those of social care workers.These two broad categories of staff refer to:
1, Professional workers who in general require accredited qualifications in areas, such as social work or comparable formal programs.
2, Less-qualified workers who provide personal assistance and care in different settings for which they may be required to undertake vocational training, short training courses or only on-the-job training.
Further details on specific qualifications requirements for each group in different European countries were researched for selected EU countries and are summarized in the following tables:



Qualifications and training for social workers

There is a large body of literature that addresses the education, training and qualifications of social workers as they form a significant proportion of the professional workforce in social services (Moriarty et al, 2015). Social workers generally require university training since the Bologna Reform harmonized university qualifications in Europe. However, the exact activities, training requirements and settings for delivering this work vary significantly across Europe (Hussein, 2011).

The literature highlights that in some European countries, such as Austria and France, university graduates with degrees that cover required 'components' of training are considered to be suitable candidates for social work roles. This was confirmed by responses from ESN members who provided supplementary information on qualifications requirements for social workers in their countries (see table 3). In other countries, for example in the UK, Ireland, Spain and Italy there are specific social work degrees that social workers are expected to hold before they can practice as a social work professional (Hussein, 2011).

In many countries, for instance Denmark, several further qualifications are available for qualified social workers, such as postgraduate studies in family therapy or psychotherapy.

Some specific tasks, particularly those related to safeguarding children, are reserved to social workers with specific qualifications (e.g. in Sweden).

Almost all the respondents to the questionnaire indicated that their countries had recognized and regulated social work training programs. In relation to compulsory training for social work, 45 per cent of respondents indicated this to be undergraduate qualifications; 19 per cent as postgraduate qualifications; 11 per cent as vocational training and 9 per cent as a higher degree diploma. With regards to the content of the studies, social work qualifications are usually generic or a mixture of specialist and generic modules (63%) with only 9 per cent indicating social work education to be specialist.

Some participants in the seminar group discussions felt the need to update social workers' training contents to acknowledge social changes as well as developments in other areas including the role of technology. Another important theme that emerged from the discussion related to the need to establish effective communication and knowledge exchange mechanisms between different universities offering social work training, and between social work students in general and other related disciplines. There were several examples of post-qualifying training opportunities that are currently in place in different countries, but these usually occur after recruitment rather than at initial training stages. The potential for technology to enhance communication with other sectors and professions was highlighted, as was its capacity to improve user involvement in social work training, and to facilitate the learning experience of social work students more generally.

Qualification and training of social Care Workers

Social care workers are defined here as those providing direct care for service users in residential or community-based services. For this group, the literature reveals a set of essential skills requirements. Many of these requirements are considered 'soft skills' (Green et al, 2014) or personal attributes such as trustworthiness, sociability and a positive attitude, and are assessed at the interview stage. Social care roles reflect key associated skills including negotiating suitable services per individual users' needs, assessment and planning, and the ability to communicate within an increasingly diverse environment (European Centre for the Development of Vocational Training, 2010).

In some countries, such as Austria and Denmark, there are specific training routes for social care workers including specialized training courses or apprenticeships. The content of such training depends on the service user group and is usually defined at the local authority level.

In other countries, such as the UK, such training is provided after recruitment and includes various components that are delivered 'in house' as well as in supervised placements.

An overview of a range of qualifications and skills for social care workers in selected countries can be found in the following table:

Table 3: Overview of social work qualifications in selected EU countries

Country	Profession	Education/training	Regulation
Austria	Social worker *(Sozialarbeiter/in)*	Undergraduate degree Specialisation options through postgraduate studies	No national legislation currently regulates or defines education and training of social workers. This competence is devolved to the nine federal states. However, a national law *(Berufsgesetz)* has been drafted and is expected to be approved in 2017.
Denmark	Social educator *(pædagog)*	Undergraduate degree	Regulated by a profession-specific Education Act *(Bekendtgørelse om uddannelsen til professionsbachelor som pædagog)* from the Ministry of Education.
	Social worker *(socialrådgiver,* literally social advisor)	4-year undergraduate degree in social work (including five months compulsory work-based training)	Regulated by a profession-specific Education Act *(Bekendtgørelse om uddannelse til professionsbachelor som socialrådgiver)* from the Ministry of Education.
France	Family mediator *(médiateur familial)*	Undergraduate degree - Level II State Diploma	The French qualifications system is organised around levels, where VI (6) is the lowest and I (1) is the highest. It is used to relate diplomas to professions/ levels of responsibility. Social work and social care professions range from level V to I. V – CAP/BEP: technical diploma obtained two years after the General Certificate of Secondary Education IV – Technical baccalaureate (secondary school qualification that enables students to enrol in selected university courses) III – Baccalaureate +2 years II – Undergraduate degree I – Postgraduate degree All professional qualifications, including those for social workers, are enshrined in the Law, specifically at the national register for professional qualifications *(Répertoire national des certifications professionnelles)*. The register was introduced by the Education code (Articles 335-12 to 22). The whole system is undergoing a major reform at the time of this publication, following the 'Social Work Covenant' *(États Généraux du Travail Social)*.
	Social and family counsellor *(conseiller en économie sociale familiale)*	Diploma III: 2-year study after Baccalaureate and 1 year work-based training Re-evaluation of Diploma III is at the very centre of the current reform of social work, following the 'Social Work Convent' *(États Généraux du Travail Social)*. The future reform will consider the year spent in work-based training as a year of study and therefore have these professions recognised as level II.	
	Early childhood educator *(éducateur de jeunes enfants)*		
	Social service assistant *(assistant de service social)*		
	Specialised educator *(éducateur spécialisé)* – works with children with disabilities and social difficulties		
	Specialised technical educator *(d'éducateur technique spécialisé)* – vocational training teacher for people with special needs		
	Educator for young children 0-7 *(éducateur de jeunes enfants)*		
	Social and family intervention worker *(technicien de l'intervention sociale et familiale)*	Level III Social service assistance diploma *(diplôme d'État d'assistant de service social)*	
	Monitor-educator *(moniteur-éducateur* – works in residential care with children and adults with disabilities)	Diploma IV – technical Baccalaureate required	
	Family assistant *(assistant familial)*	Diploma V – technical diploma (before Baccalaureate)	
	Home support worker *(auxiliaire de vie sociale)*		
	Childcare assistant *(auxiliaire de puériculture)*		

Country	Profession	Education/training	Regulation
Germany	Social worker *(Sozialarbeiter/n/ Sozialpädagoge/n)*	Undergraduate degree (mostly at universities of applied sciences *(Fachhochschulen)*)	Social work is regulated at federal state level. Depending on the area of social work (e.g. youth support, child education, social workers in the health sector or in the justice system), different sectors are responsible for regulating the rights and responsibilities of the profession.
Italy	Social worker *(assistente sociale)*	Undergraduate degree with a state examination at the end	The profession is regulated by the National Council of Social Workers in accordance with the profession's Code of Ethics as described in the Bill on the regulation of the profession of social work (2013). Social workers must register with the National Register for Social Workers in order to be able to work.
	Specialised social worker in management position *(assistente sociale specialista)*	Postgraduate degree in social services and social policies	
	Cultural and intercultural mediator *(mediatore culturale)*	Undergraduate degree or specific post-diploma courses	Not nationally regulated.
	Professional educator *(educatore professionale)*	Undergraduate degree	Nationally regulated through the 1998 Act No. 520 by the Ministry of Health. A new law to reorganise the profession is currently being discussed in Parliament.
	Family mediator *(mediatore familiar)*	Regional training courses	The profession is not nationally regulated but some regions have regulated it.
Spain	Social worker *(trabajador social)*	Undergraduate degree	The profession of social worker is regulated by the Law 10/1982, which created the official colleges of social work. The Ministry of Health, Social Services and Equality is the body responsible for regulating the profession. The General Council for Social Work is the professional body responsible for ensuring that social workers exercise the profession according to the official code of ethics. After qualification, social workers are required to register with the regional council responsible for the region they work in.
	Social educator *(educador social)*	Undergraduate degree	The academic and training requirements for social educators were nationally regulated through the decree 1420/1991, which established the core subjects that must be completed to obtain the bachelor's degree of social educator. Unlike social workers, social educators do not need to register to be able to work.
	Family mediator *(mediador familiar)*	Undergraduate degree or higher vocational training and specific training to practice mediation, which is acquired through a specific course provided by an accredited organisation	The family mediator was initially introduced by the Catalonian Law of Family Mediation in 2001, which was followed by other regional regulations. At national level, a modification of the civil code was introduced in July 2005 and this was modified by a 2013 decree.

Country	Profession	Education/training	Regulation
Sweden	Social worker *(Socionom)*	Undergraduate degree	Social workers must register with the Board for Social Work Authorisation *(Socionomauktorisation)*.
UK	Social worker	Undergraduate degree	Social work regulation is devolved to the four countries of the UK. A memorandum of understanding has been agreed between Health and Social Care Professions Council (England), the Care Council for Wales, the Northern Ireland Social Care Council and the Scottish Social Services Council (SSSC), which sets out a framework related to the regulation of social workers and the approval of social work education across the UK. After qualification, social workers are required to register with the Council responsible for the country they work in.

Around 85 per cent of respondents to the questionnaire indicated that there are minimum sets of training and qualifications required for social care workers in their countries. These qualifications ranged from basic skills (such as the General Certificate of Secondary Education), through foundation training to specialist training. See following table:

Table 2: Minimum level of training required for social care workers prior to recruitment

Country Group	Other	Basic skills	Foundation training	Higher than basic skills	Specialist training	Total
Western Europe	8	1	4	2	2	17
	47%	6%	24%	12%	12%	100%
Southern Europe	4	4	5	4	6	23
	17%	17%	22%	17%	26%	100%
Nordic Countries	4	1	2	7	2	16
	25%	6%	12%	44%	13%	100%
CEEC	5	3	3	1	4	16
	31%	19%	19%	6%	25%	100%
Total	21	9	14	14	14	72
	29%	13%	19%	20%	19%	100%

Respondents to the questionnaire identified the essential components of social care workers compulsory training as:

- Person-centred care (81%)
- Health and safety (70%)
- Communication skills/counselling (70%)
- First aid (56%)
- Child development (53%).

Similarly, 63 per cent of respondents indicated a minimum set of training or induction programs required for personal and home care workers, i.e. those providing direct care for service users in their own home.

Participants in the seminar highlighted the need to raise the profile of social care workers among the general public and in the media while simultaneously raising the standards related to their training and qualifications routes. Figures vary across countries but it is estimated that more than 50 per cent of social care workers do not have a relevant qualification.
Registration and improving regulation of the care workforce could ease access to initial and continuous training and development. This was regarded as a priority to address the increasing complexities of service user needs and the demand on the sector to attract more workers who are competent in delivering care and who have knowledge of specific conditions such as dementia. These demands for specialized knowledge are often not matched by the skills that applicants offer, which may require additional training to overcome these skills gaps.
The importance of multi-disciplinary working was widely recognized in the questionnaire and at the seminar, but developing these skills can be as difficult as it is necessary. An example is the area of children in residential care who have mental health issues, which requires residential care workers and mental health professionals to work together. Analysing six different European countries, Smith and Carroll (2014) describe the different and often unrealistic expectations on the other profession, which is often tied to the different status they hold in society. Care workers and mental health professionals often hold 'different world views' regarding not just their profession but also child development, the nature and source of the children's problems and how they should be supported. Whilst joint training can be of benefit, it is crucial to establish a continuous dialogue between the professionals, and to develop the skills and knowledge necessary to feel confident in their work with the children.

Services available for the target group in the community today

In **Slovenia** at the national level, there is a social work centre, schools and kindergartens, the police, and a health centre (with a mental health centre and a community nursing).
In the area of non-governmental organisations, the association ARS Vitae is the strongest organisation at the local level (with a day centre for children, a counselling centre for victims of violence, a shelter for the homeless, work with drug addicts, etc.).
There is also free psychological help through Insta-help, and the Association of Friends of Youth organisation offers therapeutic help.
For the elderly, there is the project SOS (Seniors for Seniors), which aims to support older people in the community. There are also some youth programmes in the local community, but coverage depends on the community. In the questionnaire, focus group participants repeatedly indicated that there are not enough programmes and services in their area to respond to the needs of families facing multiple challenges.

In **Spain**, "Here, you are listened!" is a program of the Department of Youth Barcelona, which has been progressively extended to all districts of the city. It provides tools and resources to strengthen personal and social skills and foster personal growth for adolescents and young adults ages 12 to 20.

The Health and School Program aims to improve the health of adolescents through actions that promote healthy habits, prevent risky situations, and help detect health-related problems early.

Support program for educational centers to move towards the Enriched Schools model. This program incorporates professionals in some highly complex schools in special neighborhoods with social inequities. It aims to address the psycho-social problems of children and adolescents, to have an impact on their emotional well-being.

Konsulta'm program which prioritizes attention to adolescents and young people and aims to detect and attend to early psychological suffering and/or mental health problems that adolescents and young people between the ages of 12 and 22 may have in the school, family and/or community context.

Other programs and services are also opened for this target population:
Health and mental health network services: Mental health specialized care, Rehabilitation Service, Day Hospital, Youth space, Addiction centers, etc... ; Municipality agents: Network of Youth Information Points, Youth Centers and Homes (including the facilities where the program equipment is located), Libraries, Women points of information, labour integration programs, etc. ; Social services: primary care and specialized services including residential settings for child and youth protection. ; Other social services specialized in mental health care or vulnerable groups: Social clubs, residential services, counseling services, guidance and support services for immigrants, volunteer programs, etc. and Leisure and cultural programs from civic centers, and extracurricular activities.

In **Norway** there are the following services at different levels.

Municipal level:

CWS – Child Welfare service in Trondheim municipality, is the main collaboration partner.

Connected partners in inter-disciplinary collaboration:
NAV - Norwegian Labour and Welfare Administration. NAV social, service for social benefits, programs and measures for work inclusion and social inclusion; Social Housing Services
ROP-services – Services for mental health care and drug problems; Non-profit level: NGO; The Church City mission (Kirkens Bymisjon); The salvation Army (Frelsesarmeen) and Caritas – The Catholic church help service.

Governmental level:

Family welfare office (familievern kontor); Bufetat- Child, youth, and family ministry and BUP: Psychiatric treatment for children and young people.

In **Serbia**, pedagogical assistants as a measure of support for educational institutions are recognized as an example of good practice. The pedagogical assistant cooperates with all actors at the local level, works with parents, and monitors students and their educational achievements.
Health mediators: Keeping records of the health status of members of the Roma nationality, to raise awareness of the necessity of vaccination of children, and importance of proper nutrition and hygiene habits. They provide health institutions with better insight into the health condition of residents of Roma settlements and point out to citizens of Roma nationality the importance of timely reporting to a doctor.

Local social protection community services: assessment and planning, daily services in the community, counselling-therapeutic, social-educational, and accommodation services. Services are partly funded by the government (assessment and planning services, residential and family accommodation, shelters for human trafficking, and sheltered housing for people with disabilities, except in the most developed cities and municipalities), and partly by the local governments.
The activities provided by the NGOs are as follows:

• Psychosocial and counseling support for children and parents;
• Education of parents about rights, the importance of education for children, and protection from violence;
• Workshops with children and parents for the promotion and stimulation of early development, and motivation of children and parents to complete and continue education;
• Improving cooperation and coordination;
• Support in the employment process and improvement of information and knowledge in the field of labour legislation;
• Collection of wardrobes, hygiene packages, and school supplies;
• Support for involvement in sports and cultural activities at the school and local community level;
• Assistance in collecting and obtaining documents;
• Toy library as a gathering place for children and parents;

In **Sweden**, there are different services for elderly.
Home service with residential service only - Help with cleaning, laundry and things. Alarm.
Home care - Care and care in the home. The intervention is decided by a social worker at the municipality's social services investigating needs and deciding on the intervention home care. The needs are investigated according to the individual's needs in the Centre. The goal should be for the individual to do the parts he can handle by himself and only be supported in the parts of life areas that do not work in order to live as independent a life as possible. Interventions can include getting housing services, help taking medication, social activities, walking, support with meals.
Daily activities - is an effort for the individual to have the opportunity to participate in if necessary. Daily activities are about efforts that are decided by aid workers, often because there is a cognitive need, for example in the case of dementia, to work to preserve one's abilities as much as possible.
Replacement service - is assessed as assistance and is part of the support offered to relatives when caring for a loved one at home.
Short-term accommodation - for the individual and is decided by the case manager. Short-term accommodation is offered when there is a need for special accommodation, but not in the longer term. For example, it can be a support when an individual is ready to be discharged from the hospital but has too high a need for care for the needs to be met with home care at home but has an assessment of being able to be rehabilitated enough to be able to move home.
Apartments for elderly + 55 - Nursing homes are for elderly people who are too healthy for nursing homes but who want more security and social companionship than they can get in their current home. For this type of living you do not need a decision by the municipality.
Residential care home for elderly (nursing homes) - When your care needs are so extensive that you need access to services and support around the clock, you may have the right to move to a care home. There, staff are always close by and you can have community and activities together with the other residents. The accommodation has access to a nurse around the clock. There are also occupational therapists and physiotherapists connected to the accommodation. In a nursing home, you have the right to live together with your partner.

In **Latvia**, the Adolescent Resource Center provides evidence-based, state-of-the-art and multi-disciplinary support for adolescents with a range of mental health risks and difficulties. Each adolescent and family has its own unique resources. We help you find and strengthen them by providing professional, confidential and friendly support when you need it.

Centers are available in nine Latvian cities - Riga, Liepaja, Valmiera, Daugavpils, Ventspils, Jelgava, Rēzekne, Sigulda and Tukum. We provide consultations both in person and remotely using Skype,

Whatsapp, Zoom. Center's assistance is available to young people and their families free of charge thanks to funding from the Ministry of Welfare and the Ministry of Health and Jelgavas SOS Jauniešu māja.

SOS Youth Houses are created for young people, with the aim of promoting their independence and growth for adult life. Currently, there is one SOS youth home in Jelgava, where 12 teenagers live, as well as an SOS Youth Home in Valmiera. In the SOS Youth House, they provide care from 14 to 24 years of age. In a youth home, you can learn to live even more independently, getting an education and learning the necessary skills for future life. While living here, many young people also get their first job.

In SOS homes, young people prepare for an independent life: they take care of order at home, cooking and shopping. A young person has to plan his own time and think how to rationally spend his pocket money. Also, together with the pedagogues of the youth home, you have to evaluate your future possibilities and think about where to study further and what profession to get. The youth center is also a place to learn how to resolve conflicts, overcome stress and make new friends.

Many young people who live in the youth center, after graduating from high school, continue their studies at universities in both Riga and Jelgava and are still supported by the Youth Home.

Jelgavas pilsētas jauniešu centrs

A leisure place for young people and a home for the non-governmental organizations of the city of Jelgava, including cultural associations of Jelgava minorities, where they carry out their daily work and social activities.

Services have been developed only recently, a lot has been done in the past two years as a response to Covid crisis, most of the services are in their trial/ piloting period, funded by projects.

Three main challenges in terms of social work and support for the target group

In **Slovenia**, the biggest challenge is certainly 1, the workload of professionals in SWCs (see also answer to question 3.e). Due to the workload, professionals are focusing more and more on firefighting, leaving no time for prevention work.
2, The lack of certain services in the local area to which users could be referred (e.g., if they need assistance with drug treatment or shelter for youth) is also a challenge.
The passage of the Family Code has also lengthened proceedings, resulting in children staying at the crisis centre longer (before a court decision is issued).
3, Teamwork is also a challenge. Cooperation between the different actors and institutions is well established, but when the team meeting is over, the SWC professional is left alone as case manager. The health system does its part within its means, the education system within its means, etc., and the SWC has to take care of everything else (e.g., when the hospital is busy, the doctor and the SWC professional do not sit down and discuss options, but only get a call from the hospital: ″Pick up the child, the parents are not here.″).
SWC professionals also indicated in the focus groups that they do not have enough knowledge to work with a family where sexual abuse or severe forms of violence are present, how to talk to a child, not to put words in the child′s mouth, etc.

From 2018 up to 2022, 13 teams of Konsulta'm i**n Spain** served 5.243 user' appointments (55,6 % during 2022) and 966 professional's queries from community agents. Less than 7% of people have been referred to specialized healthcare (CSMIJ or CSMA). Likewise, the young's emotional support service chat had around 700 conversations and caused six emergencies to be triggered. Konsulta'm provided services for 62,89 women, 31,5% men, 0,9% no binary and 4,8% without response. Main reasons for services were emotional distress (51,8%) difficulties with relationships (16,2%) and getting information about mental health (16,42%) and risk behaviors (7,19%).

Program assessment and other data gathered expose the following gaps in educational needs:

1, Community, holistic and preventive approach to mental health well-being, to improve coordination among the networks and integrated services (it involves knowledge about legal aspects in anonymous attention, referring, follow-up and maintaining confidentiality aspects).

2, Education and skills regarding punctual counseling and orientation: how to accompany the request, and early detect complex needs. New or updated expressions of distress. Usage of new technology for service provision: social networks, WhatsApp and others.

3, Applied gender approach in the service provision. Gender identity and diversity. Sexual harassment detection. Dysfunctional virtual relationships. Other demands showed the need for common spaces to share practices and solutions to problems and case-based supervision for teams.

In 2022, 483 community-based agents contacted Konsulta'm Program asking for information (26,3%), professional support and counselling (19,8%) and other resources' coordination among activities provided in the community (30,1 %). Gaps in professionals from these organizations are about mental health from a holistic perspective, psycho-education, managing complex situations, and community network resources knowledge.

In **Norway**, they see the following gaps in services;

1, lack of understanding and support regarding standard of living (SES-conditions) – framing of the problem

2, lack of trust between certain groups and the CW system

3, lack of real participation for those most marginalized and for the youngest children.

In **Serbia**, they see the following challenges:

1. Access to Roma families due to their housing situation and since the social protection system in Serbia doesn't have outreach workers, which makes it harder to identify families in need of help unless they report the problem themselves. Also, there is a significant amount of distrust among Roma families towards official systems of support which can lead them to choose not to report challenges they are facing, thus not receiving the support they need.

2. There is a gap in the knowledge and skills of staff working in government institutions and CSO′s. The knowledge that should be improved refers to the culturally competent practice, how to support

parenting skills in Roma families, on establishing new or improving existing social protection services, with innovative approaches, the establishment of inter-municipal services.
3. The services that are provided to Roma families are desegregated, meaning there are communities and places where there are a lot of services (besides the basic ones provided by the government) and in some smaller cities there are none. Additionally, the services and service providers are not coordinated. Certain problems also require the establishment of integrated services or at least precisely defined cooperation protocols, information exchange, and the formation of joint bodies/commissions.
4. According to the MICS survey in Serbia which included Roma settlements , over a quarter (27 percent) of children aged 1–14 years living in Roma settlements were only subjected to non-violent methods of discipline. Also, 62% were subjected to some form of psychological aggression from an adult household member, 40% were subjected to physical punishment, and 2 percent were subjected to severe physical punishment. A total of 67% of Roma children were exposed to psychological or physical aggression. Children from the materially deprived household population were more likely to be subjected to physical discipline (42%).

The western world and with this **Sweden** is currently facing 1, a demographic challenge where the proportion of elderly grows in the population more than the proportion of people in working age and children and youth. This means that in countries with an established tax-payer financed welfare system there is a negative balance as the active workforce contributing to the welfare system is smaller than the group that depends on it (e.g. for pension and healthcare). This negative trend is further accelerated as we nowadays tend to live longer and therefore further strain the care and social care systems. Sweden is a country with a well-established welfare model. It is projected that between 2023 and 2031, people of working age in Sweden will increase by four percent, which corresponds to around 253,000 people while the number of people actually being employed is estimated to increase by 169,000 persons.
At the same time, the number of people aged 80 or older will increase by almost 264,000 people - an increase of about 50% compared with today's numbers, which is the second challenge. To address the above situation and projected care needs, municipalities, private contractors and the national regions must hire 410,000 people until 2031. Of them, the elderly care sector needs to hire 111 000 people. Social care is provided by the municipalities where the main two care and social care employment groups are assistant nurses and care assistants. The demand for assistant nurses will also increase because of new guidelines of care and social care for elderly, that require that the elderly's contact person have to be an assistant nurse in Sweden. Adding to this situation the training for assistant nurses will be higher and assistant nurse will be a professional title. It should also be noted that the demographic challenge varies across the country. In 60% of the Swedish municipalities the workforce is decreasing while the elderly population is increasing sharply and hence the need to employ social care staff will be higher in areas of Sweden where the available workforce is the smallest.

3, To address the above social care need, there is a need to make the employers (e.g. municipal care organisations and private care providers) more attractive for job seekers and increase the competences of individual (current and future) care workers. The employers must also retain existing staff in a competitive job market created by the lack of skilled care workers. The report "Welfare's competence supply"(2022) SALAR addresses the need for competence development from several perspectives. Partly to develop our operations at the rate that other parts of society develop, but also based on the fact that individuals need to be strengthened in their position on the labour market.

In **Latvia**, social workers lack training in work with the target group. A methodology for social work with youth is being finalized right now after its first piloting at the end of 2022. But there is no requirement for social workers to specialize, in most municipalities there are not enough resources, not enough social workers.
There is no official specialization in social work with youth, it is still considered and treated as part of social work with families and children. Social work is often just crisis management.
When social workers complete additional studies it doesn't always translate into a more specialized position - that creates a situation when trained professionals work with their target group using specific methods and approaches in addition to their general tasks (other target groups, social benefits, documentation etc.).

Summary

Problems addressed in the labs (a)

The problems presented in the baseline differ from the various project members. However, complex needs and conditions and how they are met or not met is however a recurring theme. Social support for vulnerable and multi-challenged families is the main target group for Slovenia, Serbia and Norway. For Latvia and Spain - youths in vulnerable positions are in focus whereas Sweden will focus on social support for the elderly. There are some common factors mentioned independently of chosen target group focus. Deficiencies in the current systems of social welfare are mentioned in terms of lack of collaboration and coordination of services from different actors. For example, collaboration between public actors and NGOs, as is the case in Sweden. There is a need for development of collaboration between social workers and the families which are described from Norway and Slovenia as well as Serbia. Norway also emphasises the lack of user involvement. Another theme focuses on current working conditions for social support workers such as heavy workloads, inadequate competencies, personnel shortages.

Link between problems and integrated care (b)

All parties in the LINK project mentions the area of collaboration in different ways, According to ESN, a key driver for integrated care at an organisational level concerns the coordination of services between different stakeholders and actors. From the baseline of this project it is obvious that collaboration is one of the big challenges in the current provision of welfare, independent of different welfare contexts. There is a need for mutual collaboration between professionals working with multi-challenged families, youths in vulnerable positions with or without mental health issues. In the area of elderly care, cooperation between public and non-governmental actors need to be further developed and systematised. Within the area of collaboration and coordination, several partners mention the importance of mutual understanding of the "problem" or conditions of the specific target group.
From the baseline it can be concluded that the current welfare systems in Europe are often too fragmented and demand a lot from the individuals and groups in need of social support and service. Interdisciplinary collaboration is seen as a way forward towards integrated and person-centred social care.

Target group´s living conditions (c)

When it comes to living conditions for the different target groups in the LINK network, of course they differ to some extent but even so, there are many similarities described in the baseline. The target groups consist of people and groups in socially vulnerable positions. When it comes to multi-challenged families in contact with social welfare, extensive research shows unfavourable living conditions in various areas such as economy, physical and mental health, employment and so on. There is also an aspect of hereditary social vulnerabilities mentioned within these families. However, one can identify the target group in Sweden as the odd one out since they target the elderly in general. In this case, the living conditions are perhaps a bit more differentiated.
In the description of living conditions for vulnerable groups in society one need also to mention the aspects of intersectionality and discrimination. From society at large but also from an institutional perspective. Gender differences in reports concerning youth and mental health are mentioned by Spain. From Serbia, institutional discrimination towards the Roma community is described. Research reported in the baseline from Norway and Slovenia also brings up user experiences from contacts with the social work system. It is stated that the multi-challenged families with complex needs find it hard to navigate in the systems and often experience a corrective rather than supportive approach from social workers.

Relevant and possible stakeholders, key staff groups and organisations (d)

From all countries in the LINK project actors and stakeholders are mentioned from national, regional and local level within the welfare system. Departments and universities, municipal representatives from policy level as well as management and frontline positions. Professional representatives from different sectors, such as health care, school and police are important actors in the different labs. NGOs, sports and leisure organisations and civil Society as well as business representatives are also mentioned as important actors. In some labs, but not all, the target group is mentioned as an important stakeholder. Considering the one key driver for integrated care connected to person-centred care, user involvement and participation is of great importance in the development of Learning and innovation labs.

Educational background of frontline staff (e)

In most cases, the LINK baseline reports of similar educational backgrounds in frontline staff. Bachelor degree and trained professionals from different fields, mainly social work but also from related fields such as psychology, nursing, occupational therapy, social education and pedagogy. This is the case in public welfare as well as within non-governmental organisations. In Sweden where the target area is elder care, the largest staff group in the elderly care consist of assistant nurses, where the formal qualification is set to a high school diploma degree. Some of the countries also mention paraprofessional staff groups which is staff groups without formal training or qualifications.

Current services available for target groups in LINK (f)

All countries in LINK report that there are several services available for their target groups today, at national as well as regional/local levels and also through different kind of NGOs. Of course, this is presented differently due to differences in organising welfare. Latvia differs in

this aspect since they report that the services for their specific target group only recently has been recognized, but that a lot has happened in the last few years.
At national level all participants describe overall welfare organisations such as social work centres, schools, health centres, family welfare offices and psychiatric treatment organisations. Also specific support programs from national authorities are mentioned, for example in Spain where health promoting programs and special programs for skills and training in staff are described in order to better reach and work with youth and mental health issues. At local or regional level, municipal services are described in the different target areas. The local/regional level distributes a lot of the public sector social support. There is a lot of services available for the elderly in Sweden, the services described are all a part of municipal social services. For example living arrangements, home care and daily activities. However, there is no mention of the services rendered by non-governmental organisations specifically. NGO:s offer several services in the areas of family work (Norway, Serbia, Slovenia).

Main challenges in social work and social support for LINK target groups (g)

From the answers concerning main challenges in social support in the different members of the LINK network, three overarching themes can be identified. First, conditions concerning lack of resources in terms of supply of staff with accurate competencies as well as specific services concerning the target groups in focus. Secondly, circumstances related to the contact between social workers and the target group in focus. Both in terms of lack of participation and user involvement, but also in terms of knowledge and understanding for the living conditions of and working methods for the specific target group. Another issue mentioned from several parties, is the distrust between social workers and target groups. Thirdly, the overall perspective is mentioned which is connected to the fragmentation of welfare which results in a reactive social support system rather than a holistic and more preventive and health promoting approach.

Chapter 3 Innovation and development

Innovation and Digital Change

In **Slovenia**, the Covid 19 pandemic demonstrated that some populations (particularly families facing multiple challenges) and services in the local community are not adequately equipped with ICTs. Professionals from SWC as well as education and NGOs reported that the Covid 19 pandemic contributed to providing ICTs to families who did not have computers, phones, or access to the Internet before the pandemic, primarily because of the need for distance learning for their children (donations from schools, NGOs). SWC was also poorly equipped with ICTs; only through the Covid-19 pandemic, for example, did they get their own cameras on computers, set up Zoom online tools and MS teams, etc. During the Covid 19 pandemic, ICT helped professionals maintain contact with users in the first place, but they acknowledge that working with users remotely is not a substitute for face-to-face interaction. Participants in both focus groups agreed that digitization brings both advantages and disadvantages. They saw the advantages as facilitating the organisation of team meetings, supporting collaboration with foreign-language users (the ability to translate the content of the conversation), and encouraging contact with younger users, while the disadvantages were primarily the pitfalls of digitization (addiction to excessive use of ICT; unsafe use of the Internet; requiring staff to be more efficient - to get more done in less time). In particular, school and kindergarten staff indicated that some parents (albeit a minority) are not yet sufficiently equipped to use ICT and always need to be informed through other channels (messages through children, etc.). The community representative pointed out the uneven internet coverage in the community (e.g., in some parts of the community there is still very poor or no internet connection and residents have to look for other ways to access the internet, e.g. via the telephone).

Most services in **Spain** have the right infrastructure and workers have digital competencies regarding access to digital workspaces. Even more, after pandemic outbreaks that accelerated these possibilities and skill acquisition.

The “Barcelona, digital city plan” establishes the lines for the city to become a technological benchmark with clear public and citizen leadership. It means linking innovation to such values as social and economic justice, solidarity, ethics, and gender equality.

At this point, no barriers regarding communication are detected. The main barrier related to digitalization detected is for sharing information about users for an integrated care approach. Main reason for this barrier is related to legal issues and confidential data, fragmented for each organization or institution.

In **Norway**, the welfare services introduced main frame computers during the early 1980es and later invested in personal computer technology followed up by pads and smartphone technology. All services depend heavily on digital systems, although some platforms are suffering from lack of update and getting old and new may be hampered by software problems. The computer systems have become an integrated part of and enabling NPM and managerialism. With a widespread access to modern technology the competence to operate systems are high, but it is acknowledged that work at the computer has replaced much of the user contact, and digitalization of user contacts have challenged at least the initial relationship building with clients, but may improve contact during follow up if used in sensible ways. Access to and use of research available on the web does not seem to be common

among practitioners. Neither is the ability to read and reflect on work and challenges met during work hours.

In **Serbia**, since the occurrence of Covid 19 pandemic, the greater readiness and openness is for digitalization and the use of informational technologies among employees in different systems. During that pandemic, the majority of institutions and organizations started to function through online work. Employees are adapting to this kind of work and use of digital tools, which enabled learning and development of digital competencies. However, the challenge is that social services users, including Roma families, live in such conditions that they mostly don't have access to digital infrastructure (do not have internet, computers, or telephones), or if they have it, they are not adequately trained to use it.

In **Sweden**, the readiness for digital transformation in our community is high. But of course we have obstacles with the older generations in the society to keep up the same fast curve of development. For staff in the elderly care there is a problem with having access to computers all the time, the nursing staff works with digital documentation in their work and also uses digital tools in the daily work activities.

Some of the elderly are used to being users of digital aids in their daily life, for example alarms. Also contact with family and friends in digital meetings instead of phone calls. Often the elderly do not feel comfortable and secure using digital solutions in banking or the digital identification/signatures. As a society we are well adapted to the digital transformation but of course we have individuals and groups that are less motivated or ready to feel comfortable in the development.

In **Latvia**, considering the professionals involved and the target group, and thanks to the recent Covid-19 pandemic, the community is relatively ready for digitization. All of the professionals have basic digital competences and have ongoing experience with digital workspaces. However, in most cases only as users and/or viewers, but not as organizers or creators. People still prefer face to face contact and are more active in real life discussions than their online counterparts.

Partner Experience of innovation

In **Slovenia**, a social worker was working as part of an individual working project of help with a woman who needed a lot of support and help caring for her baby of a few months. The question arose as to how she could care for her baby after leaving the maternity home. The innovation in this case was to place the mother and her baby in a foster home.

Conducting team meetings at the school even though the SWC is the case manager. Before this innovation was introduced, there was an insistence that team meetings be held exclusively at the SWC, which was often a barrier for those invited to attend because teachers often could not attend because they did not have a substitute in the classroom. However, when team meetings were held at the school, the teachers were able to attend the meeting, at least briefly, and provide their perspective on the problem. This often facilitated and expedited the joint development of solutions.

Contacting users in an informal setting (e.g., a park, a bar). Often users (especially children and youth) feel uncomfortable and reluctant to have a conversation at the SWC. The informal setting allows SWC professionals to make initial contact with users before the actual working relationship begins. The SWC professionals reported in the focus group that their experience shows that it is much easier for the users to come to the SWC afterwards and that the cooperation with the users is easier.

The head of SWC Ptuj organized a social gathering for the SWC professionals, who supervised the interns while working on their interpersonal relationships. Through workshops and social gatherings, they were able to promote both the professional and personal parts.

In **Spain**, Konsulta'm program is innovative because of the type of intervention proposed: Consultations are free, anonymous, without prior appointment, in youth environments.

Other examples of social innovation are IPS (individual employment and support for youth), an evidence-based practice to approach young people with mental health conditions though inclusion in the workforce and/or formal education. Some organizations work from this approach in Barcelona for the youth target group. On the other hand, there is a program for teachers with the need of emotional management in students. This program helps teachers to better approach complex needs at schools and improve emotional well-being in classes. Other innovative programs are:

Home care clinic teams (ECID): Adolescents aged 12 to 18 at high risk of psychopathology and high risk of social exclusion, who have serious difficulties connecting with ordinary care services. This pilot project aims at making relationships with adolescents and their families in their own environments (street, schools, homes, etc.).

Situa't information points: for general population regarding mental health information: Associations, legal issues, health network, social benefits, job support or housing information. And for young people (16-25) with socialization problems, a program (Xarxajove) aimed at supporting vital decisions and (re)-connecting with resources and networks (health, social, etc.) Barcelona suicide prevention hot-line and points care for relatives and those around people at risk of suicide and survivors. Guide Teams: Mental health and addictions teams for young people with very complex needs. A multidisciplinary community-based intervention. Catalonia Social Services use the Self-Sufficiency Matrix tool to assess multiple dimensions of a person's life to detect social complex needs. One of its objectives is to better approach people served by creating person-centered intervention plans from an integrated care perspective.

In **Norway**: I) LIFE Erasmus. European cooperation on Learning to innovate with families. Challenging three serious problems in providing services for families with multiple challenges. A lack of professional focus on multi-challenged families and shortcomings in respect of knowledge and competence. Second, that policy has increasingly been based on the expectation that struggling families should manage their situation themselves, even if their circumstances make this very difficult to achieve. Thirdly, coordination and cooperation in the social and health services is not good enough; agencies are too much concerned with restricting their areas of responsibility. Working with practices we ran a learning/education program enabling reflection and focus on people's experienced challenges in everyday life. Research enabled new and more focused contacts and follow up by the participating social workers. The social workers also attended international gatherings focusing on common challenges and learning as well as competence to innovate and cope with uncertainty related to possible outcomes of work.
II) Life-Frogner was a project over three years experimenting with a multiple professional team across services (NAV and CWS). The everyday lives of families with multiple challenges were the target group. Further expanding the learning abilities of the team members and the management. Action research enabled the feedback loops from focus group interviews and family interviews to triangulate the performance of the team and the outcomes. Much of the same tools were used as in the EU LIFE

project. Researchers and team members met several times to assess and reflect upon the performance of the team, the cooperation with other services and the families and their children.
III) Developing tools for knowledge production in NAV services. Workers from six offices cooperated with researchers from NTNU and partners from the Netherlands over a three-year period.

In **Serbia**, the service Teddy bears reading program (Center for support of early development and family relations "Harmony") – pilot support program for early development and caring quality of children, based on joint reading with child" encompasses both parents and children from Roma families.
Project "Initiative for support to development and learning of Roma children of early age in Serbia" (CIP – Center for interactive pedagogy and Educational cultural community of Roma people "Romanipen"), aimed to strengthen parents to improve the safety and encouragement of the family environment, to improve care and raising, to develop skills of positive parenting, to support the health, development, and education of their children, to represent their and own rights.
The project "Educational program for mother and child" (Roma NGO) has aimed to improve the approach to the education of Roma children during early childhood by strengthening and developing capacities of mothers in learning practical parenting skills and a better understanding of children′s development so as lobbying at local authorities for a higher percentage of inclusivity and support to parents during enrollment of children in the preparatory preschool program.
Program of education (Center for youth integration), to include children in the educational system at an early age, as a measure of support and prevention of children getting involved in life and/or work on the streets. Children included are living in informal settlements (slums). Activities are regarding daily support services for preschoolers so they can be regular in the preschool program.
"Early marriages: violation of the rights of Roma women", (NGO „BIBIJA-Roma female center") to change the position of women in Roma families and to strengthen the role and power of Roma women in decision-making processes in Roma families. Activities in raising awareness of the negative consequences of early marriages on reproductive and mental health.

In **Sweden**, the following example shows how it is possible to let volunteers do simple chores for the elderly and how it benefits both those who give and those who receive in a mutual process. When Arvid Morin and Benjamin Kainz graduated in the summer of 2007, they started Ung Omsorg. Through their contacts with elderly care, via grandparents, they realized
that many elderly people were lonely and did not receive regular visits from loved ones. This, in combination with the fact that it can be difficult for young people to find a meaningful and developing extra job, laid the foundation for their idea. Ung Omsorg is one of the pioneers in Sweden
when it comes to social innovation and social entrepreneurship. They have received a large number of awards for their innovative idea and today work together with several of Sweden's municipalities and are present in over 100 retirement homes throughout Sweden.
The idea is based on employing young people to do simple chores for the elderly, it can be
just talking, going for a walk, reading or playing games. Something that the regular staff at nursing homes or relatives often do not have time for. Another driving force is to increase the interest of a younger generation in working in healthcare and create opportunities for us to meet across generational boundaries.
www.ungomsorg.se

Another example shows an example that relates to the lab challenge by supporting volunteer work in several respects. Volontärbyrån: Do you want to get involved in a non-profit organization but are unsure where, when and how? Or do you lead a non-profit organization that needs more volunteers?

Then Volontärbyrån could be the solution: a non-profit organization that helps people and non-profit organizations find each other.
Volontärbyrån operates a brokerage of non-profit assignments, and also works to educate and support associations on issues of non-profit involvement. Amelie Silfverstolpe founded Volontärbyrån in 2002, which organizationally falls under the interest organization Forum – idea-based organizations with a social focus. The work of the Volontärbyrån is permeated by the idea that involvement in non-profit organizations gives people a voice in society and thus an opportunity to influence social development.
www.volontarbyran.org

In **Latvia**, The following three examples are relevant:

1. The Adolescent Resource Center that was described above is a major innovation of recent years.
2. Creation of the methodology for social work with youth is another huge step forward in recognizing youth as a separate target group and employing specific methods in working with them (out of the office).
3. Deinstitutionalization project – halfway homes, group homes for youth with (mental) disabilities, various services for children with disabilities.

Social Innovation and the Project's Target Groups

In **Slovenia**, given that current research shows that families facing multiple challenges are not receiving adequate support from existing services and programmes (see also Family Pilot Project - the more needs families have, the less adequate the support), there is a need to develop appropriate innovative responses at the systemic level. At the same time, micro-social innovations in the field of target group work are very important because the target group is heterogeneous and the context in which users find themselves is constantly changing, as is the context in which we achieve good social work outcomes together with them. Micro-innovations must be developed together with the family and be oriented to the needs of the family members.

In **Spain**, social innovations search for new solutions to problems detected. It means that other solutions could not be enough to tackle a multiple-caused problem, or the approach doesn't show enough effectiveness to solve the complexity of the problem. This is the scenery with complex situations: social issues have multiple causes and new and multiple approaches are needed.

In adolescence, as in childhood, the family is one of the most important determinants of mental health and emotional well-being. Likewise, social determinants of well-being also involve relationships with peers, and other aspects such as financial issues, housing, etc. All with a high impact on mental health. Hence, earlier detection and intervention are cost-effective from a preventive approach in future generations. The impact of these interventions at early stages can change the adult′s pathway to poor or bad mental health and mental health disorders.

Especially in the transition to adulthood, social innovations may have impact in social determinants of well-being for this target-group, and may empower their autonomy, resiliency, and other skills for the future.

In case of mental challenges in young people, innovative solutions need to be applied, to give new responses to these ever-changing problems or the way they are expressed nowadays in our society.

In **Norway**, computer systems and new public management seem to focus on performance targets made by top level system operators and management. The social work with clients/people suffers from lack of focus, lack of continued contact and lack of time to assess and evaluate. The workers also lack time and intentions for learning and how to cope with the uncertainty related to social work processes, outcomes and results. Innovation comes often with the time and attention to learning and evaluation, and may be supported by research support to enable data collection and limited and focused learning horizons. The impact of knowledge production seems to be competence to cope with new and other challenges as well and may improve performance and wellbeing due to reduction of stress related to loss and incapacity to cope.

In **Serbia**, social innovations are extremely important since the existing organization, securing and providing services to Roma families, doesn't effectively respond to their needs for some cultural, language, and legal barriers. Having that in mind, it is necessary to encourage and develop new social innovations to get better responses for the needs of Roma children′s parents in general, especially during periods of early development.

In **Sweden**, based on the described lab challenge, two target groups are affected. 1) Older people in need of support and 2) people who should be given the opportunity to work as volunteers in relation to the target group of older people.
For both of these target groups, there is a motive to develop social innovations. In relation to the target group of older people in need of support, it is relevant to provide social support through social innovations that cannot currently be provided within the framework of ordinary elderly care activities. This is the type of social support that could be provided by volunteers. These volunteers are also a target group within the lab challenge. For example, they could be younger people who themselves are outside the ordinary labor market/education for various reasons or people who are retired with the motivation and ability to want to contribute with their time and expertise.

In **Latvia**, the target group requires it, there is currently a lack of resources tailored for their needs. There is insufficient collaboration between institutions and follow up of services administered.

Summary

The countries readiness for digitalisation (a)

In summary, the habits and readiness for digitalisation are reported differently and can be divided into two categories. First category, the Covid-19 pandemic, had an impact on the usage of digital technologies in Latvia, Slovenia and Serbia. During the pandemic, it turned out that services in the local community in Slovenia weren't adequately equipped with ICTs and that it was during the pandemic that professionals in the social welfare sector got their own computers with the possibility of conducting digital meetings. Serbia describes a similar situation, where the majority of organisations in the social welfare sector started to function through online work. Both countries also describe that their target groups, families with multiple challenges and the Roma families, did not always have access to the internet or digital tools. Sweden also describes that despite having a high degree of digitization, there are individuals and groups in society who do not feel comfortable or motivated to use digital

tools.
In the second category, it is reported that most organisations within the social welfare sector in Latvia, Norway, Spain and Sweden, have the right infrastructure for digital systems and that the professionals within these organisations have digital competence. Norway further describes that some digital platforms may have some software problems and that the digital tools somehow have replaced a large part of the user contact. Sweden also describes that the readiness for digitalisation in the community is high, where healthcare staff in elderly care use digital tools and digital documentation in their daily work. Even though the country is ready for digitalizations, they describe some obstacles that can challenge the usage of digital tools, where some professionals in the elderly care do not have all around the clock access to computers.

Domestic examples of social innovation work connected to the target groups (b)

There are a variety of examples of social innovations connected to the country's target groups. Both Serbia and Slovenia describe social innovation projects where the aim is to improve and strengthen parenting skills, for example “Initiative for support to development and learning of Roma children of early age in Serbia” and “Educational program for mother and child”. Even Sweden gives an example where the project “Ung Omsorg” aims to improve the well being of elderly people. Other examples of social innovations are linked to using informal or new settings instead of formal settings for meetings with clients in the daily work at social work centres (Latvia, Slovenia) and establishing relationships with adolescents and their families in their home environment (Spain). Norway gives another example with their “Life-Frogner” project, which focused on a multiple professional team across services, where the families in the project constituted the focus group that gave feedback to the teams on how they could develop their work. The similarities between all these innovations are the aim to improve for the target groups.

The importance of working with social innovations related to the target groups (c)

The countries were asked to clarify why it is important to work with social innovation related to their target groups. All countries describe a willingness to provide accurate services related to each of the countries target groups, which all receive help and support in different ways from the countries social welfare systems. The countries have a goal to provide better individual services which better meets the needs of their different target groups. Slovenia, Spain and Norway intend to create social innovations in order to better meet target groups with multiple difficulties. Slovenia wants to develop innovations on a systemic level where families with multiple problems do not receive support. Given that current research shows that families facing multiple challenges are not receiving adequate support from existing services and programmes (see also Family Pilot Project - the more needs families have, the less adequate the support), there is a need to develop appropriate innovative responses at the systemic level. At the same time, micro-social innovations in the field of target group work are very important because the target group is heterogeneous and the context in which users find themselves is constantly changing, as is the context in which we achieve good social work outcomes together with them.
Micro-innovations must be developed together with the family and be oriented to the needs of the family members.
Spain wants to develop earlier detection and interventions for adolescents in order to promote mental health. Norway describes that social work with clients suffer from lack of focus, lack of continued contact and lack of time to assess and evaluate. Serbia wants to work with social innovation since they

experience that Roma families don't effectively respond to the existing organisation and provide services, which may depend on cultural, language and legal barriers. Even Sweden has an ambition to provide better social initiatives among the target group of the elderly.

Chapter 4 Integrated care - core components

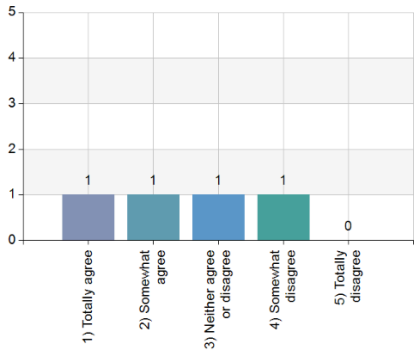
This chapter's content is not based upon the written answers of the partners, but of a special questionnaire to the partners, among which four of seven have responded.

In the following tables you will find the results of how the different partner organisations put themselves on a scale when it comes to the principles of integrated care, such as using digital tools for social innovation; working health promoting and prevention based; working with user involvement ; working in a holistic/ multiprofessional way; working evidence based and person-centred. The project asked this type of questions in order to examine gaps and needs in order to the ideal way of working with integrated care. The results of it underline the need for development. The type of organisations that run the project has been a regional planning office in Latvia (Zemgale planning region); a university in Norway (NTNU), a university in Slovenia; a university in Serbia; a research institute FAD and European social network (ESN) except for the project owner Research & Development Centre in Sweden. Together they have collaborated with health care organisations, together with NGOD; with municipalities etc.

a) The conditions for using digital tools as support for social innovations are satisfactory in our local community (overall and/or differences between stakeholders).

Namn	Antal	%
1) Totally agree	1	25
2) Somewhat agree	1	25
3) Neither agree or disagree	1	25
4) Somewhat disagree	1	25
5) Totally disagree	0	0
Total	4	100

Svarsfrekvens
100% (4/4)

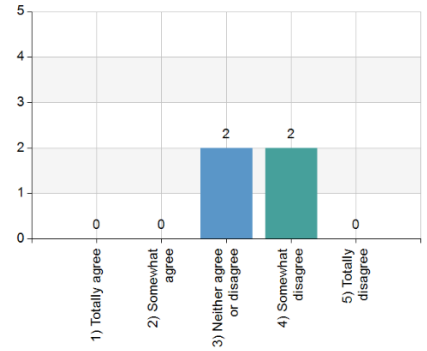


Comments:	Average (n=20) is 2,7 and standard deviation is 0,9. Comments: Respondents pointed out that accessibility varies (users are less accessible than professionals) and that it depends on the environment where people live - in some remote places there is no Internet, etc.

b) Social work and social support regarding our target group in the local community is more health promoting and preventive than problem-based and reactive.

Namn	Antal	%
1) Totally agree	0	0
2) Somewhat agree	0	0
3) Neither agree or disagree	2	50
4) Somewhat disagree	2	50
5) Totally disagree	0	0
Total	4	100

Svarsfrekvens
100% (4/4)

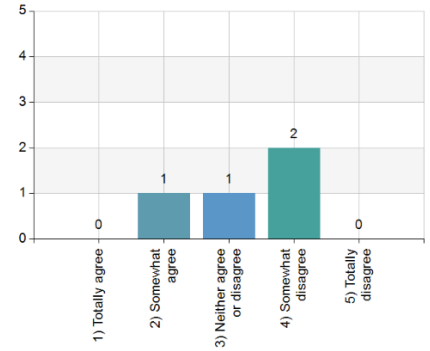


Comments:	Average (n=20) is 3,9 and standard deviation is 0,9. Comments: Participants also commented on this point to the effect that they missed more prevention activities, as well as the time and staff to do so, both in their organisation and in the local environment (in recent decades). Due to work overload, they are unable to reach out to families until very late in the process, when the need is great, the conflicts are high, and the options are limited. They point out that interagency information sharing is associated with curative activities, and some school practitioners note that while there is an increasing emphasis on prevention, the proportion of curative activities is still high.
Comments:	The program is reactive to young people's needs, and highly resolutive. At the same time, it is based on a preventive approach to mental health issues in the community.

c) In social work and social support with our target group, the conditions for working from a holistic/multi-professional perspective are satisfactory.

Namn	Antal	%
1) Totally agree	0	0
2) Somewhat agree	1	25
3) Neither agree or disagree	1	25
4) Somewhat disagree	2	50
5) Totally disagree	0	0
Total	4	100

Svarsfrekvens
100% (4/4)

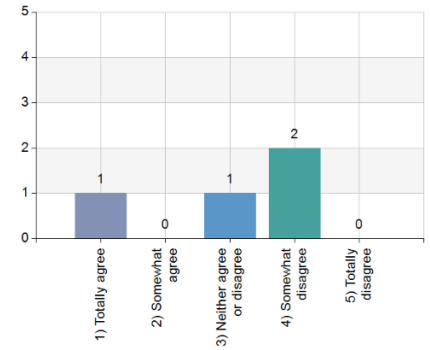


Comments:	Average (n=20) is 2,8 and standard deviation is 0,9. Comments: Some professionals mentioned the good cooperation between services, while others pointed out that they often work in bubbles and responsibilities are shifted. They added the lack of staff, lack of teamwork.
Comments:	The lack of integration and fragmentation among service providers and organizations, makes conditions more complex. It could be harder, but it still is the goal.

d) The conditions for working with a person-centered approach are satisfactory in our local community.

Namn	Antal	%
1) Totally agree	1	25
2) Somewhat agree	0	0
3) Neither agree or disagree	1	25
4) Somewhat disagree	2	50
5) Totally disagree	0	0
Total	4	100

Svarsfrekvens
100% (4/4)

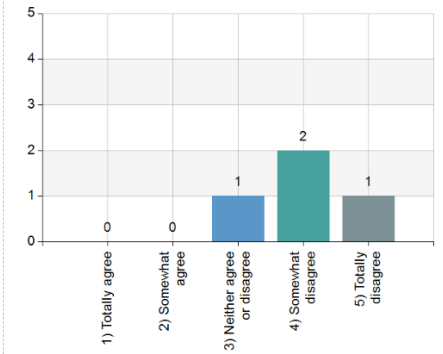


Comments:	Average (n=20) is 2,6 and standard deviation is 0,8. Comments: Professionals noted that there are no NGOs (except Ars Vitae Association) and other programmes in the local area to refer families to, that there are too few options and providers, and that those that do exist are overcrowded and disconnected from one another, with waiting lists for users.

e) We have methods for systematic work concerning user involvement in our local community.

Namn	Antal	%
1) Totally agree	0	0
2) Somewhat agree	0	0
3) Neither agree or disagree	1	25
4) Somewhat disagree	2	50
5) Totally disagree	1	25
Total	4	100

Svarsfrekvens
100% (4/4)

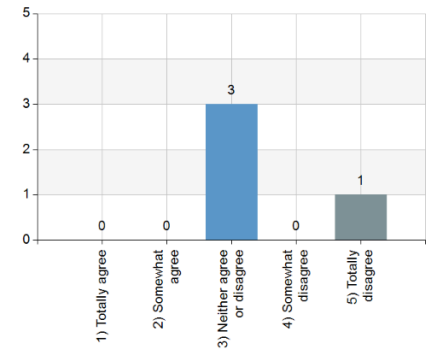


Comments:	Average (n=20) is 2,9 and standard deviation is 1. Comments: Professionals state that current services are too small (more NGOs would be needed) and also lack professional support and training. The network of support services needs to be expanded, and at affordable prices.
Comments:	Methods to involve users are not systematized.

f) Frontline staff have sufficient knowledge and skills to be able to work evidence-based for the transition towards integrated care and social support.

Namn	Antal	%
1) Totally agree	0	0
2) Somewhat agree	0	0
3) Neither agree or disagree	3	75
4) Somewhat disagree	0	0
5) Totally disagree	1	25
Total	4	100

Svarsfrekvens
100% (4/4)



Comments:	Average (n=20) is 2,6 and standard deviation is 0,8. Comments: The majority of respondents (60%) who responded to the questionnaire agreed with the point, but added in their comments that there is never enough knowledge, that knowledge in this area needs to be constantly improved, also in line with the changing challenges in society, they also see a need for systemic knowledge and skills, and some added that time (not enough of it) is a bigger challenge than knowledge.
Comments:	Although frontline staff are well prepared to perform their task, knowledge and skills regarding evidence-based interventions towards an integrated care approach could be improved. It is worth to highlight the importance of evaluation of effectiveness of interventions in this approach.

The results of the tables show four responses out of 7 possible. Each of them show a long way in order to build capacity in these approaches/ ways of working. In general the majority disagree with all the claims in the tables above.

Conclusions

According to the ESN baseline, key drivers for integrated care and support can operate at different levels - micro level focusing on the individuals, meso level focusing on organisational aspects and finally, macro level targeting overall systems of welfare. In the LINK baseline, all three levels are highlighted in different ways. Lack of resources and staff shortages are mentioned as a basis of the need for change. Current organisation of social service and support build on the idea of professional and organisational specialisation. From the baseline it can be concluded that this results in fragmented systems where individuals often find it difficult to navigate in order to get the help and service the need. All parties in the LINK network highlight the need for improved collaboration and coordination, between organisations and between different professional/staff groups.

From the baseline, a further conclusion is that the the interdisciplinary aspect is a key factor in the Learning and innovation lab development. From a learning aspect, the LINK labs could be an arena for interdisciplinary learning and development of integrated competencies and skills that challenge and possibly exceeds old patterns of organisational and professional boundaries, both in terms of work methods as well as assumptions and knowledge about the target groups in question.

There is also a need to improve collaboration between frontline staff and the individuals and groups, i.e. user involvement and participation. Representatives from the target groups in the LINK labs are key stakeholders in the development of integrated social care and support systems and this should be taken into account when forming the lab groups.
Finally, according to ESN commitment from stakeholders and effective leadership is singled out as key supporting factors for integrated care. The Learning and Innovation Lab model builds on the idea of a democratic arena for learning and innovation, where all participants have equal say. In arranging the labs, the ambition should be a broad representation from micro, meso and macro level, i.e. participants from the target groups as well as frontline staff, management and policy makers.

The learnings from the lab will be handled in the learning process by exchanges among the partner organisations and will also be a base for a digital learning program for others that want to develop their skills in working with innovations in the social area. Altogether the project hopes to ameliorate the chances to make some difference when it comes to getting closer to a solution to different actual challenges in welfare.

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Appendix: Baseline study questionnaire:

SECTION 1. SOCIETAL/NATIONAL LEVEL

a) How would you describe the overall welfare model of your country? (conservative, liberal, social-democratic, post-socialist etc)

b) Make a short description of how your country has organized the provision of social service (distribution of national, regional and local responsibilities, main actors and organization of social welfare, private or public sector, NGO/third sector organizations, family).

c) Please describe the national organization for social work education1

1 This question has a limited focus on social work education, as most of the participating researchers in the project work within this discipline. A broader educational perspective is included in section 2.

1

(university, college or high school level, degree levels for qualified social workers - bachelor, master, doctorate or other)

d) Describe the three main welfare challenges associated with the development of integrated care in your country.

e) Describe how the welfare system has an impact on the problem you have chosen for your lab?

SECTION 2. PROJECT AIM, TARGET GROUP & STAKEHOLDERS

a) What is the main problem you want to work with in your lab?

b) How does the problem address challenges related to Integrated Care?

c) According to domestic research and other written material, how can the target group's living conditions be described and understood? (Please use quantitative and qualitative measures and data).

d) Please describe the relevant and possible stakeholders, key staff groups and organizations concerning social work and social support for your target group.

e) How would you describe the educational background of frontline staff working with the target group in your community today?

f) What services are available for our target group in the community today? (Please make a full description of each service)

g) What are the three main challenges in terms of social work and social support for this target group today? (For example, where are the gaps in services or frontline education and skills, the impact or lack of impact for these services and/or education and skills etc.)

SECTION 3. INNOVATION & DEVELOPMENT

a) How would you describe the readiness for digitization in your local community (infrastructure, digital competence, access to digital

workspaces - MS Teams, Google, Zoom etc.)?

b) Please describe three domestic examples of social innovation work connected to your target group.

c) Why is it important to work with social innovations related to your target group?

2

SECTION 4. INTEGRATED CARE - CORE COMPONENTS

a) The conditions for using digital tools as support for social innovations are satisfactory in our local community (overall and/or differences between stakeholders).

(1) Totally agree

(2) Somewhat agree

(3) Neither agree or disagree

(4) Somewhat disagree

(5) Totally disagree

Comments:_____

b) Social work and social support regarding our target group in the local community is more health promoting and preventive than
problem-based and reactive.
(1) Totally agree
(2) Somewhat agree
(3) Neither agree or disagree
(4) Somewhat disagree
(5) Totally disagree
Comments:_____
c) In social work and social support with our target group, the conditions for working from a holistic/multi-professional perspective are
satisfactory.
(1) Totally agree
(2) Somewhat agree
(3) Neither agree or disagree
(4) Somewhat disagree
(5) Totally disagree
Comments:_____
d) The conditions for working with a person-centered approach are satisfactory in our local community.
(1) Totally agree
(2) Somewhat agree
(3) Neither agree or disagree
(4) Somewhat disagree
(5) Totally disagree
Comments:_____
3
e) We have methods for systematic work concerning user involvement in our local community.
(1) Totally agree
(2) Somewhat agree
(3) Neither agree or disagree
(4) Somewhat disagree
(5) Totally disagree
Comments:_____
f) Frontline staff have sufficient knowledge and skills to be able to work evidence-based for the transition towards integrated care and social support.
(1) Totally agree
(2) Somewhat agree
(3) Neither agree or disagree
(4) Somewhat disagree
(5) Totally disagree
Comments:_____