2011

National Integration Strategy Paper
FRANCE

Project:
Development of a Common Training Programme for ABI Caregivers (ABI)

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[Arièle LAMBERT, Directrice]
Arceau Anjou / MFAM
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Introduction: *This section introduces the main sections of the report as well as the primary people involved in conducting the report. It provides any information that might be needed by the reader to understand the background to the analysis.*

Aims and objectives*: This section describes the purpose(s) of the analysis.*

Methodology: *This section describes the analysis techniques used and provides step-by-step descriptions of the work carried out.*

The training needs in *[please insert your country]****:*** *This section presents a summary of the national report on training needs, conducted in workpackage 2.*

The results of the pilot testing: *This section presents a summary of the results of the pilots, conducted in workpackage 4.*

National and Regional Adaptations: *This section presents the summary of the report on the national adaptations, conducted at a previous stage of workpackage 5.*

An Integration Strategy for *[please insert your country]****:*** *This section describes a national/regional integration and exploitation strategy, which serves as a step-by-step action plan towards the implementation and accreditation of the ABI training programme in the country.*

References: *This last section lists the sources reviewed or consulted during the analysis.*

PREAMBLE

Acquired brain injuries (ABI) are an epidemic of modern society and one of the biggest medico-social problems in the western countries. High quality care is usually available in the domains of acute medicine and surgery. In the later stages as difficulties arise, all too often little is done for the long-term, often permanent problems victims and their families are facing after an ABI. The consequences of ABI are often extensive and wide ranging and can cause distress and concern for staff working directly with persons with ABI, especially new employed, low experienced staff and staff in pre-existing community service models (for persons with developmental disabilities, mental illnesses, nursing homes..) . Long-term care poses different questions and problems than acute care. The growing number of people with ABI in the community, the increased interest in ABI, the growing number of people working in the field, and the belief that ABI present problems that are not well understood or treated, have created a genuine need for specialized, formalized " how to do". A questionnaire survey report of staff working directly with persons with ABI in different institutions and organizations in Slovenia in 2008 concluded that 95% of staff needed specialized training, 80% agreed that the training curriculum should include some specific topics like cognitive, psychological and social consequences of ABI, and behavioural approach for managing challenging behaviours and promoting positive skills.

1. EXECUTIVE SUMMARY

This report outlines the process undertaken within the Consortium of the "ABI" project (Development of a common training programme for ABI caregivers), started in October 2009 and being scheduled for 25 months.

The aim of the ABI project is, by introducing knowledge and experience from different countries, to develop a common training programme for long-term ABI care-givers/providers as a uniform formal approach in staff training at a European level. The ABI project will ensure them the acquisition of necessary knowledge, skills and attitude needed to provide quality services. It will also provide recognition of competency level and potential and improve the appeal of working in services for long-term care and support for ABI.

The ABI project partnership includes the following 8 partners:

- Zavod Zarja / Slovenia (applicant organisation, coordinator),
- Zavod Korak / Slovenia,
- Zavod Naprej /Slovenia,
- VDC Nova Gorica / Slovenia,
- Regionalis Szolialis Forraskozpont Kht. / Hungary,
- Mutualite Francaise Anjou-Mayenne-Arceau-Anjou / France,
- Berufsforderungsinstitut Oberosterreich / Austria,
- European Association of Service providers for persons with disabilities (EASPD) / Belgium.

The ultimate goal of workpackage 5 is to integrate the training programme in each of the partner countries. Therefore, this report provides all information collated during the lifetime of the project. Based on these data, a clear exploitation/integration strategy will be developed per country in order to implement the training programme at national or regional level and keep it alive after the funding period.

2. INTRODUCTION

The ABI project partners were aware of the training needs of staff that provide direct care and assistance to people affected by ABI.
In December 2009 a wide training needs analysis was conducted to formally confirm the need for training and to establish a specific training programme around ABI that service providers and practitioners within France felt would be most beneficial. The training needs analysis elicited an enthusiastic response and findings of this are documented in a report (Synthesis report France and transnational report we wrote as leader of this WP, available on www.abi-project.eu). After analyzing the needs of many professionals from everywhere in the country and beneficiaries, we made an inventory of the existing ongoing and university training programmes in our specialty. We selected 21 representative courses and we evaluated them on the basis of the criteria chosen to be the objectives of the ABI programme.

The outcome of the training needs analysis was the development of the ABI Training programme. The main content of the ABI Training programme are the ABI Basic Learning Outcomes which describe the knowledge future trainees will undertake and the learning outcomes they must achieve in order to be awarded a certificate. With the aim to have theoretical material that met the ABI Basic Learning Outcomes the ABI partners designed the ABI Workbook. The goal of this educational tool is to support learners and trainers at training. The training programme was pilot tested from April 4th to April 8th 2011.

A desk review of relevant documents relating specifically to Adult Learning, Education and Training in France as well as interviews with relevant stakeholders on the matter were conducted in order to get a clear overview of the legislation and standards in France concerning the implementation and accreditation processes. The main findings are documented in a report (Report on National adaptations France, available on www.abi-project.eu).
This report will detail the process of developing the training programme, the pilot itself, feedback and what is the future for ABI training in France.

3. AIMS AND OBJECTIVES

The main aim of workpackage 5, is to bring the training programme in line with national and European standards and regulations, and to conduct a clear exploitation/integration strategy in order to get the training programme implemented at national or regional level and to keep it alive after the funding period.

As a first step, an analysis was made in each of the partner countries on the legislation and standards concerning this topic and the implementation and accreditation processes needed at national/regional level.
These 'Reports on National Adaptations' gave us a first idea of the way of working in each country, the obstacles which might occur and the national adaptations to the training programme which were needed.

Approaching the end of the project, we now have all needed information to develop an extensive integration strategy on the steps to be taken in the final stage of the project and after the projects' lifetime. This is the goal of this report.

More in detail, following information will be brought together in this National Integration Strategy Paper:

- The national report on training needs, conducted in workpackage 2;
- The results of the pilots, conducted in workpackage 4;
- The report on the national adaptations, conducted at a previous stage of workpackage 5.

Based on this information, an extensive integration and exploitation strategy is developed per country, containing a timeline and a number of detailed recommendations towards the implementation of the ABI training programme at national/regional level.

4. METHODOLOGY

The synthesis of all data collated during the projects' lifetime

As for the 'Reports on National Adaptations', a set of guidelines was conducted by EASPD, giving the project partners the opportunity to write their report in a structured and parallel way. All partners were asked to use these guidelines as a basis for their national report, which would help EASPD compiling the 'Transnational Report on integration' at the end of the project.

The guidelines consist of a series of questions, which serve only as a basis for the report to be written and should not be seen as an exhaustive list of topics. Each of the partners was given to opportunity to add freely important information specific to their country or region.

The questions to be answered by the project partners in this section of the national report, were:

1. What are the training needs of persons working in the ABI sector, in your country/region?
2. How far are these needs met in the training programme as it is conducted now?
3. Please give an overview of the results of the pilot testing in your country/region? Which feedback was given by the different stakeholders?
4. How is the education and training system organised in your country/region (the formal vocational training system as well as the boarder lifelong learning field)?
5. How is the EQF/NQF implemented in this system?
6. Which bodies are responsible for the accreditation of training and education programmes in the formal vocational training system, as well as in the broader lifelong learning field?
7. What are the obstacles which we would need to overcome when implementing the ABI training programme in your country/region?
8. Which national/regional adaptations of the ABI training programme are needed in order to get it implemented in your country/region?
9. What chances of success do you think we have?

The answers to these questions can all be found in the previous reports written during the projects' lifetime.

The development of an integration strategy

The ultimate goal of this report is the development of a national integration strategy, based on the information collated during the course of the ABI project. In order to help the project partners to develop such a strategy, a set of guidelines was conducted by EASPD. The partners were asked to use these guidelines as a basis for their national report, which would help EASPD compiling the 'Transnational Report on integration' at the end of the project.

The guidelines consist of a series of questions, which serve only as a basis for the report to be written and should not be seen as an exhaustive list of topics. Each of the partners was given to opportunity to add freely important information specific to their country or region.

The questions to be answered by the project partners in this section of the national report, were:

1. Which concrete steps need to be taken to implement the ABI training programme into the education system of your country/region and into your NQF, taking into account:
   - the obstacles to overcome;
   - the adaptations to be made;
   - the measures to be taken (at European, national and regional level) in order to improve the chances of success.
2. What more would we have to do to get it an EQF reference?
3. What would be the timeline to achieve these steps, during and after the projects' lifetime?
4. Who would actually do it, during and after the projects' lifetime?
5. Which stakeholders could be involved in the implementation process?
6. Give some concrete ideas on how to keep the project outcomes alive after the projects' lifetime.

The answers to these questions are synthesised in a step-by-step action plan, which can be found further down in this report.

5. THE TRAINING NEEDS IN FRANCE

A training needs survey and analysis among staff working with persons with ABI in different service providers, with or without expertise in ABI, in France was conducted in December 2009 to formally confirm the need for training.
The main aims of the training needs survey were to identify possible issues and staff training needs in order to deliver care and support to persons with ABI and to ensure that the training content to be developed along the ABI project covers topics that best address staff' needs and gaps in knowledge and skills. Other goals were also to inform national stakeholders about the development and the implementation of a training programme for staff working in ABI care (to improve the visibility of the project) and to identify all the settings (not necessarily all knowledgeable regarding ABI) where individuals with ABI received services.

Staff training needs survey was conducted by using a common written questionnaire which had been designed by the Contractor (Zavod Zarja) in October 2009. The questions were common to all project ABI participating countries. The questionnaire comprised different questions referring to individual training needs and self-assessment of own knowledge. Personal characteristics such as age, gender, education level, scope of work and organization were also asked for.

We distributed the questionnaire via our national network, targeting a sample population that seemed to be representative of all the professionals in our sector. We defined our target sample in such a way that it reflected the characteristics of all the professionals working with brain-injured people. We paid particular attention to the characteristics that could influence respondents' answers. We therefore made sure that we covered the full range of occupations, workplaces and regions. It should be noted that the healthcare and medico-social professions in France are dominated by women, who therefore represent a large sample in this study.

The questionnaire was distributed mainly to paramedical workers. However, we also made sure that it was distributed to special education teachers, medical psychology assistants, trainers, doctors, social workers, secretaries, etc.

The organisations in which these professionals work are also relatively representative of existing services in France: hospitals, functional rehabilitation centres, in-home medical and social services, assessment and rehabilitation services, halfway residences, etc. The questionnaire was sent out to locations throughout France.

A total number of 55 questionnaires were returned.

Data collection method: We chose two collection methods: by post and online. In many cases, we contacted the respondents by telephone before sending out the questionnaire in order to explain the background to our request, and to stress the importance of distributing the questionnaire to professionals in different branches and of meeting the timeline.

Data processing: We used a data processing programme that enabled us to access a very broad spectrum of data. Hence, we did not use the recommended Excel file, which did not seem adequate in terms of its data comparison capability.

- We mainly used the table sort feature. This resulted in the "frequency distribution" table, showing the number or percentage of individuals in each modality. First, we highlighted the most and least important areas of competence for the professionals.
- We also presented the self-estimated knowledge of the professionals in each area.
- We then compared this data in order to define possible areas of discussion regarding training programme content.
- Finally, we identified areas in which the professionals felt they lacked theoretical training, and areas in which they felt they needed more practical training.

Having processed the data from all the questionnaires, we applied multi-criteria filters to generate sub-populations and to refine our analysis according to “occupational category”. We applied the above analysis procedure to each of the following categories: administrative, medical, social and educational, and paramedical.

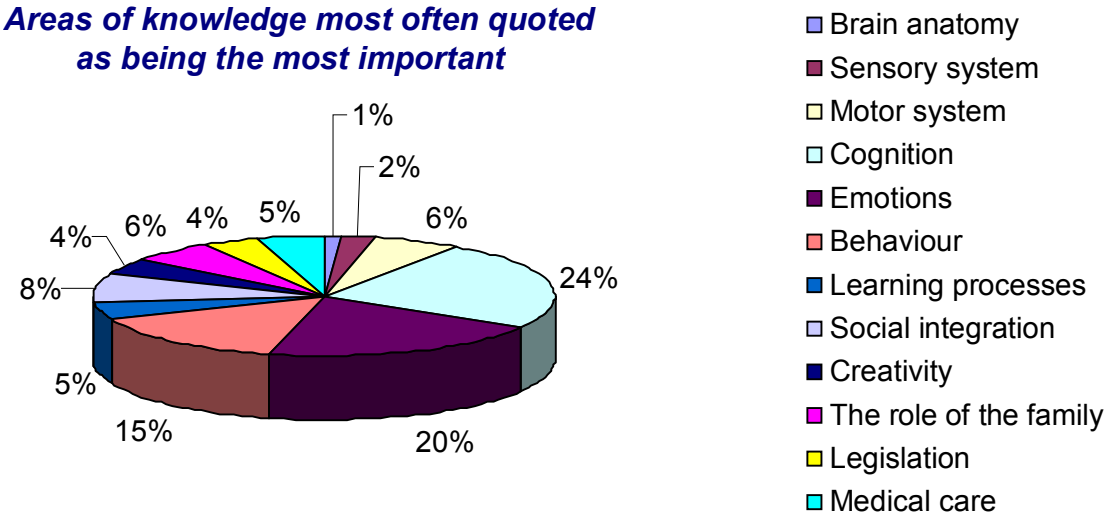
What the questionnaires told us? The questionnaires gave us a wealth of details about:

- ***how staff perceived their existing own knowledge and skills regarding ABI,***
- ***the gaps between staff´s actual knowledge and the required/needed knowledge and skills in order to deliver quality care and support,***
- ***The training needs identified by staff.***

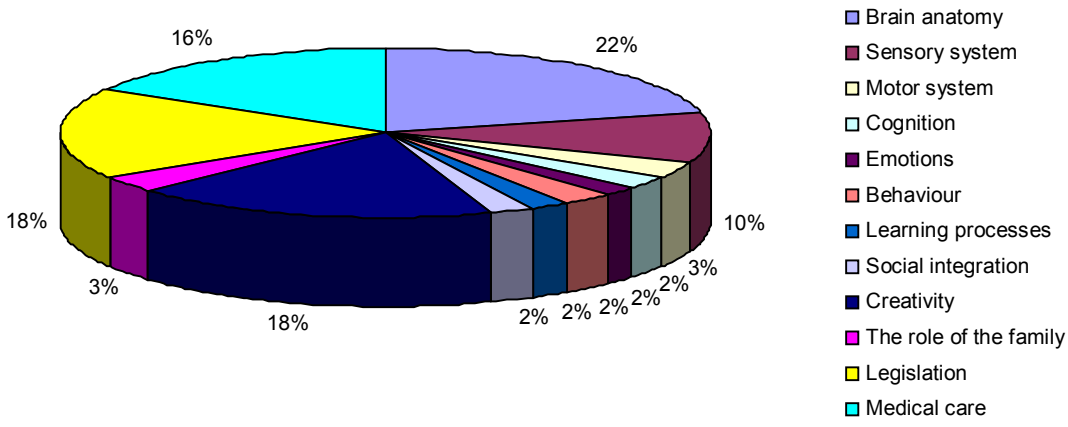
Knowledge and skills gaps have been declared by staff in all the 12 areas surveyed: Anatomy of the Brain, The Sensory system, The Motor system, Cognition, Emotions, Behaviour, Learning, Integration, Motivation, Creativeness, Cooperation with relatives, Regulations, Health nursing. The main training needs identified by staff were in those topics/areas where more staff indicated a lack of knowledge and where they needed training.

MAIN TOPICS WHERE TRAINING NEEDS HAVE BEEN DECLARED BY STAFF

The most important areas of knowledge were identified as ***cognition, the emotions and behaviour.*** If we look at all the completed questionnaires, we can see that 59% of the respondents placed one of these areas of knowledge in the top three.



The areas of knowledge most often quoted as being the least important are brain anatomy, creativity and legislation (for all groups of professionals).



On top of this study, we performed 2 other tasks in order to cross the results and give more room to the opinion of the users: we first adapted the questionnaire for professionals to survey 17 beneficiaries (users with ABI and their families); then we analyzed 21 specialization courses available in ongoing training in the field of ABI.

Identification of user expectations

The surveys gave us a wealth of details about the training needs and skills identified by users.
In answer to the question "*Can you tell us what you expect of the professionals you are seeing?"* **most of the users talked about life skills and behaviour. They expect professionals to be available, attentive and understanding.**

The following answers (to less open questions) indicate that users expect two main things from professionals:

- assistance in their daily living activities, given their various disabilities and difficulties
- availability, appropriate behaviour, a respectful attitude and, above all, consideration of their opinions

In general, users define the roles and obligations of professionals according to their job, and do not have the same expectations of all of them. Consequently, the level of knowledge expected from these professionals differs. The answers given by the users seem to be influenced by the services and organisations working with them, and by the knowledge they have of these services and organisations (which provides a point of reference for them).

Identification of existing training programmes in France

We relied on the Internet and on contacts within our network to identify continuing training programmes focusing specifically on brain injury. We distinguished courses that lead to a degree or a diploma from those that do not. We then defined a set of quality criteria, which

was used as a working framework at the national conference. We selected structural criteria for each category (diploma/non-diploma courses) and developed an evaluation grid that could be used to analyse all the components of the training courses identified
The criteria defined are based on the criteria specified in the quality procedure, and in the AFNOR and ISO quality standards relative to continuing vocational training.

We identified **21 programmes,** which are presented in French synthesis report:

- 5 degree courses (3 inter-university degrees, 2 university degrees)
- 16 non-diploma courses relating exclusively to brain injury; these courses are provided by organisations working with disabled people.

Short training programmes are continually changing, both in terms of structure, content and methods. So, for two reasons, we focused exclusively on programmes lasting for at least 5 days: firstly, so that we could establish comparison indicators, and secondly because shorter programmes did not seem to be significant, despite the importance attributed to them in our introduction. Moreover, there is nothing in between these 5-day programmes and university degrees (in terms of continuing education). This deficit is clearly a target for the ABI project.

Therefore, the purpose of the assessment conducted at the national conference was to analyse these programmes on the basis of pre-defined criteria and, by comparing them with the needs expressed by long-term caregivers, to define best training practices for the “ABI” project.

5 participants in the conference hold university or continuing education teaching positions in addition to their main occupation. They were therefore doubly qualified to identify best practices

The national conference gave us a wealth of details about the best practices and contents for this kind of programme.

20 recommendations for developing a high-quality training programme

1. Aim to develop explicit professional skills, based on the needs expressed by professionals and by employers in the sector.

2. Develop a “key competence” framework for those involved in the long-term care of brain-injured people. This should include a common core of knowledge and skills, to ensure that all professionals in the sector adopt the same approach to patient care.

3. The programme should aim explicitly to improve the level of service quality provided.

4. Recruit participants from different backgrounds, with the ultimate aim of promoting a multidisciplinary approach to patient care.

5. Make sure that the participants are working at the time of the course.

6. Group sessions together over one week to minimise disruption to work commitments.

7. Select a training site close to a university or a business community, such as Paris and Bordeaux in France. Make sure that courses are equally available in all the major regions (in France: North/West, North/East, the Paris region, South/East and South/West).

8. Define 2 separate courses of specialisation, according to level: one for medium-qualified professionals (up to advanced [high school] level in France) and one for graduate-level professionals and beyond. Objectives: diversify the offer and reach the least -informed professionals.

9. Develop full, 3 to 5-day modules on the different topics and issues encountered by professionals in their day-to-day work, focusing on: the evaluation of abilities and of living habits, the development of "made-to-measure action plans" and the implementation of "personal projects".

10. Allocate 3 to 5 days to each specific module in order to cover topics in depth and implement a wide range of training materials.

11. Define training content according to the difficulties encountered in the following specific areas: supportive care, work adjustment training, rehabilitation, integration, psychological support, family mediation and medical care.

12. When defining content, bear in mind the different approaches and reference models that may be used in other countries and continents.

13. Always discuss the role of the International Classification of Functioning, Disability and Health (ICF) and of the Disability Creation Process (DCP), the implementation of which is compulsory in Quebec (Canada).

14. Make sure that the programme allows for alternance training and that it is long enough to impact on professional behaviour through the gradual putting into practice of new knowledge.

15. Include regular practical work, structure the course around case analyses and studies, use a wide range of teaching materials, and promote discussions between professionals and the analysis of practices.

16. Introduce a course completion certificate. Evaluate the level achieved through a practical assessment of observable skills.

17. Recruit teaching staff from different backgrounds: experienced professionals, employer representatives qualified in the field of brain injury, and university academics. Include doctors to provide a link between hospital care and long-term care.

18. Appoint a programme coordinator to ensure quality.

19. Develop literature on the course – endorsed by reputed teaching staff – and distribute it through resource centres.

20. Keep prices reasonable so as not to discourage enrolments.

Recommendations regarding target, contents and the major topics:

Contents and main topics:

- Introduction to the brain, to ABI and TBI
- Impacts, impairments and consequences
- Care pathway, stages of rehabilitation and continuum
- Overall approach and specific strategies to care and support ABI users
- Organisation of the staffs / skills and value / management
- Legal and ethical issues
- Working with relatives/ multidisciplinary team/ networking
- Empowering persons with ABI/ rights and well treatment

Target:

With regard to the engineering of the "ABI" project, Arceau Anjou has suggested developing 2 separate courses of specialisation to ensure that the training needs of all ABI professionals are met. These 2 courses would be available to participants on completion of a common module, open to all professionals regardless of basic training and experience

- Common general knowledge module / 5 days
- Specific courses
    1. Course of specialisation 1 for intermediary professions, families and relatives, volunteers, future employers, social services, ...
    2. Course of specialisation 2 for high-level professionals

At the end of each module the participants would receive a certificate of competencies. Experts at the national conference in February 2010 stressed the importance of selecting and preparing trainers to deliver the modules.

The outcome of the training needs analysis in four project ABI partner countries was the development of the common ABI Basic Learning Outcomes, which are the agreed definitions of the 10 main areas of learning /basic knowledge/ learners will undertake. The outcomes to be achieved are clearly stated so that learners know exactly what they have to be able to do, trainers know what training or learning is to be provided and organisations know the skill levels required of their people. They describe the results of the learning rather than the

learning process itself. The ABI Basic Learning Outcomes are the main content of the ABI Training programme and they are the benchmark for all countries for the basic knowledge in ABI staff will gain regardless of the country of origin. They ensure a comparable base for knowledge but with allowing each partner to create, choose and specify its appropriate own training methods considering the standards and requirements for professional practice in his country.

Module1: Introduction to ABI
Module 2: Rehabilitation and care process
Module 3: Understand their role in the care process
Module 4: The values of social care
Module 5: Promote a positive and supportive approach
Module 6: Risk management
Module 7: Safety at work
Module 8: Communicating positively
Module 9: Promote skills for independence
Module 10: Develop as a worker

The ABI Basic Learning Outcomes led to the designing of the overall format of the ABI Training programme and to the development of training materials. With the aim to have theoretical material that met the ABI Basic Learning Outcomes the ABI partners designed the ABI Workbook. The goal of this educational tool is to support learners and trainers at training and to increase knowledge regarding ABI, to outline skills that are useful in working with persons with ABI, to highlight resources that may be of use to persons with ABI and their family members and to assist learners to feel more comfortable and confident in their interactions with persons with ABI.

Developing the ABI Workbook took thought, effort, and time (5 months). After having determined the Workbook's audience, scope, and contents, the writing tasks were divided. ABI French partner wrote 3 modules out of total 10: Module 2/3/9.

The ABI Workbook was developed according to the Guidelines adopted by the ABI Partnership. The first version was written in English.
After the first draft of the entire Workbook was generated and edited, partners translated it from English to French and reviewed it.

6. THE RESULTS OF THE PILOT TESTING

At the 3rd ABI project meeting in Hungary in November 2010 it was agreed by the ABI partners that the pilot tests of the training programme would run in 3 countries (Slovenia, France and Hungary) in a common format from April 2011 to May 2011 but with allowing each partner to create, choose and specify its appropriate own training methods considering the standards and requirements for professional practice in his country.

PREPARATION

It took three months in France to organise the test run of the ABI training programme, which took place from 4 to 8 April in Angers. The preparatory phase included a number of WP3 activities, for example:

- The finalisation and thorough verification of the workbook, which had to be amended in several places, especially where it referred to current regulations. The regulations in France are not only extensive but necessary, insofar as the social and care sector relies heavily on third parties to fulfil its public service role;
- The development of tools for the final assessment of participants; and
- The selection of trainers on the basis of clearly-defined criteria.

We carried out a test run of the training programme on the basis of these elements, using a participatory approach involving various people:

- 4 members of the Arceau Anjou ABI project team,
- 11 trainers highly specialised in caring for brain-injured people
- 6 examiners in charge of assessing the results of the programme
- 15 participants from 7 different institutions. We wanted to extend the scope of the project as far as possible beyond the boundaries of our reference area, in accordance with our long-term integration strategy. We also decided to vary the professions represented in the group of participants, in line with the global, multidisciplinary treatment approach recommended by both health authorities and regulatory bodies. Therefore, 9 professions were represented.
  It should be noted that we had a lot of applications for the training programme, despite careful targeting. We had to limit the number of participants to 15. We felt we could not go above this number, even though we had had over 30 applications. This confirms that the training programme filled a clearly-identified gap in the market, as demonstrated during WP2; and
- 7 observers from external organisations, representing the different professional groups involved in caring for disabled persons and in European projects

We had to hold numerous preliminary meetings in order to:

1. Inform our partners on the underlying philosophy of the project and on the rules operating within the ABI consortium, and, in particular, explain to them how to integrate the “main areas”, the “basic learning outcomes” and the “content guide” into their sessions.
2. Define the most relevant training programme possible.

3. Take care of practicalities:
4. Prepare the final assessments:
5. Prepare the training materials:

IMPLEMENTATION

The training programme went according to plan, with 15 people taking part. It is really not possible to have more than 15 participants, as such big groups do not allow for enough individual attention during practical tasks. In fact, we concluded that a group of 12 would be better.
Given the learning outcomes defined and the number of subjects addressed (10), the schedule was very tight. It was therefore difficult to adopt an active teaching/learning approach. In fact, the number of training sessions decided upon at the meeting in Hungary was not conducive to an integrated approach focusing on student participation through simulation exercises, which are time consuming. The training programme was designed in a relatively academic fashion, which we now feel should be reconsidered. It seems that the professionals participating in the programme need more specialised training, concentrating on action plans and strategies rather than on the more general aspects that most of them are already familiar with (communication, safety, etc.). Nevertheless, to avoid piling up content, we opted for half-day sessions comprising several inter-related modules.

The training programme took place in 2 locations so that the participants could see first-hand the different types of setting in which brain-injured people live. This was very much appreciated. As a result, we were able to place the participants in different situations and, in particular, show them how to help brain-injured people perform everyday tasks, how to respond in emergencies and how to use special equipment correctly.

Given the intensive nature of each session, and despite the constant efforts of the trainers to concentrate on the objectives defined, it was difficult to stay on schedule. As a result, the training sessions "ran over" into the time set aside for breaks. Otherwise, the group was very attentive and involved. They asked a lot of questions, which not only took up more time but also led to frustration on both sides, as we were unable to answer in any depth.

We also decided to offer a number of training sessions run by more than one trainer. Therefore, 4 half-day sessions were run by two trainers. This was meant to reflect the multidisciplinary nature of care.
Overall, the pace of training was fast, which was tiring for the participants. This was clearly noticeable by the end of the week.

The last half-day was devoted to the assessments. Several months beforehand, we had organised a mock examination exercise based on case studies to gauge the most appropriate level of assessment. This exercise (which took place in April 2011) clearly showed that multiple-choice questionnaires are too simple in scope, and that case studies are more suited to assessing content assimilation and the understanding of ABI treatment strategies. Furthermore, case studies are subject to an oral examination by two examiners, which provides an opportunity to delve deeper into some areas of knowledge that are only briefly touched upon in the multiple-choice questionnaire (the random nature of which can work in

the candidate's favour). The assessment process does not test all the learning outcomes targeted, as that would take too much time and require too many resources.

However, insofar as Arceau Anjou has developed a certificate of proficiency to validate learning outcomes, we also had to mention the aspects that had not been assessed. This certificate will enable the participants to come away with a document detailing the training course, and will also give employers an indication of their employability and of their skills in certain areas.

EVALUATION

Feedback for the training was obtained through evaluation forms distributed at the end of the training to ***the participants and the observers*** that attended training.

All the results are in the national and transnational pilot reports.

General feedback : OVERALL IMPRESSION OF THE TRAINING PROGRAMME

	Excellent	Good		Average	Acceptable	Poor
OVERALL IMPRESSION	2	Part Obs	10 5	2	❑	❑

	FOR TRAINEES	FOR OBSERVER
How would you improve this course?	❑ Clarify the course objectives. 2 ❑Reduce content covered in course. 3 ❑Increase content covered in course. 2 ❑Update content covered in course . 1 ❑Improve the instructional methods. 3 ❑**Make course activities more stimulating. 6** ❑Improve course organization. 3 ❑Make the course less difficult. 3 ❑Make the course more difficult 0 ❑**Slow down the pace of the course. 9** ❑Speed up the pace of the course. 0 ❑**Allot more time for the course. 5** ❑Shorten the time for the course. 1 ❑Improve the tests used in the course. 3 (MCQ)	❑ Clarify the course objectives. 0 ❑Reduce content covered in course. **1** ❑Increase content covered in course. **1** ❑Update content covered in course . 0 ❑Improve the instructional methods. 0 ❑Make course activities more stimulating. **2** ❑Improve course organization. **1** ❑Make the course less difficult. 0 ❑Make the course more difficult . 0 ❑Slow down the pace of the course. **1** ❑Speed up the pace of the course. 0 ❑Allot more time for the course. **1** ❑Shorten the time for the course. 0 ❑Improve the tests used in the course. **1 (MCQ)**

General feedback : OPPORTUNITIES TO IMPROVE THE TRAINING

FOR TRAINEES	
What other improvements would you recommend in this course? *More time should be given to the subject of ageing in ABI patients* *There should be a greater focus on the role of family members* *There should be more time for discussion*	**Are there any subjects you would have liked to be included?** *Neuropsychological rehabilitation*
Which parts of the training programme do you feel will be most useful back at work? *All of them (5 people)* *Medical aspects / 4* *Legislation / 5* *Disability assistance / 5* *Simulation exercises / 1* *Neuropsychological dysfunction / 8* *Multidisciplinarity / 2* *Psychological and emotional aspects / 4*	**Which parts of the training programme do you feel will be least useful, or not at all useful back at work?** *Medical aspect (1 person)* *Legislation (3 people)* *Disability assistance (1 person)*
FOR OBSERVERS	
What other improvements would you recommend in this course?	*Split the course into 2 separate sessions* *Make more use of practical simulation exercises*
Are there any subjects you would have liked to be included?	*Focus more on the role of family members*

CONCLUSIONS

A number of conclusions can be drawn from these questionnaires. Most importantly, they confirm several suggestions that were made during the preparatory phase:

1. The intensity of the programme is not conducive to practical work, which we unfortunately had to reduce. In addition, we decided not to tackle all the modules as they are laid out in the workbook, e.g.
   - Module 4, which we rewrote to bring it into line with our specific context; and
   - Modules 7 and 8, which contain very general information with which our target audience is already familiar.

   On the other hand, we added some specialised content to our programme, relating to brain-injured people, notably how to communicate with them and how to manage psychological and emotional disorders;
2. The fact that the training course lasts only one week, and is therefore very intensive, not only made it difficult for us to fit the content into the schedule but it also did not give the participants enough time to assimilate everything they had learned;
3. It was difficult to reconcile the rigid format and generalist approach of the workbook with the need to develop other, more interactive training materials reflecting the reality of treatment practices;
4. The training course contained nothing on working with the families of patients, which is a very important aspect of treatment programmes and a very widespread practice in France. It is missing from the community programme issued by the ABI consortium. Ultimately, we would like to address this subject in greater depth;
5. The necessity of having highly-effective trainers to ensure the quality of the training content;
6. The size of the group, which bordered on being too big. We opted for a group of 15, so that we could reach as many people as possible. However, it is difficult to provide individual attention and to carry out practical work in a group of this size;
7. The fact that medical aspects were not dealt with first was seen as a slight drawback, and this should not happen again;
8. The fact that a lot of the participants asked for copies of the materials used by the trainers suggests that the workbook is not adapted to local situations. The consortium opted for a “one-size-fits-all” workbook, but the participants need up-to-date information that is relevant to their local context and, in particular, to France, where treatment strategies are highly regulated;
9. The target audience must be more clearly defined in order to optimise the training modules and methods. Most of the participants were new recruits, who already had training in the social and care field but did not specialise in looking after ABI patients. It has already been established that such specialists are needed in long-term social and care departments and facilities, but it would be difficult to mix them with less qualified staff who, nonetheless, would like to benefit from awareness training (receptionists, maintenance staff, cooks, drivers, etc.); and
10. If the target audience is redefined, then the final assessment system must also be revised and the multiple-choice questionnaire must be made more difficult.

On the whole, the training course was a success. It has encouraged us to pursue the adoption of such a programme, which delivers the specialised knowledge needed by professionals and raises the quality of care.

RECOMMENDATIONS

The following recommendations take into account the various impressions of the trainers and organisers, who got together at the end of the week to share their thoughts about the course. They are also based on the assessments made by the observers and the participants. They consist of 8 main points:

1. Size of the group: We recommend groups of 12 at the most;
2. Length of the training course: The course should be split into two sessions of 3 days. There should be a gap between each session so that the participants have time to assimilate what they have learned, and to reduce the level of fatigue. An extra day would also allow for more simulation exercises;
3. Include a module on working with and for the families of victims;
4. Update the workbook, which is too general in some parts. Make sure that the workbook focuses more on acquired brain injury; bring it into line with national situations, which shape the care strategies adopted;
5. Reconsider the assessment methods used, and make the multiple-choice questionnaire more difficult if the target population consists essentially of new employees in the social and care sector and of community carers;
6. It is very important to increase the amount of practical work (carry out simulation exercises, so that the participants better understand the difficulties and challenges involved in caring for ABI patients);
7. Develop a training strategy focusing on practical work rather than academic knowledge; and
8. Set up multidisciplinary groups, so that all the different skills needed to deliver high-quality care are taken into consideration.

All of these points will be discussed at the meeting due to be held in Austria on 26 May.

7. NATIONAL AND REGIONAL ADAPTATIONS

1. How is the European Qualification Framework (EQF) and the National Qualification Framework (NQF) implemented in France?

About the integration of EQF in France we looked for information in European-scale studies, because the medico-social sector in France is little involved in that aspect of things and we only had very little information.

The medico-social vocational area depends on the rules established by the ministry in charge, which drafts a list of authorized professions for which jobs are subsidised in the framework of a public service mission passed on to medico-social institutions.

There are regional delegates of central administration in the new Regional Health Agencies (ARS), replacing the DRASS, and the list of authorized functions can be accessed. Such functions, since the 2002 social modernisation law, can be achieved by VAE (validation of competences acquired through experience), following a procedure indicated in a decree.

In order to assess the possibility to integrate the EQF/NQF standards through this European project, we have read the French interim "EQF project/ network testing" report about the list of accreditation levels in the French framework and their integration into the European framework.

The EQF network testing project, steered by the national commission for vocational accreditations (CNCP), aimed at experimenting the feasibility of matching national accreditation frameworks and the European framework as defined by the April 2008 recommendation. European partners from 8 countries networked together. Like the CNCP, the partners included agencies in charge of listing the national accreditations. These European partners had decided to each work with a national support and follow up group. For France, this group included all the certifying ministries, social partners and the Céreq.

- This report clearly demonstrates the French specificities in terms of accreditation and the difficulty in France to implement mutual recognition at the scale of the EU, but it also highlights the benefits of CEC (European centre for accreditations) and the fact that training and accreditation bodies know very little of it: only government agencies and some experts are aware of its existence so far.

- The "EQF network testing project" interim report places increased emphasis on a national framework for accreditations, which puts a limitation on the approach wanted by our consortium for the development of our training programme. Indeed, in terms of potential mutual basic learning outcomes ABI accreditation approach, we

could only use the national framework and would have to comply with a certain number of decrees (see appendix).

In France the national framework of accreditations is organised by the Jan. 17, 2002 law, which generated the creation of a national repository of vocational accreditations (RNCP), listing all accreditations delivered in France. Besides, the law added an extra requirement to comply with in order to be listed in the RNCP: each accreditation must be achievable through the validation of competencies, acquired by formal or informal training (VAE: validation of competences acquired through experience).

This specific point is not an option in the ABI project and would be impossible to implement with regard to the regulatory framework:

Three types of accreditations to be registered have been defined:

- The accreditations delivered by the Ministry of Education and 6 other ministries in charge of Farming, Culture (only for some accreditations), Employment, Health, Social affairs, Youth and sports, which have dedicated commissions made of government representatives and social partners.
- Accreditations delivered by professional branches based on agreements between the social partners
- Accreditations delivered by other ministries, public or private institutions or consular chambers.

The total amounts to about 13,000 accreditations (10,000 of which are delivered by universities or “grandes écoles” = higher education). 85 % of the repository is made up of the first category of accreditations, those registered by right. The other categories can be registered after an opinion is given by the CNCP, made up of 16 representatives of the state and 12 representatives of the social partners, according to a specific procedure.

General accreditations such as: Brevet des collèges (O level equivalent), géneral Baccalauréats (A level equivalent), are not included in the repository. However, the ministry of Higher education and Research has decided to register all university accreditations because they are considered to have professional objectives. This is why there are so many university accreditations by right in the RNCP.

2. Accreditation of training and education programmes:

Since the Jan 17, 2002 modernisation law, all accreditations must appear in the form of a list of competencies and activities, and not knowledge. Thus, the wish to register a function and therefore to obtain accreditation matches a desire to be recognised in the professional area.

However, there are two ways of obtaining accreditation:

- Resort to the CNCP (national commission for professional accreditation), who has the mission to grant professional accreditation and manages the RNCP.
- Resort to the ministries in charge (Health and Sports, Labour and solidarity, etc…)

In the case of resorting to the ministry in charge, the ministry will study the request for accreditation (granted exceptionally if no specific function is indicated) or authorisation (more likely, but with a very heavy and lengthy procedure).

In 2012, an "authorisations" chapter will be added to the national accreditation repository, which will open the possibility to make more "unordinary" requests, even though they match the updating of working environments. This possibility has to be looked at for potential future integration of the ABI project.

For a CNCP request, five criteria have to be met to achieve accreditation, and are looked at during the examination of the request for registration:

1) The training must lead to a function and not to a specialisation.
2) Recognition by the professional environment is necessary for the targeted vocational qualification, and the professional environment must state the need for such qualification.
3) The reference documents must include two aspects :
    - *a professional activity document (RAP – referential d'activités professionnelles), which defines functions, activities and skills.*
    - *an accreditation reference document, indicating the organisation and the supporting documents to testify for the acquisition of skills*
4) The accreditation will not be registered if the placement rate in employment is lower than 70 %.
5) All accreditations must be achievable by VAE (VAE: validation of competences acquired through experience).

About the basic learning outcomes ABI, criteria 1 and 5 are immediately eliminatory, and the others could be slightly amended, especially n° 3 because the design of the BESCLO partly matches the expected approach. Indeed, it keeps a "knowledge" aspect and does not indicate homogenous functions connected to a position because our programme targets a specialisation useful in a multidisciplinary approach.

These points are therefore negative for a request for accreditation in France, which we therefore cannot consider for this project.

3. The organisation of the education and training system:

We were the pilots of WP2, for which we listed the existing vocational training programmes which could be relevant for the management of ABI persons:

There are two categories of initial post-bac (post-A level) training programmes:

1- initial training given in a L/M/D university cycle

The L/M/D reformation (licence/ master/ doctorat = PHD) covers a set of measures adapting the French higher education system to European standards. It designed an architecture based on 3 grades: licence, master degree and PhD, the organisation of teaching in semesters and teaching units, the implementation of European funds, and the supply of a description appendix to the diploma. The texts to initiate the reformation were published in 2002, but it took several years to be implemented, and in 2010 some training programmes, especially in the area of health, still have not been modified.

University-generated jobs are the minority in our professional area and are mostly found in the following areas:

- executives and managers
- psychologists (neuropsychologists, clinical psychologist, and industrial psychologist)…

The minister of Higher education and Research has decided to register all university accreditations, because it considers them to have a professional finality.

2- Initial training programmes delivered by training institutions authorized by health and medicosocial control authorities (ministry of Health and of Social affairs…)

These initial training programmes, usually accessible by admission tests after the baccalauréat, train professionals in the medical, paramedical, social and educational areas. They are delivered by specialised institutions depending from ministries (Health and Sports, labour, Social relations and Solidarity) and regulated by a set of official texts among which the CASF (social action and family law) for example. Such institutions are dispatched throughout the territory according to an administrative rationale of regional and local presence on the basis of several criteria (size of the cities and population, links with other institutes, links with universities or hospitals, networking possibilities….).

These training programmes are subject to a training reference document and a registered skills reference document. Such reference documents are updated regularly, and especially since the 2002 law, with the creation of the RNCP (national repository of vocational accreditations).

Performing the profession requires the title which usually has no equivalent in other circuits of training and teaching. Collective bargaining agreements and employers' trade unions abide by the classifications for these authorised titles.

Many such titles have difficulties to be approved or equivalenced because they are not part of the university approach and a heated debate is currently taking place in France about the recognition of such titles.
They are usually recognised as level III (baccalauréat + 2 years) despite 3 full years of study, and such classification puts a limitation on further university studies (especially access to the master's degree).

Employments covered by such titles and training programmes represent the majority of jobs in our area and mostly cover the following functions:

- Nurse, health care aide
- Physiotherapist, occupational therapist, speech therapist, psychomotility therapist
- Social service assistant
- Special education teacher
- ….

3- <u>Ongoing training :</u>

There are a great many offers in the area of ongoing training in the medicosocial sector. Ongoing training also applies to many of the training programmes mentioned before and candidates can have access to the same titles as candidates coming from initial training. Only the status changes (students, job seekers on a training programme, worker on an ongoing training programme…). Ongoing training can have several objectives: qualification, securing of training path, adaptation to the job, etc…

The market and the organisation of ongoing training are regulated by Book IX (article L) of the Labour law, "of ongoing vocational training in the framework of lifelong vocational learning".

As for accreditations, the process is based on the aforementioned one through the RNCP system. But many ongoing training programmes are not part of the diploma-generating training system which would enable them to have access to a registered training.

Indeed such programmes and actions can be very short in time, with restricted objectives focused mostly on perfecting or specialising skills and will not get accreditation. Only a certificate of attendance can be delivered.

Training engineering deployed by those programmes can have several logics, one of which may consist in using the 8 levels identified in the EQF framework to identify the learning outcomes obtained if the training programme is not part of a diploma-generating approach. Unfortunately it is very difficult to have a detailed overview of such practices, given the extent of the French ongoing training market.

On the basis of a study carried out in WP2 on ongoing training systems existing in the area of specialised training programmes for the management of persons with ABI, our diagnosis allows us to conclude that none of the 22 listed training programmes takes into account the integration of the EQF standards, either because few were part of a university curriculum leading to a diploma, or because most of them met specific one-time needs for specialisation and were organised without knowing this possible framework.
This was an additional motivation for us to construct a programme with this requirement.

▶ **An alternative in specialisation: university diploma (DU)**

A University diploma (DU) is, in France, granted by a university, unlike the L/M/D which are national diplomas, granted by the state.
The DU covers a restricted area and is meant to be temporary or professional. Each university has authorisation to grant specific DUs. The access mode, the duration of studies, the assessment mode may vary according to the objective of the diploma. The DUs are organised by one university while DIU bring together several universities delivering the same training (often in different cities). They are not part of the L/M/D system and are managed locally, outside of the budget granted by the ministries (allocation par student), and their fees are similar to those of private sector ongoing training. They are many such diplomas in our area of activity.

The ministry of Higher education and Research has decided to register all university accreditations since they are considered as having a professional finality.

4. *FINDINGS AND RECOMMENDATIONS*

Given the impossibility to obtain national and mutual recognition of accreditations, and given the specific needs that the ABI programme must satisfy, the French partner does not consider to amend the programme or to change the reference document. This system is designed to provide the necessary specialisation in terms of:

- Adapting new employees to their functions in a multidisciplinary approach, which is a key for a good management of persons with ABI.
- Improving employability and professional mobility of the people with the lowest level of qualification of the sector.
- Improving the quality of care, especially trying to improve good treatment.
- Rising awareness of the general population about all players involved.

These orientations meet the objectives that may be pursued by vocational training as defined by Labour law and the social modernisation law, and the ABI system could be integrated into the training schemes of employing companies and disseminated widely through an integration strategy.

Such integration strategy will require to identify on the French territory institutions like Arceau Anjou, which can organise and deliver training and comply with the pilot project.

This means a thorough work is necessary on the criteria defining the quality of trainers and the quality of the organising institutions, which will have to have an authorisation as a training centre, on top of their medicosocial activity.

To date, we can break down France into 5 major regions: Ile de France (Paris region)/north-east/south-east/North-west/south-west, which allow for integration of the project through institutions of reference with a great experience in taking care of persons with ABI and with highly skilled employees.

To date, it is not realistic to connect this programme to an initial training institution, given the required expertise and the great variety of qualifications required for trainers. However, with integration in mind, we could offer specialised institutions and universities the expertise of the ABI programme in order to enhance employability and adaptation of job seekers coming from these curricula.

As a conclusion, for lack of a real accreditation capacity, we would like to increase the integration of the pilot project, in order to meet the needs in additional training expressed by employers, employees, and users (see results of WP 2).

8. AN INTEGRATION STRATEGY FOR FRANCE

As explained in the reports on the various steps of the project, the French team had to acknowledge a certain number of constraints which were not in favor of the implementation of the programme.

However, given:

- the existing an growing number of institutions working with ABI persons and the therefore growing need for training of professionals,
- the needs expressed by employers, users and professionals,
- the success of the pilot training session and the requests we have received since it was delivered,
- our organization , which comprises a training center approved by the Ministry of Health, Employment and Vocational training,
- our experience in disseminating training programmes resulting from European programmes…..
- the amendments made to the first programme, enabling it to exist side by side with the university and specialized trainings (DIUTC),
- the ability of our training teams to face the volume of requests for training,

We have decided to deliver the ABI training programme twice a year.

Two sessions have already been scheduled, and will be closely monitored in order to bring any required modification. Indeed, the session starting Nov.7, 2011 was designed on the basis of recommendations coming from the pilot programmes carried out in last April.

Some modifications have been made, and we still have to assess them.

- A slightly smaller group (ideally 12)
- More emphasis on practical situations in order to develop intervention strategies, and therefore a longer training (40hours)
- Organizing the programme in two separate periods, in order to allow the outcomes and skills to mature (especially on the part about medical and neuropsychological training/module 1 mostly)
- More information about the work to users' families.

Besides, we still think that we miss a specific training about the aging of disabled ABI persons, and we may add some input about this in the future, with the approval of the leader Zavod Zarja and of the partners.

This is why, during the first year of integration of the project (Nov. 2011- June 2012), we would like to invite our coordinator Mrs. Danielle Jagodic to participate in one of our sessions in order to work jointly on continuous improvement and to continue with the transfer and exchange of skills between France and Slovenia.

The current steps of the programme integration:

Month	Objectives	Activities
Sept. 11	***Finalize all the French versions of the supporting documents for the ABI training*** ***Review the educational material*** ***Develop new methodologies for the practical part of the training*** ***Finalize the administrative and financial conditions of access to the training***	• Translation and proof-reading • Fine-tuning of the educational material • Draft conventions
Oct. 11	***Make sure that the trainers have integrated the ABI guidelines as defined by the consortium*** ***Hire new trainers meeting the defined criteria*** ***Draft the training conventions*** ***Prepare the November training session***	• Train the ABI trainers on Oct. 7, 2011 • Recruit an ergonomist trainer specialized in job preservation and adaptation of the working environment for ABI persons. • Develop the administrative and financial supports in cooperation with the training center.
	Ensure the ongoing improvement and the compliance of the project	• General coordination and management of the project
	Gradually publicize the training offer	• Disseminate the training offer to the identified partners.
Nov. 2011	***Ensure good quality training***	• First ABI session outside of the project (Nov. 7, 8, 9 and 23, 24 , 25)
	Validate the improvements identified during the final phase of development.	• Set up an internal and external steering committee (ABI project team + a specialized doctor) • Report to the contractor on the basis of the evaluation documents defined by the consortium (see WP4 report)
Dec 2011	***Disseminate and valorize the programme***	• Update of the website • Dissemination to the target audience at country level, and not only local. • Conference to the Pays de la Loire Region brain injury network.

The purpose of this first period will therefore be:

- To keep the dynamics of the first two years of the project,
- To test the improvements decided during the last transnational meetings.
- To start a continuous improvement approach
- To train 12 more people and thus contribute to the dissemination of the project locally.

The next steps of integration:

The objective of these next steps is to consolidate the programme and to secure partnerships with employers and with higher education institutions wishing to offer a specialized training (universities, special education schools…). Depending on the demand, the project team will check if the chosen schedule (2 yearly sessions with 12 trainees) is relevant or if it should be revised. We also try to retain the team of trainers by enhancing discussions among the team members and officially recognizing the added value of their presence.

Month	Objectives	Activities
Jan 2012	***Continue the development of the validation tools necessary for the examinations on the basis of the previously agreed principles. Disseminate and valorize the programme.***	• Publish a newsletter about the results of the first training session and disseminate the training offer
Feb 2012	***Disseminate and valorize the programme.***	• Integrate the training modules into vocational training schemes.
Mar 2012	***Ensure a good quality training***	• Second national training session for 12 participants (March 5, 6, 7 and 14, 15, 16)
May 2012	***Evaluate the programme in order to fine-tune it Strengthen the continuation of cooperation with the first contractor and the exchange of competencies.***	• Steering and evaluation committee.

sept 2012	***Measure the impact of the training in work situations***	• Remote satisfaction survey with the participants of the 2 sessions • Evaluation of the impact of the training on employers in terms of skills acquired and demonstrated in the field.
Oct 2012	***Measure the impact of the training in work situations***	• report to the contractor on the basis of the evaluation supports defined in the consortium
Nov 2012	***Ensure a good quality training***	• third ABI session
Dec 2012	***Assess the system in order to make potential adjustments for 2013. Prepare the strategy for the dissemination of the offer***	• Steering and evaluation committee • Marketing.

9. REFERENCES

- LAMBERT A. (2011). ABI pilot training report France. http://www.abi-project.eu
- LAMBERT A. (2010). National Synthesis report on training needs France http://www.abi-project.eu
- LAMBERT A. (2010). transnational report on training needs http://www.abi-project.eu
- LAMBERT A. (2010). Report on national adaptations France http://www.abi-project.eu
- Projet EQF Network Testing : Point d'étape sur le référencement des niveaux de certifications du cadre national français vers le cadre européen Auteur: Groupe de travail français du projet. Novembre 2008 / www.eqfnet-testing.eu
- Loi de modernisation sociale: Loi n° 2002-73 du 17 janvier 2002 parue au JO n° 15 du 18 janvier 2002 / www.legifrance.gouv.fr
- Commission nationale de la certification professionnelle / www.cncp.gouv.fr